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Stephanie A. Navarro Silvera  
*Montclair State University*, silveras@montclair.edu

Meera Jain  
*University of Toronto*

Geoffrey R. Howe  
*Columbia University - Mailman School of Public Health*

Anthony B. Miller  
*University of Toronto*

Thomas E. Rohan  
*Albert Einstein College of Medicine*, thomas.rohan@einsteinmed.org

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Dietary carbohydrates and breast cancer risk: A prospective study of the roles of overall glycemic index and glycemic load

Stephanie A. Navarro Silvera1,8, Meera Jain1, Geoffrey R. Howe1, Anthony B. Miller2 and Thomas E. Rohan1

1Department of Epidemiology and Population Health, Albert Einstein College of Medicine, New York, NY, USA
2Department of Public Health Sciences, University of Toronto, Toronto, Canada
3Department of Epidemiology, Mailman School of Public Health, Columbia University, New York, NY, USA

We examined breast cancer risk in association with overall glycemic index (GI), glycemic load (GL), and dietary carbohydrate and sugar intake in a prospective cohort of 49,613 Canadian women enrolled in the National Breast Screening Study who completed a self-administered food frequency questionnaire between 1980 and 1985. Linkages to national mortality and cancer databases yielded data on deaths and cancer incidence, with follow-up ending between 1998 and 2000. During a mean follow-up of 16.6 years, we observed 1,461 incident breast cancer cases. GI, GL, total carbohydrate and total sugar intake were not associated with breast cancer risk in the total cohort. However, there was evidence of effect modification of the association between GI and breast cancer risk by menopausal status (p = 0.01), the hazard ratio for the highest versus the lowest quintile level of GI being 0.78 (95% CI = 0.52–1.16; p trend = 0.12) in premenopausal women and 1.87 (95% CI = 1.18–2.97; p trend = 0.01) in postmenopausal women. The associations between GI and GL were not modified by body mass index (BMI) or by vigorous physical activity among pre- or postmenopausal women. Similarly, the associations between GI/GL and risk in postmenopausal women were not modified by BMI, vigorous physical activity, or ever use of hormone replacement therapy (HRT), although the associations were slightly stronger among those who reported no vigorous physical activity (p trend = 0.02), among those who reported ever using HRT (p trend = 0.02) and among normal-weight women (BMI < 25 kg/m2; p trend = 0.03). Our data suggest that consumption of diets with high GI values may be associated with increased risk of breast cancer among postmenopausal women, possibly more so among subgroups defined by participation in vigorous physical activity, ever use of HRT and those who are not overweight.

Key words: breast neoplasms; glycemic index; glycemic load; prospective cohort; National Breast Screening Study (NBSS)

Material and methods

Study population

The study, which has been described in detail elsewhere,17 was conducted among participants in the Canadian National Breast Screening Study (NBSS), a randomized controlled trial of screening for breast cancer.18 A total of 89,835 women aged 40–59 years were recruited into the trial between 1980 and 1985.

Questionnaires

At recruitment into the study, participants completed a self-administered questionnaire that sought information on demographic characteristics, lifestyle factors, menstrual and reproductive history, as well as use of oral contraceptives and replacement estrogen. Starting in 1982 (that is, after some participants had completed their scheduled visits to the screening centers), a self-administered food frequency questionnaire (FFQ) was distributed to all new attendees at all screening centers and to women returning to the screening centers for rescreening.19 The FFQ sought information on usual portion size and frequency of consumption of 86 food items and included photographs of various portion sizes to assist respondents with quantifying intake. A comparison between the self-administered questionnaire and a full interviewer-administered questionnaire, which has been subjected to both validity and reliability testing19 and used in a number of epidemiologic studies,20 revealed that the 2 methods gave estimates of intake of the major macronutrients and dietary fiber that were moderately to strongly correlated with each other (reported correlation coefficients ranged from 0.47 to 0.72).19 A total of 49,613 dietary questionnaires were returned and available for analysis.

Calculation of nutrient intake, overall glycemic index and glycemic load

Data from the completed self-administered food frequency questionnaires were used to estimate daily intake of nutrients using a database for Canadian foods that has been described elsewhere.20 Data from the food frequency questionnaire were also used to estimate overall glycemic index and glycemic load. Glycemic index values of foods were obtained from published reports based on studies in North America.4 Overall glycemic index was calculated by multiplying the carbohydrate content (in grams) of a given food item by the number of servings per day of that food item and its glycemic index value, summing all food items and including photographs of various portion sizes to assist respondents with quantifying intake. A comparison between the self-administered questionnaire and a full interviewer-administered questionnaire, which has been subjected to both validity and reliability testing19 and used in a number of epidemiologic studies,20 revealed that the 2 methods gave estimates of intake of the major macronutrients and dietary fiber that were moderately to strongly correlated with each other (reported correlation coefficients ranged from 0.47 to 0.72).19 A total of 49,613 dietary questionnaires were returned and available for analysis.

Glycemic index (GI) is a means of classifying the carbohydrate content of individual foods according to their postprandial glycemic effects and hence their effects on blood insulin levels.1–3 Using glycemic index values and the carbohydrate content of foods, the total glycemic effect of the diet (glycemic load) can be estimated.4 Consumption of high GI diets has been associated with hyperinsulinemia,1–4,5 while low GI diets have been shown to be strongly correlated with each other (reported correlation coefficients ranged from 0.47 to 0.72).19 A total of 49,613 dietary questionnaires were returned and available for analysis.

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*Correspondence to: Department of Epidemiology and Population Health, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Room 1301, New York, NY 10461. Fax: +1-718-430-8653. E-mail: ssilvera@acem.yu.edu

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from white bread (depending on the standard used). When the reported glycemic index values for foods were observed to vary across studies, we used the mean of the reported values of glycemic index for that food. The main foods contributing to glycemic load in the cohort are listed in a footnote to Table I.

Ascertainment of incident breast cancer cases and deaths

Cases were women who were diagnosed during follow-up with incident breast cancer, ascertained by means of computerized record linkage to the Canadian Cancer Database. Deaths were ascertained by means of record linkage to the National Mortality Database. Both of these databases are maintained by Statistics Canada. The linkages to the databases yielded data on cancer incidence and mortality to 31 December 2000 for women in Ontario, 31 December 1998 for women in Quebec and 31 December 1999 for women in other provinces in Canada. Among the women for whom dietary data were available, we identified 1,461 incident breast cancers.

Statistical analysis

Of the 49,613 women with dietary data, we excluded women with extreme energy intake values (at least 3 standard deviations above or below the mean value for log energy intake; n = 502). These exclusions left 49,111 women available for analysis, among whom there were 1,450 incident cases of breast cancer. Cox proportional hazards models (using age as the time scale) were used to estimate hazard ratios (HRs) and 95% confidence intervals (CIs) for the association between energy-adjusted quintile levels of glycemic load, overall glycemic index, total carbohydrates and total sugar, as well as breast cancer risk; energy adjustment was performed using the residual method. For these analyses, cases contributed person-time to the study from their date of enrollment until the date of diagnosis of their breast cancer, and noncases contributed person-time from their date of enrollment until the termination of follow-up (the date to which cancer incidence data were available for women in the corresponding province) or death, whichever occurred earlier. Multivariate models included the variables listed in the footnote of Table II. To test for trend, we fitted the median value of each quintile as an ordinal variable in the risk models and evaluated the statistical significance of the coefficient using the Wald test. We examined the associations overall and within strata defined by menopausal status. Women who reported having regular menstrual periods within the past 12 months or who had had a hysterectomy without bilateral oophorectomy and were less than 45 years of age were classified as premenopausal. Women whose menstrual periods ceased prior to 12 months before baseline, those who had had a bilateral oophorectomy and those who had had a hysterectomy and were over 55 years of age were considered postmenopausal. In addition, the associations overall and within menopausal strata were examined further within subgroups defined by body mass index (defined as weight (kg)/height (m²)); weight and height were measured at baseline[25], self-reported vigorous physical activity (defined as jogging, running, brisk walking, vigorous sport, bicycling, heavy housework, etc.) and use of hormone replacement therapy (ever vs. never). Given the relatively small number of cases within each stratum of pre- and postmenopausal women, we categorized overall glycemic index and glycemic load by quartiles for the latter analyses. Stratum-specific multivariate models included the variables listed in a footnote in Table III. Interaction effects were tested independently of each other such that in the analysis of interaction with BMI, physical activity and HRT use were controlled for; in the analysis of interaction with physical activity, BMI and HRT use were controlled for; and in the analysis of interaction with HRT use, BMI and physical activity were controlled for. Tests for interaction were based on likelihood ratio tests comparing models with and without product terms representing the variables of interest. Use of the life test procedure in SAS showed that the proportional hazards assumption was met in this data set. All analyses were performed using SAS version 9 (SAS Institute, Cary, NC).

Results

The average duration of follow-up for cohort members was 16.6 years, corresponding to a total of 811,649 person-years of follow-up for the cohort. The mean age at diagnosis for the cases was 54.8 ± 6.5 years. For the cohort as a whole, the mean ± SD of the energy-adjusted overall glycemic index and glycemic load were 74.6 ± 12.2 and 144.5 ± 42.5 g/day, respectively. There was a

### TABLE I - AGE-ADJUSTED BASELINE DISTRIBUTIONS OF BREAST CANCER RISK FACTORS BY QUINTILES OF ENERGY-ADJUSTED GLYCEMIC LOAD

<table>
<thead>
<tr>
<th>Quintiles of energy-adjusted glycemic load (g/day)</th>
<th>&lt;119</th>
<th>120–139</th>
<th>140–155</th>
<th>156–175</th>
<th>&gt;175</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean overall glycemic index</td>
<td>72.5 (53.7)±1</td>
<td>78.4 (53.6)</td>
<td>79.7 (53.6)</td>
<td>81.7 (53.7)</td>
<td>84.3 (53.7)</td>
</tr>
<tr>
<td>Mean glycemic load (g/day)</td>
<td>98.6 (28.7)</td>
<td>129.5 (28.7)</td>
<td>147.2 (28.7)</td>
<td>164.5 (28.7)</td>
<td>196.0 (28.7)</td>
</tr>
<tr>
<td>Mean total carbohydrates (g/day)</td>
<td>149.8 (137.9)</td>
<td>179.0 (137.8)</td>
<td>198.6 (137.8)</td>
<td>216.6 (137.8)</td>
<td>253.9 (137.9)</td>
</tr>
<tr>
<td>Mean total sugar (g/day)</td>
<td>58.7 (73.3)</td>
<td>71.6 (73.2)</td>
<td>79.6 (73.2)</td>
<td>86.3 (73.2)</td>
<td>103.0 (73.3)</td>
</tr>
<tr>
<td>Mean total fiber (g/day)</td>
<td>17.4 (14.3)</td>
<td>20.0 (14.3)</td>
<td>21.2 (14.3)</td>
<td>22.1 (14.3)</td>
<td>23.2 (14.3)</td>
</tr>
<tr>
<td>Mean energy intake (kcal/day)</td>
<td>2106 (1442)</td>
<td>2027 (1441)</td>
<td>2046 (1441)</td>
<td>2059 (1441)</td>
<td>2121 (1441)</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>48.1 (5.5)</td>
<td>48.4 (5.5)</td>
<td>48.5 (5.7)</td>
<td>48.8 (5.7)</td>
<td>48.9 (5.7)</td>
</tr>
<tr>
<td>Postmenopausal at baseline (%)</td>
<td>18.0</td>
<td>19.4</td>
<td>19.8</td>
<td>21.1</td>
<td>21.9</td>
</tr>
<tr>
<td>Mean BMI (kg/m²)</td>
<td>25.2 (10.2)</td>
<td>25.1 (10.2)</td>
<td>24.7 (10.2)</td>
<td>24.6 (10.2)</td>
<td>24.3 (10.2)</td>
</tr>
<tr>
<td>Ever smoker (%)</td>
<td>24.9</td>
<td>21.7</td>
<td>19.3</td>
<td>17.8</td>
<td>16.4</td>
</tr>
<tr>
<td>Mean alcohol intake (g/day)</td>
<td>16.1 (28.0)</td>
<td>10.0 (27.9)</td>
<td>7.6 (27.9)</td>
<td>5.5 (27.9)</td>
<td>3.6 (27.9)</td>
</tr>
<tr>
<td>Some vigorous physical activity (%)</td>
<td>18.8</td>
<td>20.5</td>
<td>20.8</td>
<td>21.0</td>
<td>19.1</td>
</tr>
<tr>
<td>Age at menarche ≤ 12 years (%)</td>
<td>20.8</td>
<td>20.7</td>
<td>20.4</td>
<td>19.4</td>
<td>18.8</td>
</tr>
<tr>
<td>Mean duration of oral contraceptive use (months)</td>
<td>37.6 (108.6)</td>
<td>35.7 (108.6)</td>
<td>33.8 (108.6)</td>
<td>32.0 (108.6)</td>
<td>28.3 (108.6)</td>
</tr>
<tr>
<td>Mean duration of hormone replacement therapy use (months)²</td>
<td>14.4 (85.3)</td>
<td>13.5 (85.2)</td>
<td>13.1 (85.2)</td>
<td>12.6 (85.2)</td>
<td>13.7 (85.2)</td>
</tr>
<tr>
<td>Mean number of live births</td>
<td>2.6 (6.1)</td>
<td>2.6 (6.1)</td>
<td>2.6 (6.1)</td>
<td>2.6 (6.1)</td>
<td>2.6 (6.1)</td>
</tr>
<tr>
<td>First-degree relative with breast cancer (%)</td>
<td>20.0</td>
<td>19.8</td>
<td>20.5</td>
<td>20.5</td>
<td>19.3</td>
</tr>
<tr>
<td>Age at first birth</td>
<td>23.8 (10.5)</td>
<td>24.2 (10.4)</td>
<td>24.4 (10.4)</td>
<td>24.5 (10.4)</td>
<td>24.6 (10.5)</td>
</tr>
</tbody>
</table>

*The main foods contributing to glycemic load in the cohort include white bread (sliced), rolls, muffins, potatoes (baked, boiled, mashed), French fries, cakes, cookies, rice, pasta, pizza, cold breakfast cereals, pies and tarts, cola, other soft drinks, citrus fruits and juices and other fruits, crisp snacks (such as potato chips or popcorn), candy, chocolate, peas, beans and lentils, hot breakfast cereals, dark and whole grain breads, corn, root vegetables other than potatoes, jam, jelly and honey, sugar in tea or coffee, icecream, peanut butter. Numbers in parentheses represent the standard deviation. Among postmenopausal women only. 

...
Glycemic load (g/day) | Cases/person-years | Hazard ratio (95% CI)
---|---|---
< 119 | 297/163,012 | 1.0 (referent)
120–139 | 285/162,580 | 0.95 (0.80–1.13)
140–155 | 300/162,186 | 1.03 (0.87–1.22)
156–175 | 286/162,307 | 1.00 (0.84–1.19)
> 175 | 282/161,563 | 1.00 (0.84–1.18)

*p for trend | 0.84 | 0.70
Overall glycemic index | | |
< 60 | 293/161,898 | 1.0 (referent)
61–71 | 307/162,474 | 0.99 (0.81–1.21)
72–81 | 281/162,182 | 0.91 (0.72–1.15)
82–96 | 287/162,623 | 0.93 (0.71–1.22)
> 96 | 282/162,471 | 0.88 (0.64–1.21)

*p for trend | 0.41 | 0.38
Total carbohydrate (g/day) | | |
< 143 | 284/162,780 | 1.0 (referent)
144–175 | 302/162,771 | 1.11 (0.93–1.37)
176–206 | 265/162,475 | 0.92 (0.76–0.96)
207–249 | 323/162,366 | 1.18 (0.97–1.43)
> 249 | 276/161,257 | 1.01 (0.79–0.93)

*p for trend | 0.67 | 0.86
Total sugar (g/day) | | |
< 52 | 284/162,201 | 1.0 (referent)
53–68 | 284/162,631 | 1.02 (0.86–1.22)
69–83 | 315/162,812 | 1.14 (0.96–1.36)
84–103 | 291/162,443 | 1.08 (0.89–1.30)
> 103 | 276/161,562 | 1.00 (0.81–1.24)

*R for Trend | 0.74 | 0.38

2-fold variation in mean glycemic load values between the lowest and highest quintile levels (Table I).

Compared to those with relatively low glycemic load values, women with high glycemic load values reported lower alcohol consumption, were less likely to have ever smoked, had a shorter mean duration of oral contraceptive use, had a longer mean duration of hormone replacement therapy, and consumed more total carbohydrates, sugar, and fiber (Table I). No appreciable variation was observed in mean energy intake, participation in vigorous physical activity, parity, or age at first birth by quintile levels of glycemic load. The patterns for overall glycemic index were similar to those for the glycemic load (data not shown).

Table II shows that in age- and energy-adjusted models, there was no association between glycemic load, overall glycemic index, total carbohydrate, or total sugar intake and risk of breast cancer. After multivariate adjustment, the hazard ratios remained essentially unchanged.

Risk of breast cancer associated with glycemic load differed little between premenopausal and postmenopausal women. However, there was some suggestion of effect modification of the association between overall glycemic index and breast cancer risk by menopausal status (Table III). Among premenopausal women, the highest versus the lowest quartile level of overall glycemic index was associated with a 22% reduction in risk (95% CI = 0.52–1.16; *p* = 0.12), while among postmenopausal women, the highest versus the lowest quartile level of overall glycemic index was associated with an 87% increased risk of breast cancer (95% CI = 1.18–2.97; *p* = 0.01). On formal testing, the interaction between overall glycemic index and menopausal status was statistically significant (chi-square (3) = 12.05; *p* = 0.01). There was no association between total sugar intake and breast cancer risk among pre- or postmenopausal women (*p* = 0.74 and 0.19, respectively; data not shown). Likewise, total carbohydrate consumption was not associated with risk among either pre- or postmenopausal women (*p* = 0.73 and 0.58, respectively; data not shown).
shown). On formal testing, menopausal status did not modify the association between either total sugar intake [chi-square (3) = 2.34; p = 0.50] or total carbohydrate consumption [chi-square (3) = 2.94; p = 0.40] and breast cancer risk.

Within the total study population, there was no evidence of effect modification of the association between glycemic load and overall glycemic index and breast cancer risk by BMI or vigorous physical activity (data not shown). Likewise, Table IV shows that the associations between glycemic load and overall glycemic index and breast cancer risk among premenopausal women were not modified by BMI or vigorous physical activity. In addition, BMI and participation in vigorous physical activity did not modify the association between either total sugar intake or total carbohydrate intake and breast cancer risk (data not shown).

Table V shows the associations between glycemic load and overall glycemic index and breast cancer risk among postmenopausal women, stratified by BMI, participation in vigorous physical activity and HRT use. As with premenopausal women, the association between glycemic load and breast cancer risk among postmenopausal women did not appear to be modified by any of these variables. With respect to overall glycemic index, the highest versus lowest quartile level was associated with increased risk among both overweight/obese (HR = 1.57; 95% CI = 0.78–3.13; p trend = 0.25) and normal weight postmenopausal women (HR = 1.99; 95% CI = 1.06–3.72; p trend = 0.03). As well, among women who participated in vigorous physical activity, the highest versus lowest quartile level of overall glycemic index was associated with a 78% increase in risk (95% CI = 0.76–4.18; p trend = 0.26), while a hazard ratio of 1.86 (95% CI = 1.07–3.21; p trend = 0.02) was observed for the highest versus the lowest quartile level among postmenopausal women who did not participate in any vigorous physical activity. Furthermore, among ever users of HRT, the highest versus lowest quartile level of overall glycemic index was associated with a 2.2-fold increased risk of breast cancer (95% CI = 1.16–4.00; p trend = 0.02), whereas among never users, there was a 58% (95% CI = 0.79–3.18; p trend = 0.27) increased risk of breast cancer at the uppermost quartile level. There was no statistical evidence for interactions between overall glycemic index and BMI [chi-square (3) = 2.01; p = 0.57], participation in vigorous physical activity [chi-square (3) = 2.10; p = 0.55], or HRT use [chi-square (3) = 2.09; p = 0.55] in relation to breast cancer risk among postmenopausal women. Similarly, the associations between total sugar intake and total carbohydrate intake and risk of breast cancer did not appear to be modified by BMI, participation in vigorous physical activity, or HRT use among postmenopausal women (data not shown).

### Discussion

High glycemic index diets are associated with increased insulin secretion, which may affect breast cancer risk by several mechanisms, including alteration of cell cycle kinetics (insulin facilitates the transit of cells through the G1 phase of the cell cycle), inhibition of apoptosis and elevation of plasma estrogen levels via lower production of sex hormone-binding globulin.

In the prospective study reported here, there was no association between overall glycemic index or glycemic load and breast cancer risk over a 16-year follow-up period in the total study population. Likewise, no association was found between either total sugar or total carbohydrate intake and risk of breast cancer. There was some suggestion of increased risk in association with overall glycemic index among women who were postmenopausal at baseline, while statistically nonsignificant reductions in risk were observed at each level of overall glycemic index (above that for the reference category) among premenopausal women. The differences between pre- and postmenopausal women were characterized further upon stratification by body mass index (kg/m²) and participation in vigorous physical activity, wherein small, statistically nonsignificant decreases in risk were observed in association with glycemic load and overall glycemic index within strata of BMI and participation in vigorous physical activity among premenopausal women, and positive associations were found within strata of BMI and vigorous physical activity in postmenopausal women. In postmenopausal women, there were also increased risks observed in relation to HRT use. There is some suggestion that the associations were slightly stronger among women who had ever used HRT and those who never participated in vigorous physical activity, but there was no statistical evidence of effect modification by these variables.

In our study population, glycemic load was not associated with risk, whereas overall glycemic index was associated with breast cancer risk within specific subgroups. In trying to understand these differences, it is important to note that these indexes reflect slightly different characteristics of dietary carbohydrate intake. Overall glycemic index provides information on overall carbohydrate quality in the diet by comparing the effect of isoenenergetic intakes of carbohydrate, while total dietary glycemic load, by taking into account the amount of carbohydrate consumed, provides information on both the quality and quantity of total dietary carbohydrate intake. This, while the study participants who developed breast cancer may have consumed a wider variety of high glycemic index foods (and thus had a poorer-quality diet with respect to carbohydrate) in comparison to women who did not develop breast cancer during follow-up, they may not have consumed these foods in a way that would have been reflected in the glycemic load index.
large enough quantities for glycemic load to have an effect on breast cancer risk.

Given that high body mass index and lack of physical activity are generally associated with increased fasting insulin and decreased insulin sensitivity, women who are obese or who do not participate in physical activity may have a more pronounced insulin response to foods with higher glycemic values. Further, high glycemic value diets are associated with increased fasting insulin and decreased insulin sensitivity, women who are obese or who do not participate in physical activity may have a more pronounced insulin response to foods with higher glycemic values. Further, high glycemic value diets are associated with increased fasting insulin and decreased insulin sensitivity, women who are obese or who do not participate in physical activity may have a more pronounced insulin response to foods with higher glycemic values. 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Further, high glycemic value diets are associated with increased fasting insulin and decreased insulin sensitivity, women who are obese or who do not participate in physical activity may have a more pronounced insulin response to foods with higher glycemic values. Further, high glycemic value diets are associated with increased fasting insulin and increased physical activity and hormone replacement therapy use

<table>
<thead>
<tr>
<th>BMI (kg/m²)</th>
<th>Visceral fat activity</th>
<th>Hormone replacement therapy use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases/person years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glycemic load (g/day)</td>
<td>None</td>
<td>Some</td>
</tr>
<tr>
<td>&lt; 125</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>125–147</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>148–169</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>&gt; 169</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>Overall glycemic index</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 63</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>64–76</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>77–92</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
<tr>
<td>&gt; 92</td>
<td>1.0 (referent)</td>
<td>1.0 (referent)</td>
</tr>
</tbody>
</table>
| Multivariable models included age (age at baseline), BMI in kg/m² (<25, 25–29, ≥30), alcohol (zero plus for levels of intake), use of hormone replacement therapy (never plus four levels of duration), use of oral contraceptives (never plus four levels of duration), parity (zero plus 3 levels), age at menarche (<12 vs. ≥12 years of age), age at first live birth (<23, 25–29, ≥30), first degree relative with breast cancer (yes/no), history of benign breast disease (yes/no), intake of energy (as a continuous variable), energy-adjusted total fiber intake (as a continuous variable), study center and randomization group. Three of the previous studies also examined dietary carbohydrate and/or dietary sugar intake in relation to breast cancer risk.
overall glycemic index might be associated with increased risk among women who are postmenopausal, perhaps more so among those who do not participate in vigorous physical activity or who have ever used HRT. However, these observations require confirmation in other studies.

References


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SILVERA