The Negative Correlation of Spice Intake and Colorectal Cancer: A Statistical Analysis of Global Health Databases

Shinjit Mani,¹ Nathan Pramanik,¹ Deeksha Rao,¹ Stuti Sharma,¹ Timur R. Akhmetov.²

Abstract

Background: Colorectal Cancer (CRC) has multiple risk factors and depends highly on diet. Positive associations of red meat and processed meat intake and CRC have been proven, but no research has been conducted on the relation of spice intake and CRC risk. Various in-vitro studies have demonstrated the anticancer activity of chemicals present in spices, which is the main driving force for our statistical analysis. Methods: We analyzed Global Burden of Disease (GBD) database, Food and Agricultural Organization of United Nations (FAO) database, and Global Dietary Database (GDD) using Pearson correlation statistics to find any significant correlation, mainly between spice intake and CRC risk. Data from 1990 to 2013 of 100 countries was collected for the analysis. Twenty-three-year average values (±SD) were calculated for CRC risk, spice, red meat, processed meat, vegetable, and fruit intake. CRC risk is taken as dependent variable whereas all other were independent variables. All variables were analyzed using Pearson correlation analysis. Results with p<0.05 were further analyzed using regression analysis. Results: Pearson correlation showed that spice intake had a significant negative correlation (r= -0.301, p=0.002) whereas red meat (r= 0.722, p<0.001) and processed meat (r= 0.339, p<0.001) had a significant positive correlation with CRC risk. Conclusion: Significant negative correlation between spice intake and CRC risk indicates that higher spice intake can be preventive against cancer and possibly decrease the risk of colorectal cancer in populations with higher CRC risk.

Key Words: Spices; Colorectal Cancer; Red Meat (Source: MeSH-NLM).

Introduction

Colorectal Cancer (CRC) is the second most prevalent cancer in the world both in males and females according to the Global Burden of Disease database.¹ The highest prevalence is seen among countries in Europe, North America, and West Pacific region.² Such global distribution is related to the fact that CRC risk is highly dependent on dietary factors. Red meat is defined as “Meat from mammals”, and processed meat is defined as “Meat preserved by smoking, curing or salting, or adding of chemical preservatives”.³ The positive relation between red meat and processed meat intake and CRC has already been proven.⁴ Polycyclic aromatic hydrocarbons, heterocyclic aromatic amines, and N-nitroso compounds are carcinogens found to be present in red meat and processed meat are responsible for the malignant transformation of glandular epithelial cells, which line the colon and rectum.⁵ Some studies suggested positive impact of vegetable and fruit intake to detox the risk of CRC.⁶ But the studies that were done so far to explore the relation of spice intake with CRC have shown conflicting results.⁷ ⁸ ⁹

Spices are defined as “Aromatic vegetable substances, used to give special flavor to food”.⁴ Some studies have shown high spicy food intake is related to an increased CRC risk,¹⁰ ¹¹ whereas other in-vitro studies explored the possibility of finding novel active biochemical substances with cancer preventive actions in spices.¹² ¹³ It was found that polyphenols are abundant in spices.¹⁴ Polyphenols are known to prevent carcinogenesis by inhibiting cytochrome P450, which prevents DNA damage by various mechanisms such as direct radical scavenging and modulation of phase II metabolizing enzymes, and can also induce mechanism of apoptosis in the event of DNA damage.¹⁵ ¹⁶ ¹⁷ Gingerol (Ginger) and Thumoquinone (Black cumin/ Nigelia Sativa) are other types of polyphenols that have chemoprotective actions, which are currently being explored by researchers. Thymoquinone is known to upregulate the miR-34a and downregulate Rac1 expression, decreases NF-κB and IκBα phosphorylation, and can decrease the activity of ERK1/2 and P38.¹⁸ Gingerol, on the other hand, shows anti proliferative, cytotoxic, and antimutator activity by regulating various cellular mechanisms, such as Bax/Bcl2, TNF-α, NF2, p65/NF-κB, SAPK/JNK, caspases-3, caspase-9, and p53.¹⁹ ²⁰ ²¹ Turmeric is a spice extensively used in curries, which contains at least 25 active chemical substances, such as Curcumine and Turmerone, that have antioxidant, neuroprotective, cytotoxic, anti-inflammatory, antiangiogenic, antitumor activities.²² ²³ Among all these, Curcumine is one of the most effective bioactive substance studied extensively so far. Curcin can induce apoptosis in response to cell damage by various mechanisms such as downregulating COX-2, NF-κB, P38-JNK, and by upregulating DR4, Fas ligand, P53, P38.²⁴ ²⁵ It also inhibits metastasis by microRNA expression regulation, and an autophagy modulator by itself.²⁶ ²⁷ Other than that, coriander and cinnamon were also found to have anticancer activities.²⁸ ²⁹ Among the spices, Capsaicin is an exception, which is known to be tumorogenic. Capsaicin is widely found in paprika, pimento, chili, jalapenos. The carcinogenic properties are mediated through EGFR and TRPV1 pathway, to increase COX2 and induce inflammation.³⁰ Arguably, a low to moderate dose of capsaicin showed anticancer activity is some preclinical studies,³¹ ³² thus the results are conflicting.
In real world data, South Asian countries with high spice intake were seen to have lesser rates of CRC. For this to be true, spice intake should have some protective effect against CRC. However, no research has been conducted on the relation of spice intake and CRC on a global scale. The contrast between research data and real-world data, and the results of previous in-vitro studies were the driving force behind this statistical analysis. Thus, we collected data from three global health databases on CRC incidence per 100,000 and five possible dietary factors, which may be responsible to modify the risk of CRC, and analyzed them to gain a global perspective of the CRC risk and its relation to diet. The aim of the analysis was to determine if there was a significant correlation between the selected dietary factors and CRC risk.

**Methods**

In total, three databases were considered for this analysis, the Global Burden of Disease (GBD) database for data on CRC, Food and Agricultural Organization of United Nations (FAO) database, and Global dietary database (GDD). Out of 195 countries, data from 100 countries was used. We excluded the countries listed in Low Income Food Deficit Countries (LIFDC) by Food and Agricultural Organization of United Nations (n=52), and also the low and lower-middle income countries as per World Bank Criteria (n=40). Further, the countries with incomplete data were excluded (n=3). This resulted in 100 countries for statistical analysis, as shown in Figure 1A. This analysis considers populations of all ages and both males and females. A total of 95 countries (mainly LIFDC, low and lower-middle income countries) were excluded from the analysis because they had extremely low intake of the dietary factors that were selected for analysis. Including such countries with very low intake of all dietary components carries the risk of a bias in the results. Thus, the above-mentioned criteria were used to exclude LIFDC and low and lower-middle-income countries (Figure 1A).

We included data from 1990 to 2013 for CRC incidence and all dietary factors except for the processed meat intake, for which data was only available for the years 1990, 2005, and 2010 from GDD. The five dietary factors which included were spice, red meat, processed meat, vegetable and fruit intake (Figure 1B). Data for all dietary factors (except processed meat) was collected from the food balance sheet of FAO database. The unit for food intake was “kilogram per annum” as shown in Figure 1C. Data on three categories of spices were available on FAO database i.e. ‘Paprika’, ‘Pimento’, ‘Others’. Out of these 3 categories we took only the data from the category ‘Others’. For data on ‘Paprika’ and ‘Pimento’ was excluded from the analysis because they had extremely low intake of the dietary factors that were selected for analysis. Including such countries with very low intake of all dietary components carries the risk of a bias in the results. Thus, the above-mentioned criteria were used to exclude LIFDC and low and lower-middle-income countries (Figure 1A).

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We used IBM SPSS statistics v23 for all statistical analysis. Histograms with normal distribution curves were used to visualize the data distribution of all dietary factors. Boxplots were used to compare the data distribution among the variables. Average annual risk (%) of CRC was the dependent variable and the rest were taken as independent variables. All the variables were analysed using Pearson correlation analysis. A 95% CI of the Pearson correlation coefficient was calculated according to the formula of Fisher's transformation. Scatter-dot plot was used to visualise the correlation statistics, using trend line and 95%CI of the correlation. The correlation results with p<0.05 were then analysed using forward and backward regression analysis for further confirmation. The data was also analysed using partial correlation analysis to determine any possible dependency between independent variables.
The Negative Correlation of Spice Intake and Colorectal Cancer: A Statistical Analysis of Global Health Databases

Results

Overall, the result shows the dynamics of CRC risk and food intake along with their correlation. Figure 2A describes the data on red meat and processed meat on the background of CRC incidence rate per 100,000. There was higher red meat consumption among the countries with higher CRC incidences, such as Germany (81.24 per 100000; 60.93 kg/annum), New Zealand (78.36 per 100000; 73.73 kg/annum), Denmark (72.38 per 100000; 66.88 kg/annum) with exceptions such as Croatia (65.91 per 100000; 37.16 kg/annum), and Bulgaria (51.16 per 100000; 37.86 kg/annum). Some of the countries with low CRC incidence were found to have higher red meat intake, which is similar to the countries with high CRC risk, i.e. Paraguay (6.34 per 100000; 55.21 kg/annum), Samoa (6.46 per 100000; 44.57 kg/annum), Brazil (10.76 per 100000; 46.54 kg/annum). The reverse is also observed in the case of Japan, where the red meat and processed meat intake is relatively less (28.18 kg/annum; 2.83 kg/annum) with the highest CRC incidences (82.71 per 100000) among all the 100 countries. A positive was also observed between processed meat intake and CRC incidences. However, some countries such as Panama (11.46 per 100000; 21.79 kg/annum), Colombia (9.94 per 100000; 18.95 kg/annum), and Costa Rica (14.4 per 100000; 17.93 kg/annum) had higher processed meat intake but decreased CRC risk. Overall, the trend for both red meat and processed meat consumption is positive with increasing CRC incidence. The data plot in Figure 2B shows most of the countries with higher CRC incidences consume low spice i.e. Germany (81.24 per 100000; 0.24 kg/annum), Italy (77.70 per 100000; 0.025 kg/annum), Czech Republic (76.8 per 100000; 0.065 kg/annum), and the opposite was seen with the countries with low CRC incidences, with some exceptions, such as Iraq (3.21 per 100000; 0.034 kg/annum), Belize (5.34 per 100000; 0.007 kg/annum), Dominican Republic (6.51 per 100000; 0.029 kg/annum) and Gabon (6.90 per 100000; 0.057 kg/annum). Altogether, there is an inverse relation between spice consumption and CRC incidence. The data plot on vegetable and fruit intake is not shown, as the correlation inverse relation between spice consumption and CRC incidence. The data showed the model fit or R^2 for red meat was highest (R^2=0.596) followed by processed meat (R^2=0.111) and spice intake (R^2=0.091). In forward and backward regression analysis (data not shown) we found that the predictive power of CRC risk is highest in “Average Red Meat Intake”. The partial correlation (Table 3) was conducted to answer the question of interdependence of the dietary factors. As the results show,
“Average Red Meat Intake” had a significant positive partial correlation to CRC (0.727, p<0.001), while “Average Processed Meat Intake” (-0.035, p=0.735) and “Average Spice Intake” (-0.043, p=0.675) had no significant partial correlation.

**Discussion**

It is worth mentioning that the negative correlation between spice intake and CRC is a novel finding. The positive correlation of red meat and processed meat with CRC is in agreement with previous studies. Different research has shown conflicting results regarding vegetable consumption and fruit consumption and their effect on CRC, where some showed a negative relation, others denied any relation at all. In our research, we did not find any significant correlation. Data on spice intake shows high positive skewness with mode value much less than mean value, this confirms that the majority of the countries have less than average spice intake. Model fit (R²) plays a major role in the

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**Figure 4.** Statistical Analysis of Data Sets. A-E. Histogram showing the normal distribution and the skewness of the data. F. Boxplots to compare between different dietary intake factors. G-K. Dot plot distribution, visualization of correlation analysis with 95%CI along with the corresponding boxplots.
forward and backward regression, which explains the decreased predictive power by “Average Processed Meat Intake” and “Average Spice Intake”. As per the data on partial correlation, red meat intake is found to be the major cause of CRC irrespective of the processed meat and spice intake, while processed meat intake has no significant influence on CRC by itself. And most importantly, spice intake does not influence CRC risk alone, the significant negative correlation is seen when red meat intake is considered. In conclusion, our results indicate that spice intake can have a beneficial effect among the population with high red meat intake, which may decrease the risk of CRC in the long term, but vegetable and fruit intake may not have any additional benefit to deter CRC risk. This new finding in this analysis agrees with the preclinical studies that demonstrated the anticancer properties of various spices.13,14

It is important to mention the limitations of this analysis. In the FAO database, there was no mention of any particular spices in the category ‘others’, which compromises the accuracy of the results to some extent. The other two categories ‘Paprika’ and ‘Pimento’ were not taken into the analysis. Previous studies suggested that high amounts of spicy food that are rich in chilies may cause chronic inflammation in gastrointestinal tract and in long term can trigger cancer, with some conflicting results claiming capsaicin in low doses can have anti-cancer activities.25,26 Due to these conflicting results we did not consider ‘Paprika’ and ‘Pimento’ for the analysis. Recent data for every country as not available. Data of food intake later than the year 2013 was not available in FAO database, thus we took the data from 1990 to 2013 for our analysis. The GDD had the data only for the year 1995, 2005, 2010. These three years of data was used in calculation of processed meat intake, which may have limited the accuracy of the analysis. With more accurate data and a larger sample size the model fit of the data can be improved and enhance accuracy.

The risk of cancer can vary from population to population, depending on multiple factors from behavioral to biological. For instance, this is seen in Japan where despite high spice intake and low red meat intake, there is higher CRC risk, possibly due to their genetic predisposition for gastrointestinal cancer. This contrasts with Europe and North America, where high CRC risk is largely due to unhealthy dietary pattern containing high red meat.25

Thus, studies conducted within a particular population may not provide an exact picture of a disease or treatment. Therefore, an analysis using global databases is important. In recent years, global health has become an important topic of discussion. It is important to view disease as a global issue which needs a large-scale solution. It is not enough to improve individual health to create a sustainable future with a healthy population. To do so requires addressing the social, behavioral and dietary changes which can be implemented on a large scale within the population. The novel finding in this analysis is the negative correlation of spice intake and CRC risk. The most important question that arises from this data is: what is the adequate amount of spice intake that can help decrease the CRC risk? To answer this question, future research needs to be conducted, using different population groups with variable risks. Our results show that a simple addition of spice in the diet may be beneficial to the population where red meat intake is high, and provides an incentive to further explore the cancer preventive mechanism of the spices, and their use in the field of global health and cancer prevention.

### Table 2. Results of Pearson Correlation Analysis.

<table>
<thead>
<tr>
<th>Spice Intake (kg/annum) (1990-2013)</th>
<th>Average Risk (%) of CRC during the year 1990-2013 (n=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation Statistics $R$ (P value - 2 tailed)</td>
<td>95% CI of correlation coefficient* Regression analysis R square</td>
</tr>
<tr>
<td>Average Spice Intake (kg/annum) (1990-2013)</td>
<td>-0.301 (0.002)</td>
</tr>
<tr>
<td>Average Red Meat Intake (kg/annum) (1990-2013)</td>
<td>0.772 (0.001)</td>
</tr>
<tr>
<td>Average Processed Meat Intake (kg/annum) (1990, 2005, 2010)</td>
<td>0.332 (0.001)</td>
</tr>
<tr>
<td>Average Vegetable Intake (kg/annum) (1990-2013)</td>
<td>0.176 (0.080)</td>
</tr>
<tr>
<td>Average Fruit Intake (kg/annum) (1990-2013)</td>
<td>-0.095 (0.733)</td>
</tr>
</tbody>
</table>

### Table 3. Results of Partial Correlation Analysis.

<table>
<thead>
<tr>
<th>Average Risk (%) of CRC during the year 1990-2013 (n=100)</th>
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<tbody>
<tr>
<td>Partial Correlation</td>
</tr>
<tr>
<td>Average Red Meat Intake (kg/annum) (1990-2013)</td>
</tr>
<tr>
<td>Controlling for spice and processed meat</td>
</tr>
<tr>
<td>Average Processed Meat Intake (kg/annum) (1990, 2005, 2010)</td>
</tr>
</tbody>
</table>

### References


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Author Contributions


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