Dietary Flavonoids and Risk of Stroke in Women

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Background and Purpose—To date, few studies have examined associations between the wide range of flavonoid subclasses and risk of ischemic, hemorrhagic, and total stroke.

Methods—We conducted a prospective study among 69 622 women from the Nurses' Health Study. Total flavonoid and subclass intakes were calculated from semiquantitative food frequency questionnaires collected every 4 years using an updated and extended US Department of Agriculture flavonoid database.

Results—During 14 years of follow-up, 1803 incident strokes were confirmed. After adjusting for potential confounders, women in the highest compared with the lowest quintile of flavanone intake had a relative risk of ischemic stroke of 0.81 (95% CI, 0.66–0.99; $P=0.04$). Citrus fruits/juices, the main dietary source of flavanones, tended to be associated with a reduced risk for ischemic stroke (relative risk, 0.90; 95% CI, 0.77–1.05) comparing extreme quintiles.

Conclusions—Total flavonoid intake was not inversely associated with risk of stroke; however, increased intake of the flavanone subclass was associated with a reduction in the risk of ischemic stroke. Citrus fruit consumption may be associated with a reduction in stroke risk, and experimental data support these epidemiological associations that the flavanone content of citrus fruits may potentially be cardioprotective. Further prospective studies are needed to confirm these associations. **(*Stroke*. 2012;43:00-00.)**

Key Words: citrus fruits ■ flavanones ■ flavonoids ■ hemorrhagic ■ ischemic ■ polyphenols ■ stroke

A healthy lifestyle and adherence to a Dietary Approaches to Stop Hypertension (DASH) style or Mediterranean diet, high in fruits, vegetables, and total flavonoids, are associated with reduced stroke risk.[1–3] Higher fruit and vegetable intake, per se, has also been associated with reduced risk of stroke,[4] and dietary flavonoids may explain some of this protective association. Experimental evidence suggests several protective mechanisms including improving vascular endothelial function, exerting neuroprotective and anti-inflammatory effects,[5–7] enhancing nitric oxide production, and binding to thromboxane A2 receptors.[8–11]

However, the relative impact of different dietary flavonoid subclasses on risk of stroke is unclear and small differences in chemical structure between subclasses can alter bioactivity.[10] For several subclasses, including the anthocyanins, flavanones, and flavonols, emerging in vitro and epidemiological data support a reduction in risk of ischemic stroke with increased intake.[5,10] A higher intake of anthocyanins was associated with a 12% reduction in risk of hypertension, a potent risk factor for stroke,[12] and citrus fruits, a rich source of flavanones, reduced ischemic stroke risk,[13,14] although 2 studies that previously assessed flavanone intake did not observe protective effects in relation to risk of ischemic stroke.[15,16] Most previous prospective studies have predominantly focused on the flavonol subclass with equivocal findings.[15–19] However, a recent meta-analysis showed that a high flavonol intake was associated with a reduced risk of both fatal and nonfatal stroke.[20] Potential reasons for the inconsistent findings may relate to measurement error in dietary assessment or the lack of availability of comprehensive food composition tables covering the range of flavonoid subclasses. Therefore, no previous published prospective studies on stroke had the opportunity to use an updated food database that integrated levels of intake of the wide range of subclasses consumed in the habitual diet.[21,22]

Using the updated database to more accurately assess intake, we examined the relationship of the 6 main subclasses of flavonoids commonly consumed in the US diet, flavanones, anthocyanins, flavan-3-ols, flavonoid polymers, flavonols, and flavones, with risk of ischemic, hemorrhagic, and total stroke. We hypothesized, on the strength of the available mechanistic and human data, that a high intake of anthocyanins, flavanones, and flavonols would be associated with a reduced risk of ischemic stroke.

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Methods

Study Population

In 1976, the Nurses' Health Study (NHS) enrolled 121 700 female nurses aged 30 to 55 years who returned a mailed questionnaire regarding lifestyle and medical history.[23] Participants received follow-up questionnaires biennially to record newly diagnosed illnesses and to update lifestyle factors and every 4 years received semiquantitative food frequency questionnaires (FFQs).[24,25] The FFQ from 1990 was used as a baseline because of the inclusion of a sufficient number of fruits and vegetables to more accurately estimate flavonoid intake. In 1990, a total of 80 332 women completed the FFQ. Those who had implausible values for total caloric intake (<500 or >3500 kcal/day) or too many missing items were excluded (1448), resulting in 78 884 with FFQ data. We excluded those who reported a history of cerebrovascular disease or cancer before 1990 (9262), leaving a total of 69 622 women for this analysis. We stopped updating dietary information if cancer or cerebrovascular disease was diagnosed during follow-up, although these individuals continued to contribute follow-up time. The Institutional Review Board at Brigham and Women's Hospital reviewed and approved this study and participants provided implied consent by virtue of returning their questionnaires.

Assessment of Flavonoid Intakes

Dietary intake data were collected from NHS participants in 1990 and subsequently every 4 years. FFQs administered before 1990 contained fewer questions on specific flavonoid-rich fruits and vegetables (for example, onions were absent from questionnaires before 1990). A database for assessment of intake of the different flavonoid subclasses was constructed as previously described.[12] Intakes of individual compounds were calculated as the sum of the consumption frequency of each food multiplied by the content of the specific flavonoid for the specified portion size. We derived intakes of the 6 main subclasses commonly consumed in the US diet; specifically, flavanones (eriodictyol, hesperetin, naringenin), anthocyanins (cyanidin, delphinidin, malvidin, pelargonidin, petunidin, peonidin), flavan-3-ols (catechins, epicatachins), flavonols (quercetin, kaempferol, myricetin, isohamnetin), flavones (luteolin, apigenin), and polymers (including proanthocyanidins, theaflavins, and thearubigins). Total flavonoid intakes were derived by addition of the component subclasses (flavanones, anthocyanins, flavan-3-ols, polymers, flavonols, flavones). Cumulative intakes (energy-adjusted) were calculated for a given questionnaire cycle by averaging the intake for the current and preceding FFQs.[26] The validity and reproducibility of the FFQs have been reported previously; for example, correlations between several major dietary sources of flavonoids, including fruits, vegetables, tea, and wine, measured by diet records and FFQs were 0.70, 0.50, 0.77, and 0.83, respectively.[27,28]

Outcome Assessment

We requested permission to review medical records of all participants who reported a physician diagnosis of a stroke during follow-up. Physicians blinded to risk factor status reviewed the medical records. Cerebrovascular pathology due to infection, trauma, or malignancy was excluded and "silent" strokes discovered only by radiological imaging were also excluded. Strokes were confirmed using the National Survey of Stroke criteria,[29] requiring neurological deficit of rapid or sudden onset lasting ≥24 hours or until death. Fatal strokes were identified by next of kin, postal authorities, or the National Death Index and confirmed by medical records, autopsy reports, and death certificates with stroke listed as the underlying cause. We categorized types of stroke as ischemic (embolic or thrombotic), hemorrhagic (subarachnoid or intraparenchymal), and unknown. Strokes that required hospitalization and for which confirmatory information was obtained but medical records were unavailable were designated as probable (25% of total strokes). Because the exclusion of probable strokes did not alter the results, we included both confirmed and probable strokes in this analysis.

Statistical Methods

Participants contributed person-time of follow-up from the date of return of the 1990 questionnaire to the date of stroke diagnosis, death, or end of follow-up (June 2006). Mantel-Haenszel age-adjusted incidence rate ratios and 95% CIs were obtained relative to the incidence rates among those in the lowest quintile of nutrient of interest. We used Cox proportional hazard modeling to assess the associations between different flavonoid subclasses and risk of stroke. We used separate models for ischemic and hemorrhagic stroke given that the underlying biological mechanisms for the subtypes may differ. In multivariate models, we adjusted for age (continuous), body mass index (<25, 25–29.9, or ≥30 kg/m^2), physical activity (metabolic equivalents/week, in quintiles), alcohol consumption (0, 0.1–4.9, 5–14.9, 15–29.9, ≥30 g/day), energy intake (kcal/day, in quintiles), use of multivitamin supplements (yes, no), use of aspirin (nonuser, <6/week, 6+ per week), menopausal status (premenopausal, dubious menopause, postmenopausal), postmenopausal hormone use (never, past, or current hormone use), smoking (never, past, and current), and history of Type 2 diabetes, coronary heart disease, hypercholesterolemia, or hypertension. We stopped updating dietary information if cancer (all except nonmelanoma skin cancer) or coronary heart disease was diagnosed. All analyses were conducted with SAS software, Version 9 (SAS Institute, Inc, Cary, NC). All probability values are 2-sided.

In secondary analyses, we stratified by hypertension and aspirin use, which were updated through follow-up, to evaluate potential interactions.

Results

During 14 years of follow-up among the 69 622 participants included in the analyses, we documented 1803 cases of stroke (943 ischemic, 253 hemorrhagic, and 607 of unknown type). Baseline characteristics of the study population according to quintiles of total flavonoid intake are presented in Table 1. Women with higher total flavonoid intake tended to smoke less; exercise more; have greater intakes of fiber, folate, fruits, and vegetables; but lower intakes of caffeine and alcohol.

The median intake of total flavonoids was 232 mg/day and the median intakes of the flavonoid subclasses across quintiles are shown in Table 1. The polymer subclass contributed most to total flavonoid intake, whereas the contribution to total intake from flavones was negligible. Tea was the main food contributor to total flavonoid intake with apples and oranges/orange juice as other significant contributors. Flavan-3-ols were predominantly consumed from tea, whereas blueberries were the main source of anthocyanins, and oranges/orange juice were the main contributors to flavanone and flavone intake (Supplemental Figure I; http://stroke.ahajournals.org).

Flavanone intake was inversely related to risk of ischemic stroke; women in the top quintile of flavanone intake had a relative risk (RR) of 0.81 (95% CI, 0.66–0.99; P for trend=0.1; Quintile [Q] 5 versus Q 1; P=0.038) compared with those in the lowest quintile (Table 2). When we further adjusted for calcium or magnesium, the results were not materially altered (data not shown). Given that 95% of the flavanones were derived from citrus fruit and juice consumption (Supplemental Figure I), a high intake of citrus fruits/juice tended to be associated with a reduced risk of ischemic stroke (RR, 0.90; 95% CI, 0.77–1.05; Q5 versus Q1). Citrus fruits and juices contain other constituents that may reduce the risk of stroke, including vitamin C and potassium. The addition of vitamin C to the flavanone multivariate model had

Table 1. Age-Standardized Baseline Characteristics of 69 622 Women in the Nurses' Health Study According to Quintiles of Total Flavonoid Intake in 1990

	Quintiles of Total Flavonoid Intake				
	Q1	Q2	Q3	Q4	Q5
Total flavonoids, mg/d	96.8	161.7	232.0	356.3	761.2
Postmenopausal, %	70	69	69	70	69
History of high cholesterol, %	36	38	37	38	37
History of diabetes, %	4	4	4	4	5
History of hypertension, %	30	29	29	30	30
Current smoking, %	27	17	13	12	14
Current postmenopausal hormone use, %	26	29	30	30	28
Alcohol, g/d	6.5	5.7	5.0	4.5	3.8
Regular aspirin use, 6+ tablets per wk	10	10	10	10	10
BMI, kg/m^2	26.0	25.7	25.6	25.5	25.6
Multivitamin users %	34	38	40	39	38
Physical activity mets/wk	13.1	15.8	16.7	17.4	15.2
Energy intake, kcal/d	1786	1812	1798	1747	1595
Caffeine, mg/d	296	261	251	245	270
Fiber, g/d	15.2	17.6	19.0	19.6	18.9
Fruits and vegetables, portions/d	4.7	6.0	6.7	6.9	6.0
Whole grains, g/d	16.0	19.2	20.2	20.5	19.9
Folate, μg/d	370	421	445	455	462
Calcium, mg/d	941	990	1005	1000	978
Sodium, mg/d	1896	1843	1821	1807	1837
Potassium, mg/d	2612	2821	2934	2982	2990
Magnesium, mg/d	281	302	310	312	309
Omega 3, g/d	1.2	1.2	1.2	1.2	1.2
Flavonols, mg/d	9.6	12.5	15.3	19.6	34.3
Flavones, mg/d	1.0	1.7	2.0	2.1	2.0
Flavanones, mg/d	18.9	35.5	44.3	48.4	44.9
Flavan-3-ols, mg/d	8.6	15.1	25.1	51.9	175.0
Anthocyanins, mg/d	5.8	10.3	13.6	16.6	16.5
Polymers, mg/d	48.6	86.7	134	227	669

All variables are age-standardized; all nutrients are energy-adjusted.
Q indicates quintile; BMI, body mass index.

little effect on the RR (0.80; 95% CI, 0.64–0.99), whereas potassium slightly attenuated the association (RR, 0.83; 95% CI, 0.67–1.03).

In models adjusting for age and smoking, flavone intake was inversely associated with risk of total and ischemic stroke; however, the RR was attenuated after further adjustment for stroke risk factors (Table 2; Supplemental Table I).

There were no significant associations between any subclass and hemorrhagic stroke (Supplemental Table II). We stratified by hypertension and aspirin use to investigate if these factors modified the relationship between flavonoid subclass intake and risk of stoke but there were no significant effect modifications (P for interaction >0.05).

Discussion

To our knowledge, this is the first prospective study to examine the main dietary flavonoid subclasses on risk of stroke using an updated, comprehensive food database.[12] Over 14 years of follow-up, high flavanone intake was associated with a 19% lower risk of ischemic stroke, a finding that fits with existing data on the protective effect of citrus fruit consumption.[4,13,14] The main dietary sources of flavanones were orange and grapefruit juices (63%), oranges (34%), and grapefruits (4.8%; Supplemental Figure I) and in food-based analyses, we similarly observed a trend toward an inverse association for citrus fruit intake and total and ischemic stroke (RR, 0.90; 95% CI, 0.77–1.05; Q5 versus Q1). On a mg/100 g basis, oranges are a richer source of flavanones; however, given the frequency of consumption of fruit juices, juices are the main source in the US diet.[22] Given the higher flavanone content of citrus fruits and the sugar content of commercial fruit juices, public health recommendations should focus on increasing citrus fruit intake.

In two previous prospective studies, citrus fruit (including juice) intake but not intake of other fruits protected against risk of ischemic stroke and intracerebral hemorrhage.[13,14]

Table 2. Flavonoid Subclass Intake and Risk of Ischemic Stroke Among 69 622 Women in the Nurses' Health Study

	Quintiles of Flavonoid Intake Subclasses					*P* for Trend
	Q1	Q2	Q3	Q4	Q5	
Flavonols, mg/d	<10.15	10.16–13.62	13.63–17.86	17.87–25.14	>25.14	
No. of ischemic stroke cases	191	181	169	203	199	
No. of person-years	106 193	106 545	106 375	106 331	106 354	
Age and smoking RR (95% CI)	1.0	0.91 (0.74–1.12)	0.84 (0.68–1.03)	0.96 (0.78–1.17)	0.94 (0.77–1.14)	0.94
Multivariate model* RR (95% CI)	1.0	0.94 (0.76–1.15)	0.87 (0.70–1.07)	1.00 (0.82–1.22)	0.96 (0.79–1.17)	0.94
Flavones, mg/d	<0.94	0.94–1.45	1.46–2.00	2.01–2.69	>2.69	
No. of cases	189	175	187	194	198	
No. of person-years	1 062 330	105 439	106 800	106 820	106 409	
Age and smoking RR (95% CI)	1.0	0.90 (0.73–1.11)	0.89 (0.73–1.09)	0.86 (0.70–1.05)	0.81 (0.66–0.99)	0.048
Multivariate model* RR (95% CI)	1.0	0.93 (0.75–1.14)	0.92 (0.75–1.13)	0.91 (0.74–1.12)	0.88 (0.72–1.08)	0.26
Flavanones, mg/d	<13.72	13.72–27.50	27.51–42.71	42.72–62.95	>62.95	
No. of cases	199	164	184	199	197	
No. of person-years	106 354	106 376	106 379	106 322	106 367	
Age and smoking RR (95% CI)	1.0	0.82 (0.67–1.01)	0.84 (0.69–1.03)	0.84 (0.69–1.03)	0.75 (0.62–0.92)	0.02
Multivariate model* RR (95% CI)	1.0	0.84 (0.69–1.04)	0.87 (0.71–1.07)	0.89 (0.73–1.09)	0.81 (0.66–0.99)	0.10
Flavan-3-ols, mg/d	<12.26	12.26–19.85	19.86–35.83	35.84–75.83	>75.83	
No. of cases	217	185	174	181	186	
No. of person-years	106 318	106 381	106 361	106 375	106 363	
Age and smoking RR (95% CI)	1.0	0.83 (0.68–1.01)	0.79 (0.64–0.96)	0.82 (0.67–1.00)	0.85 (0.70–1.04)	0.59
Multivariate model* RR (95% CI)	1.0	0.86 (0.71–1.05)	0.82 (0.67–1.00)	0.85 (0.70–1.04)	0.87 (0.72–1.06)	0.59
Anthocyanins, mg/d	<5.40	5.40–9.19	9.20–13.56	13.57–20.21	>20.21	
No. of cases	195	185	186	196	181	
No. of person-years	106 315	106 395	106 387	106 331	106 370	
Age and smoking RR (95% CI)	1.0	0.87 (0.71–1.07)	0.86 (0.70–1.06)	0.91 (0.75–1.12)	0.82 (0.67–1.01)	0.17
Multivariate model* RR (95% CI)	1.0	0.89 (0.72–1.09)	0.89 (0.73–1.10)	0.96 (0.78–1.18)	0.89 (0.72–1.11)	0.59
Polymers, mg/d	<77.10	77.10–118.54	118.55–176.23	176.24–306.04	>306.04	
No. of cases	209	203	176	167	188	
No. of person-years	106 337	106 346	106 369	106 381	106 365	
Age and smoking RR (95% CI)	1.0	0.96 (0.79–1.17)	0.85 (0.69–1.04)	0.79 (0.65–0.97)	0.89 (0.73–1.09)	0.33
Multivariate model* RR (95% CI)	1.0	0.99 (0.82–1.21)	0.90 (0.73–1.10)	0.83 (0.68–1.02)	0.93 (0.76–1.14)	0.47
Total flavonoids, mg/d	<150.69	150.69–213.37	213.38–296.60	296.61–470.81	>470.81	
No. of cases	203	205	175	171	189	
Person-years	106 343	106 345	106 373	106 377	106 360	
Age and smoking RR (95% CI)	1.0	0.94 (0.77–1.14)	0.80 (0.65–0.98)	0.77 (0.62–0.94)	0.86 (0.70–1.05)	0.22
Multivariate model* RR (95% CI)	1.0	0.98 (0.80–1.19)	0.84 (0.68–1.03)	0.81 (0.66–1.00)	0.90 (0.73–1.11)	0.36

Q indicates quintile; RR, relative risk.

*Multivariate model adjusted for age, physical activity, smoking, hormone replacement therapy, body mass index, aspirin use, Type 2 diabetes, hypercholesterolemia, history of coronary heart disease, alcohol, menopausal status, energy, use of multivitamins, history of hypertension.

Vitamin C has often been cited as the potentially protective constituent and plasma vitamin C levels are inversely associated with stroke risk.[3] In our analyses, vitamin C intake was not associated with a reduction in total or ischemic stroke risk (data not shown). The addition of vitamin C to our model did not substantially attenuate the relationship between flavanones and ischemic stroke risk, suggesting that flavanones may be another important cardioprotective constituent of citrus fruits. However, in a population-based study like ours, it is impossible to disentangle the relative influence of all the constituents of citrus fruits. The risk reductions we observed with increased flavanone intake are supported by experimental data because naringenin and hesperetin exert a diverse array of neuroprotective effects in vitro by interacting with mitogen-activated protein kinase, P13 kinase/Akt, and protein kinase C signaling pathways.[30–32] Recently naringinen was the most potent anti-inflammatory flavonoid tested; it inhibited inducible nitric oxide synthase expression and nitric oxide release due to its ability to inhibit p38 mitogen-activated protein kinase and STAT-1 phosphorylation/activation.[32] The flavanone hesperetin has also been shown to increase nitric

oxide release from endothelial cells and upregulate endothelial nitric oxide synthase expression.[33]

We observed a modest inverse association between a higher intake of flavones and anthocyanins and risk of total and ischemic stroke, although these data did not reach statistical significance. Growing in vitro mechanistic evidence suggests potential beneficial effects of specific flavonoids and their biologically active metabolites in reducing ischemic stroke development, including inhibitory effects on platelet function, thrombosis, inflammation, and protection against ischemia–reperfusion injury and arrhythmia.[10,34] Specifically, for several subclasses, including flavones and anthocyanins, evidence is emerging for beneficial effects by suppressing neuroinflammation and improving cerebral blood flow.[5] Flavonoid metabolites may inhibit platelet function through multiple mechanisms (included blocking Fyn kinase activity and the tyrosine phosphorylation of Syk and PLCg2 after internalization), which are differentially influenced by specific structural characteristics[10]; key structural attributes for the inhibition of platelet function include a B-ring catechol moiety, presence of a planar C-4 substitution, and C-3 hydroxylated C ring[10] at concentrations known to be achieved in plasma after ingestion of flavone- and flavonol-rich foods.[8,9]

We found no evidence for an inverse association for flavonols and risk of total, ischemic, or hemorrhagic stroke. This contrasts with important data from a recent meta-analysis,[20] which showed that a higher intake of flavonols was associated with a lower risk of stroke. Habitual intakes of flavonols in our study were low (median intake 14.5 mg/day), whereas median intake of flavanones was much higher (30.4 mg/day). Further studies are therefore required to examine the effects of flavonols on stroke risk, particularly focusing on stroke type because we had few hemorrhagic stroke cases (n=253).

To date, most previous cohort studies have focused specifically on the flavonol quercetin,[17,20] or specific flavonoid-rich foods like tea.[35] In the Iowa Women's Study, no association between intake of any flavonoid subclass and stroke mortality was observed; however, data on nonfatal stroke were not available.[16] In the Finnish study, men in the highest compared with the lowest quartile of flavonol intake had a lower risk of ischemic stroke.[15]

Limitations of our study warrant discussion. Although we adjusted for possible confounders, there is still the possibility of residual or unmeasured confounding. However, given our detailed and updated adjustment for potential confounders, it is unlikely that these would account for the observed results. Although our follow-up rates exceed 85%, follow-up is not perfect and could theoretically induce some dilution bias of effect estimates. We used repeated measurements of diet to obtain a more accurate assessment of long-term flavonoid intake and to reduce measurement error. Mean cumulative dietary flavonoid intakes were calculated from a database developed using the most recent US Department of Agriculture databases[21,22] with additional input from other sources. These data sets allowed us to quantify a broad range of flavonoid subclass intakes more robustly than previous analyses. However, there is wide variability in flavonoid content of foods depending on geographical origin, growing season, different cultivars, agricultural methods and processing, and a lack of biomarkers to integrate intake with the extensive metabolism these compounds undergo in vivo. Finally, it is possible that our findings for flavonoid subclasses might be due to other nutrients found in the foods that contribute most to these subclasses.

Increased consumption of fruits and vegetables has been associated with a reduced risk of stroke. In a meta-analysis of existing cohort studies,[4] those consuming 3 to 5 servings/day and >5 servings/day had an 11% and 26% reduction in risk of stroke, respectively, compared with those consuming <3 servings/day. However, these data could not determine which specific fruits/vegetables or their constituents exerted these protective effects. Our findings suggest that bioactive compounds present in citrus may potentially be associated with a reduced risk of stroke. Further prospective studies are needed to confirm these associations together with further molecular mechanistic data on flavanones to inform and optimize the design of randomized trials of flavanone and citrus-based foods to potentially reduce ischemic stroke risk.

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Dietary Flavonoids and Risk of Stroke in Women

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SUPPLEMENTAL MATERIAL

Dietary flavonoids and risk of stroke in women - online supplement

Supplement Table 1. Flavonoid sub-class intake and risk of total stroke among 69,622 women in the Nurses' Health Study.

	Quintiles (Q) of flavonoid intake subclasses					
	Q1	Q2	Q3	Q4	Q5	P for trend
Flavonols (mg/d)	<10.15	10.16-13.62	13.63-17.86	17.87-25.14	>25.14	
No. of cases	353	331	333	387	399	
No. of person years	106031	106395	106211	106147	106154	
Age and smoking RR (95% CI)	1.0	0.89(0.76-1.03)	0.87(0.75-1.01)	0.97(0.84-1.12)	1.02(0.89-1.18)	0.18
Multivariate model* RR (95% CI)	1.0	0.93(0.80-1.08)	0.93(0.80-1.08)	1.03(0.89-1.19)	1.06(0.91-1.22)	0.13
Flavones (mg/d)	<0.94	0.94-1.45	1.46-2.00	2.01-2.69	>2.69	
No. of cases	338	342	358	376	389	
No. of person years	106181	105272	106629	106638	106218	
Age and smoking RR (95% CI)	1.0	0.97(0.83-1.12)	0.93(0.80-1.06)	0.90(0.78-1.05)	0.85(0.73-0.99)	0.02
Multivariate model* RR (95% CI)	1.0	1.02(0.88-1.19)	1.01(0.86-1.17)	1.00(0.86-1.16)	0.95(0.82-1.10)	0.40
Flavanones (mg/d)	<13.72	13.72-27.50	27.51-42.71	42.72-62.95	>62.95	
No. of cases	355	319	343	390	396	
No. of person years	106198	106221	106220	106131	106168	

Age and smoking RR (95% CI)	1.0	0.88(0.76-1.02)	0.86(0.74-1.00)	0.91(0.78-1.05)	0.83(0.72-0.96)	0.053
Multivariate model* RR (95% CI)	1.0	0.92(0.79-1.08)	0.93(0.80-1.08)	0.99(0.86-1.15)	0.89(0.77-1.04)	0.30
Flavan-3-ols (mg/d)	<12.26	12.26-19.85	19.86-35.83	35.84-75.83	>75.83	
No. of cases	390	331	343	367	372	
No. of person years	106145	106235	106192	106189	106177	
Age and smoking RR (95% CI)	1.0	0.81(0.70-0.94)	0.83(0.72-0.96)	0.91(0.78-1.05)	0.94(0.82-1.09)	0.36
Multivariate model* RR (95% CI)	1.0	0.86(0.75-1.00)	0.89(0.77-1.03)	0.97(0.84-1.12)	0.97(0.84-1.11)	0.50
Anthocyanins (mg/d)	<5.40	5.40-9.19	9.20-13.56	13.57-20.21	>20.21	
No. of cases	350	375	349	366	363	
No. of person years	106160	106205	106224	106161	106188	
Age and smoking RR (95% CI)	1.0	0.96(0.83-1.11)	0.86(0.74-1.00)	0.90(0.77-1.04)	0.86(0.74-1.00)	0.059
Multivariate model* RR (95% CI)	1.0	1.01(0.87-1.17)	0.93(0.80-1.08)	0.99(0.85-1.15)	0.96(0.82-1.12)	0.56
Polymers (mg/d)	<77.10	77.10-118.54	118.55-176.23	176.24-306.04	>306.04	
No. of cases	380	350	330	370	373	
No. of person years	106166	106199	106215	106178	106180	
Age and smoking RR (95% CI)	1.0	0.89(0.77-1.03)	0.84(0.72-0.98)	0.94(0.81-1.08)	0.96(0.83-1.11)	0.61
Multivariate model* RR (95% CI)	1.0	0.94(0.81-1.09)	0.91(0.79-1.06)	1.00(0.86-1.16)	0.99(0.86-1.15)	0.64

Total Flavonoids (mg/d)	<150.69	150.69-213.37	213.38-296.60	296.61-470.81	>470.81	
No. of cases	358	362	327	375	381	
Person years	106218	106188	106221	106173	106188	
Age and smoking RR (95% CI)	1.0	0.93(0.80-1.07)	0.82(070-0.95)	0.93(0.80-1.08)	0.97(0.84-1.13)	0.57
Multivariate model* RR (95% CI)	1.0	0.98(0.85-1.14)	0.88(0.76-1.03)	1.00(0.86-1.16)	1.00(0.87-1.17)	0.53

***Multivariate model** – adjusted for age, physical activity, smoking, HRT, BMI, aspirin use, type 2 diabetes, hypercholesterolemia, history of CHD, alcohol, menopausal status, energy, use of multivitamins, history of hypertension

Relative risk (RR) and 95% confidence interval (95% CI), No.(number)

Supplement Table 2. Flavonoid sub-class intakes and risk of hemorrhagic stroke among 69,622 women in the Nurses' Health Study.

	Quintiles (Q) of flavonoid intake subclasses					
	Q1	Q2	Q3	Q4	Q5	P for trend
Flavonols (mg/d)	<10.15	10.16-13.62	13.63-17.86	17.87-25.14	>25.14	
No. of cases	52	46	44	43	68	
No. of person years	106332	106680	106500	106491	106485	
Age and smoking RR (95% CI)	1.0	0.90(0.61-1.35)	0.87(0.58-1.31)	0.83(0.55-1.25)	1.29(0.90-1.86)	0.08
Multivariate model* RR (95% CI)	1.0	0.96(0.64-1.43)	0.95(0.63-1.42)	0.88(0.58-1.32)	1.33(0.92-1.92)	0.07
Flavones (mg/d)	<0.94	0.94-1.45	1.46-2.00	2.01-2.69	>2.69	
No. of cases	49	58	48	52	46	
No. of person years	106470	105556	106939	106962	106561	
Age and smoking RR (95% CI)	1.0	1.25(0.85-1.83)	1.00(0.67-1.49)	1.05(0.70-1.56)	0.87(0.58-1.31)	0.27
Multivariate model* RR (95% CI)	1.0	1.35(0.92-1.99)	1.12(0.74-1.68)	1.18(0.79-1.76)	0.95(0.62-1.43)	0.48
Flavanones (mg/d)	<13.72	13.72-27.50	27.51-42.71	42.72-62.95	>62.95	
No. of cases	55	42	47	60	49	

No. of person years	106498	106498	106516	106461	106515	
Age and smoking RR (95% CI)	1.0	0.82(0.55-1.22)	0.88(0.59-1.30)	1.06(0.73-1.54)	0.79(0.54-1.18)	0.57
Multivariate model* RR (95% CI)	1.0	0.88(0.58-1.31)	0.97(0.65-1.44)	1.18(0.81-1.72)	0.82(0.55-1.22)	0.64
Flavan-3-ols (mg/d)	<12.26	12.26-19.85	19.86-35.83	35.84-75.83	>75.83	
No. of cases	66	36	46	49	56	
No. of person years	106469	106530	106489	106507	106493	
Age and smoking RR (95% CI)	1.0	0.58(0.38-0.87)	0.76(0.52-1.12)	0.81(0.56-1.18)	0.92(0.64-1.31)	0.40
Multivariate model* RR (95% CI)	1.0	0.61(0.41-0.93)	0.82(0.56-1.21)	0.87(0.60-1.27)	0.91(0.63-1.30)	0.58
Anthocyanins (mg/d)	<5.40	5.40-9.19	9.20-13.56	13.57-20.21	>20.21	
No. of cases	56	60	45	45	47	
No. of person years	106454	106520	106528	106482	106504	
Age and smoking RR (95% CI)	1.0	1.09(0.76-1.58)	0.83(0.56-1.24)	0.85(0.57-1.26)	0.89(0.60-1.32)	0.35
Multivariate model* RR (95% CI)	1.0	1.18(0.81-1.70)	0.92(0.62-1.37)	0.95(0.63-1.42)	0.96(0.64-1.44)	0.56
Polymers (mg/d)	<77.10	77.10-118.54	118.55-176.23	176.24-306.04	>306.04	
No. of cases	63	44	43	43	60	
No. of person years	1063483	106505	106502	106505	106493	
Age and smoking RR (95% CI)	1.0	0.76(0.51-1.12)	0.748(0.52-1.15)	0.77(0.52-1.14)	1.05(0.73-1.50)	0.28

Multivariate model* RR (95% CI)	1.0	0.82(0.55-1.20)	0.84(0.56-1.25)	0.81(0.55-1.21)	1.04(0.72-1.50)	0.44
Total flavonoids (mg/d)	<150.69	150.69-213.37	213.38-296.60	296.61-470.81	>470.81	
No. of cases	54	55	44	37	63	
Person years	106492	106495	106504	106511	106486	
Age and smoking RR (95% CI)	1.0	1.07(0.73-1.56)	0.88(0.59-1.32)	0.73(0.48-1.12)	1.23(0.85-1.78)	0.22
Multivariate model* RR (95% CI)	1.0	1.13(0.77-1.66)	0.94(0.63-1.41)	0.77(0.50-1.18)	1.22(0.83-1.79)	0.35

***Multivariate model** – adjusted for age, physical activity, smoking, HRT, BMI, aspirin use, type 2 diabetes, hypercholesterolemia, history of CHD, alcohol, menopausal status, energy, use of multivitamins, history of hypertension

Relative risk (RR) and 95% confidence interval (95% CI), No. (number)

Supplement Figure 1. Dietary Sources of total and sub-classes of flavonoids in the Nurses' Health Study participants