



Scientific Advisory Committee on Nutrition

# **Update on folic acid**

July 2017

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# Membership of Scientific Advisory Committee on Nutrition

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## Summary

### Purpose

- S1. This report has been prepared in response to a request by Food Standards Scotland (FSS) for the Scientific Advisory Committee on Nutrition (SACN) to provide advice on whether its previous recommendations regarding mandatory folic acid fortification (2006; 2009), still apply. It updates SACN's previous reviews in relation to potential adverse effects of folic acid on specific health outcomes and its recommendations on folic acid fortification (2006; 2009).

### Background

- S2. The term *folate* refers to naturally occurring folates and to folic acid, a synthetic form used for food fortification and in supplements. In the UK, fortification of food products with folic acid is on a voluntary basis.

### **Folate and neural tube defects**

- S3. Conclusive evidence from randomised controlled trials (RCTs) has shown that folic acid supplementation during the early stages of pregnancy can reduce the risk of the fetus developing neural tube defects (NTDs). Although all women of childbearing age are advised to take a daily supplement of folic acid prior to conception and until the 12th week of pregnancy, evidence suggests that the current recommendations are not being followed and that only around half of all pregnancies in Britain are planned.
- S4. Significant reductions in the prevalence of NTDs among live births have been reported in countries with mandatory folic acid fortification policies.

### **SACN's previous advice on mandatory folic acid fortification**

- S5. In 2006 SACN recommended mandatory fortification of flour with folic acid to improve the folate status of women most at risk of NTD affected pregnancies but stipulated that it should only be introduced alongside restrictions on voluntary fortification. This was to ensure no increase in the numbers of people with folic acid intakes above the Guidance/Tolerable Upper Intake Level (GL/UL)<sup>1</sup> and no substantial increase in mean folic acid intake or folate status of the UK population.
- S6. In 2007, SACN was asked by the Chief Medical Officer to consider two studies (Cole et al., 2007; Mason et al., 2007) suggesting potential adverse effects of high folic acid intakes on colorectal cancer risk. Following consideration of these studies, together with findings from a then unpublished<sup>2</sup> meta-analysis of RCTs, SACN concluded that there were still uncertainties regarding folic acid and cancer risk but reiterated its previous recommendation for mandatory folic acid fortification accompanied by controls on voluntary fortification, guidance on supplement use and appropriate population monitoring.

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<sup>1</sup> In the USA and Europe, a UL of 1 mg/d of folic acid was set for adults. ULs for children were extrapolated from the UL for adults on the basis of relative body weight. In the UK, a GL of 1 mg/d of folic acid was set for adults. GLs were not set for children as there were no data reporting adverse effects in children.

<sup>2</sup> Vollset et al (2013).

57. In February 2016, SACN was asked by FSS if its previous (2006/2009) risk assessments remained valid. This was because, in the absence of any progress regarding mandatory folic acid fortification in the UK, Scottish Ministers were considering whether to proceed unilaterally with mandatory folic acid fortification of flour in Scotland. SACN therefore agreed to conduct a review of relevant evidence published since its previous risk assessments.

### **Terms of reference**

58. The terms of reference were to:
- Conduct a review of major new evidence (with an emphasis on systematic reviews and meta-analyses) published since SACN's 2006 and 2009 reports on folate and folic acid, to assess whether its previous advice stands.
  - Provide comments in relation to the modelling exercise carried out by the Food Standards Agency for SACN's 2006 report and any updated modelling exercise undertaken by FSS.

### **Potential adverse effects of folic acid fortification**

59. The evidence review only considered potential adverse effects of folic acid on specific health outcomes. These were: masking/exacerbation of low vitamin B12 status; cognitive decline in older individuals; cancer (prostate, breast, colorectal and overall); and long term effects of unmetabolised folic acid (UMFA) in the systemic circulation.
510. Literature searches were restricted to studies published since 2005<sup>3</sup>. Only systematic reviews and meta-analyses were considered in relation to cognitive decline and cancer; individual studies were considered in relation to UMFA because the evidence base was less extensive.

### ***Cognitive health: Masking or exacerbation of low vitamin B12 status; cognitive decline in older individuals***

511. Clinical symptoms associated with vitamin B12 deficiency include anaemia and neurological impairment. Treatment with high doses of folic acid can alleviate the anaemia (*'masking'* the vitamin B12 deficiency) which could delay diagnosis of vitamin B12 deficiency and may lead to irreversible neurological damage. It has also been suggested that folic acid might directly exacerbate neurological degeneration associated with marginal vitamin B12 status.
512. In 2006, SACN concluded that folic acid intakes up to 1 mg/d were not associated with neurological impairment in older people with low vitamin B12 status. Systematic reviews and meta-analyses published since then, of intervention studies of folic acid supplementation and observational studies, indicate either no relationship with cognitive decline or a lower risk associated with higher folate status.
513. No systematic reviews have evaluated the risk of folic acid masking or exacerbating vitamin B12 deficiency in adults. Evidence for this outcome is mainly from folic acid interventions over 1 mg/d. The prevalence of vitamin B12 deficiency with or without anaemia did not increase after mandatory fortification in the USA.

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<sup>3</sup> The cut-off date for SACN's full risk assessment in 2006.

## **Cancer**

- S14. In 2006 and 2009, SACN concluded that there were uncertainties regarding folic acid and cancer risk.
- S15. *Prostate cancer risk*: Findings from the different types of study are inconsistent and overall the evidence is inconclusive. Meta-analyses of RCTs of folic acid supplementation show no effect of folic acid on prostate cancer risk. Observational studies of dietary or total folate intake do not suggest an association. Observational studies of serum or plasma folate concentration suggest higher prostate cancer risk in men with relatively high serum or plasma folate concentration. The MTHFR genetic studies also suggest that higher blood folate concentrations are associated with an increased risk of prostate cancer.
- S16. *Breast cancer risk*: Findings from the different types of study are inconsistent but overall do not suggest an adverse association. Meta-analyses of RCTs report no effect of folic acid supplementation on breast cancer risk. Observational studies of dietary and total folate intake do not show an association with breast cancer risk. Observational studies of serum or plasma folate concentration also report no association. The MTHFR genetic studies suggest higher blood folate concentrations are associated with lower breast cancer risk.
- S17. *Colorectal cancer risk*: Findings from the different types of study are inconsistent and overall the evidence is inconclusive. Meta-analyses of RCTs report no effect of folic acid supplementation on colorectal cancer risk. Meta-analyses of observational studies are heterogeneous but suggest a protective association of folate intakes above about 400 µg/d. Observational studies of serum or plasma folate concentration provide no clear evidence of an association with colorectal cancer risk. The MTHFR genetic studies suggest that higher blood folate concentrations are associated with an increased colorectal cancer risk.
- S18. *Overall cancer risk*: Findings from the different study types are inconsistent but overall do not suggest an adverse association. RCTs show no effect of folic acid supplementation on overall cancer risk. The MTHFR genetic studies suggest higher folate concentrations reduce overall cancer risk.
- S19. It is difficult to draw firm conclusions on folate and cancer risk on the basis of evidence from RCTs and observational data. The data are heterogeneous and, overall, do not suggest a detrimental effect of folic acid/folate on cancer risk. However statistical power is generally low, particularly for the RCTs. There are also uncertainties about the inference of nutritional effects from genetic evidence.

## **Unmetabolised folic acid**

- S20. In 2006, SACN concluded that there were insufficient data to assess the long-term effects of exposure to UMFA in the systemic circulation. Evidence published since then shows no clear dose-response relationship between folic acid intake and the appearance of UMFA in the systemic circulation. UMFA comprises 1-3% of total folate regardless of age, level of intake, and whether blood is sampled in the fasted or non-fasted state. These observations question the interpretation that levels of UMFA are indicative of intakes above the short term capacity of the body to metabolise folic acid.

### **The potential impact of mandatory folic acid fortification**

- s21. FSS commissioned an update of previous modelling carried out by SACN (2006) and the Food Standards Agency (2007/8) to estimate the efficacy and safety of various options for adding folic acid to the diet. SACN did not carry out this activity but advised FSS on possible approaches and commented on the results at a draft stage. Findings from the modelling exercise indicate that there are combinations of mandatory folic acid fortification with capping of voluntary fortification and supplements that can achieve reductions in NTD risk. These scenarios also decrease the prevalence of both low intakes and intakes above the GL/UL while the increase in mean population intakes of folic acid is similar to that previously suggested by SACN.

### **Recommendations**

- s22. SACN's previous recommendation (2006 and 2009) for mandatory folic acid fortification to improve the folate status of women most at risk of NTD-affected pregnancies remains unchanged. The evidence published since SACN's previous reports (2006 and 2009), on potential adverse effects of folic acid, does not provide a substantial basis for changing this recommendation.
- s23. SACN's previous recommendations stipulated that mandatory fortification should only be introduced alongside restrictions on voluntary dietary fortification with folic acid and clear guidance on the use of folic acid supplements. This was to ensure no increase in the numbers of people with intakes above the GL/UL. These recommendations remain unchanged.
- s24. In keeping with SACN's previous recommendation, implementation of mandatory folic acid fortification should be accompanied by measures for monitoring folic acid intakes and blood folate concentrations of the population. This is to ensure mandatory folic acid fortification does not lead to an increase in the proportion of the population with folic acid intakes above the GL/UL.
- s25. Current government advice for all women who could become pregnant is to take 400 µg/d of folic acid prior to conception and until the twelfth week of pregnancy. Women with a history of a previous NTD-affected pregnancy are advised to take 5 mg/d of folic acid prior to conception and until the twelfth week of pregnancy<sup>4</sup>. This recommendation was endorsed by SACN in 2006 and 2009 and remains unchanged.

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<sup>4</sup> Diabetes UK recommends that all women with diabetes, who are planning a pregnancy, should take a daily folic acid dose of 5 mg.

## 1) **Introduction**

### **Purpose**

1. This report has been prepared in response to a request by Food Standards Scotland (FSS) for the Scientific Advisory Committee on Nutrition (SACN) to provide advice on whether its previous recommendations regarding mandatory folic acid fortification (2006; 2009) still apply. This report updates SACN's previous reviews of potential adverse effects of folic acid on specific health outcomes and its recommendations on folic acid fortification (2006; 2009).

### **Folate and folic acid**

2. The term *folate* describes a family of B-group vitamins. There are large numbers of naturally occurring folates that are found in a wide variety of foods. Rich sources include liver, yeast extract and green leafy vegetables (e.g., spinach and kale).
3. Folic acid is a synthetic form of folate. It is widely used for food fortification and in supplements because it is more stable in foods than natural folates and is better absorbed. In the UK, fortification of food products with folic acid is on a voluntary basis. Foods which are voluntarily fortified with folic acid include breakfast cereals and reduced fat spreads.

### **Folate and neural tube defects**

4. Conclusive evidence from randomised controlled trials (RCTs) has shown that folic acid supplementation during the early stages of pregnancy can reduce the risk of the fetus developing neural tube defects (NTDs) (Czeizel & Dudas, 1992; MRC Vitamin Study Research Group, 1991). The two most common NTDs are anencephaly and spina bifida.
5. All women who could become pregnant are therefore advised to take a daily supplement of folic acid (400 µg) prior to conception and until the 12th week of pregnancy (Department of Health, 1992). Folic acid supplements of 5 mg/d are recommended to prevent the occurrence of NTDs in the offspring of men or women with spina bifida themselves or women with a previous pregnancy affected by NTD (Department of Health, 1992). Diabetes UK recommends that all women with diabetes planning a pregnancy should also take a folic acid supplement of 5mg/d<sup>5</sup>.
6. Findings from a large cross-sectional UK study, of women (n=466,860) attending an antenatal screening (between 1999 and 2012) for Down syndrome and NTDs, suggest that the current recommendations are not being followed (Bestwick et al., 2014). The proportion of women taking folic acid supplements prior to pregnancy declined from 35% in 1999-2001 to 31% in 2011-12; only 6% of women aged under 20y took folic acid supplements before pregnancy compared with 40% aged 35-39y. The Health Survey for England 2002 (Blake et al., 2003) reported that only 43% of mothers in the most socioeconomically deprived areas were likely to increase their folate intake compared

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<sup>5</sup> [https://www.diabetes.org.uk/Guide-to-diabetes/Living\\_with\\_diabetes/Pregnancy/](https://www.diabetes.org.uk/Guide-to-diabetes/Living_with_diabetes/Pregnancy/)

to 70% of mothers from the least socioeconomically deprived areas. In addition, it has been estimated that only 55% of pregnancies in Britain are planned (Wellings et al., 2013).

7. Significant reductions in the prevalence of NTDs among live births have been reported in countries with mandatory folic acid fortification policies. For example in the USA, where mandatory folic acid fortification was introduced in 1998 (140 µg folic acid per 100 g flour), an immediate and stable 28% reduction in prevalence was observed for anencephaly and spina bifida post-fortification (1999-2011) (Williams et al., 2015). Internationally, a systematic review (179 studies) and meta-analysis (123 studies) reported that prevalence of spina bifida (1985-2010) was lower in geographical regions with mandatory compared with voluntary fortification (35 vs 52 per 100,000 live births, stillbirths and terminations of pregnancy respectively) (Atta et al., 2016). These findings confirm that the policy of mandatory folic acid fortification has been effective in reducing NTD risk in those countries where it has been introduced.

### **Background**

8. In 2000, the Committee on Medical Aspects of Food and Nutrition Policy (COMA)<sup>6</sup> concluded that universal fortification of flour with folic acid would significantly reduce the number of conceptions and births affected by NTDs (Department of Health, 2000). In July 2002, the Food Standards Agency (FSA) advised Health Ministers not to introduce mandatory fortification at that time due to outstanding concerns that folic acid might mask the symptoms of vitamin B12 deficiency in older people (see paragraph 48).
9. In 2006, following an extensive review of the evidence, SACN recommended mandatory fortification of flour with folic acid to improve the folate status of women most at risk of NTD-affected pregnancies in the UK (women with the lowest folate intakes: younger women from the most socioeconomically deprived areas, who do not follow advice regarding periconceptional supplementation with folic acid or do not routinely consume supplements or foods that are voluntarily fortified with folic acid) and to also improve the folate status of other population groups in the UK (SACN, 2006).
10. The Committee recognised, however, that mandatory fortification combined with voluntary fortification and inappropriate supplement use would also increase the proportion of people in the UK at risk of exceeding folic acid intakes above the Guidance/Tolerable Upper Intake Level (GL/UL) (see paragraphs 35-37). SACN stipulated, therefore, that mandatory fortification should only be introduced alongside restrictions on voluntary fortification of foods with folic acid. This was to ensure no increase in the numbers of people with a folic acid intake above the GL/UL and no substantial increase in the mean folic acid intake or folate status of the UK population.

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<sup>6</sup> SACN succeeded COMA in 2001.

11. In June 2007, based on SACN's advice, the FSA recommended mandatory folic acid fortification of wheat flour (alongside controls on voluntary fortification and guidance on supplement use) to UK Health Ministers.
12. In October 2007, the Chief Medical Officer asked SACN to consider two studies (Cole et al., 2007; Mason et al., 2007) suggesting potential adverse effects of high folic acid intake on colorectal cancer risk. Preliminary data from both studies had been considered by SACN in its 2006 report which concluded that the relationship between folic acid and cancer risk was unclear. As a precaution, SACN had recommended that there should not be a substantial increase in the average population intake of folic acid or in the numbers consuming intakes above the GL/UL for folic acid.
13. In addition to the studies by Cole et al. (2007) and Mason et al. (2007) SACN considered the results from a then unpublished meta-analysis of RCTs<sup>7</sup> on the effects of folic acid on risk of cardiovascular disease, which also reported on cancer risk.
14. Following a detailed assessment of these data, SACN concluded that there were still uncertainties regarding folic acid and cancer risk. The Committee reiterated its previous recommendation for mandatory fortification of flour with folic acid and again stipulated that it should only be introduced if it was accompanied by controls on voluntary fortification, guidance on supplement use and appropriate population monitoring. In addition, people aged over 50y and those with a previous history of colorectal adenomas were advised not to consume supplements containing folic acid above the reference nutrient intake for folate of 200 µg/d (SACN, 2009).
15. SACN wrote to UK Health Ministers in October 2015<sup>8</sup> to alert them to evidence from other countries on the safety of folic acid fortification at the levels proposed in 2006 and the associated improvements in folate status and falls in the prevalence of NTDs. SACN also expressed concern that, in the absence of mandatory fortification, the low folate status of women of reproductive age in the UK may have been exacerbated by reduced levels of voluntary fortification by some sectors of the food industry in compliance with SACN's 2006 and 2009 recommendations.
16. In February 2016 FSS informed SACN that, in the absence of any progress regarding mandatory folic acid fortification in the UK, Scottish Ministers had indicated a wish to proceed unilaterally with mandatory folic acid fortification of flour in Scotland. FSS was, therefore, requesting advice from SACN on whether its 2006/2009 risk assessments remained valid.
17. In addition to the request from FSS, SACN had received submissions expressing concern about potential risks of folic acid fortification.

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<sup>7</sup> Vollset et al (2013).

<sup>8</sup> Available at <https://www.gov.uk/government/groups/scientific-advisory-committee-on-nutrition>

18. In this context, SACN agreed to conduct a review of relevant evidence published since its 2006 and 2009 risk assessments.

#### **Terms of reference**

19. A small Working Group of SACN Members, with relevant expertise, was established in April 2016 to take this work forward. The terms of reference were to:
  - Conduct a review of major new evidence (with an emphasis on systematic reviews and meta-analyses) published since SACN's 2006 and 2009 reports on folate and folic acid, to assess whether its previous advice stands.
  - Provide comments in relation to the modelling exercise carried out by the FSA for SACN's 2006 report and any updated modelling exercise undertaken by FSS.

## **2) Methodology**

### **Scope of report**

20. In this report, SACN's review of the evidence was restricted to potential adverse effects of folic acid identified as areas of concern in its previous risk assessments, in reports on folic acid by other organisations (see paragraph 25) and in submissions to SACN. These were: masking or exacerbation of low vitamin B12 status; cognitive decline in older individuals; and cancer (prostate, breast, colorectal and overall). In addition, the appearance of unmetabolised folic acid (UMFA) in the systemic circulation has raised concerns regarding long-term effects of exposure to folic acid. Therefore, evidence on potential adverse effects of UMFA was also considered.
21. Although FSS's request for advice related to folic acid as the proposed fortificant, studies of dietary and total folate intake were also considered because the biological effect is likely to depend on the total intake of natural and synthetic folates rather than folic acid *per se*.
22. The purpose of reviewing the evidence for potential adverse effects of folic acid on specific health outcomes was to assess whether there was any new evidence that might cause SACN to alter its previous advice (2006; 2009) regarding mandatory folic acid fortification.
23. A separate modelling exercise was commissioned by FSS to explore the impact of mandatory folic acid fortification on the total folate intakes of the UK population. This information was used to estimate reduction in NTD risk associated with various fortification scenarios. SACN was not involved in executing this activity since it related to risk management rather than risk assessment; however, the Committee provided input on the approach and was given the opportunity to review and comment on the results.

24. An assessment of the sufficiency of folate intakes and status of the general UK population was beyond the scope of this review but in its letter to UK Health Ministers in October 2015 (see paragraph 15) SACN noted that, since publication of its 2006 report, low folate status in the UK remains a concern<sup>9</sup>. Information on folate intakes of the UK population from the National Diet and Nutrition Survey (NDNS) years 1-4 (2008/9-2011/12) was published in May 2014 (Bates et al., 2014) and data on blood folate status of the UK population were published in March 2015 (Bates et al., 2015). The thresholds used to define biochemical deficiency were those agreed by a consultation held by the World Health Organization (WHO) in 2008. However, in February 2016, Public Health England published a correction notice<sup>10</sup> stating that the threshold levels used to define biochemical deficiency would need adjustment because the WHO thresholds for biochemical deficiency were based on different assays from those used in the NDNS.

#### **Process for consideration of the evidence**

25. Literature searches were restricted to studies published since 2005 (the cut-off date for SACN's full risk assessment in 2006). Since then, the following five organisations have considered the evidence on folic acid: European Food Safety Authority (EFSA) (2014), the Food and Drug Administration (FDA) (2016), Food Safety Authority of Ireland (FSAI) (2016), National Toxicology Program (NTP) (2015); and the Norwegian Scientific Committee for Food Safety (VKM) (2015). The reports of their findings were considered for their potential utility as a reference resource and basis for this review. Although they provided useful background and context, none were considered to be sufficiently comprehensive to serve as an alternative to undertaking the current review. A summary of their key findings and conclusions is provided in Annex 1.
26. In order to complete the review in a timely fashion only systematic reviews and meta-analyses were considered although narrative reviews were used for background information when appropriate. For most of the health outcomes considered, several meta-analyses were identified (summarised in Tables 1-21, Annex 2). In general, if a number of systematic reviews/meta-analyses address the same health outcome then, dependent on the search inclusion criteria, they would be expected to include many of the same individual studies (published up to that time). The most recent meta-analysis would therefore be expected to include the largest number of studies and cases of disease and, consequently, provide the most reliable summary of the evidence.
27. Individual studies were considered in relation to UMFA (summarised in Tables 22-25, Annex 2) because the evidence base was less extensive than for the other potential adverse health outcomes under consideration.

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<sup>9</sup>Available at <https://www.gov.uk/government/groups/scientific-advisory-committee-on-nutrition>

<sup>10</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/501058/Notice\\_of\\_required\\_corrections\\_NDNS\\_blood\\_folate\\_thresholds\\_170216.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/501058/Notice_of_required_corrections_NDNS_blood_folate_thresholds_170216.pdf)

28. In assessing the evidence, effects or associations in studies were judged to be statistically significant (hereafter referred to as '*significant*') if the results reported a p-value < 0.05 or a confidence interval that excluded a null effect.
29. In drawing conclusions, the evidence was considered to be '*inconsistent*' where there was evidence of an association or effect but the relationship went in different directions within a study type or between different study types. In studies where statistical power was likely to be low, the absence of a significant association or effect could not be considered to equate to no association or effect and this is reflected in the conclusions.
30. Details of the literature search are provided in Annex 3.

### **3) Folate metabolism**

31. Folates comprise an aromatic pteridine ring linked to p-aminobenzoic acid and one or more glutamate residues. Naturally-occurring folates are broken down in the gut by folate conjugase in the mucosal brush borders from folate polyglutamates to the monoglutamate form. Upon absorption, the monoglutamates are converted in the mucosal cells to 5-methyl tetrahydrofolic acid (5-MTHF), which is usually the only form found in plasma. 5-MTHF is taken up by cells but cannot be retained intracellularly unless it is metabolised to tetrahydrofolate (THF). THF can be conjugated into polyglutamate forms, which prevents it leaving the cell.
32. Folic acid is not conjugated and is therefore better absorbed. Before it can become active, folic acid has to be reduced to THF and methylated. The reduction is catalysed by dihydrofolate reductase (DHFR). Reduction of folic acid by DHFR is the rate limiting step in the biotransformation of folic acid to 5-MTHF and activity of this enzyme is low in human tissue. The majority of a physiological dose of folic acid is transported in the portal vein to the liver, which is the main site of metabolism in humans (Patanwala et al., 2014). Low activity of DHFR in the gut mucosa and the liver may explain the appearance of unmetabolised folic acid in the systemic circulation following consumption of folic acid in food and supplements (Kelly et al., 1997; Bailey et al., 2010). The implications for health of the presence of unmetabolised folic acid in the systemic circulation are considered in section 5 (paragraphs 104-125).
33. For a detailed review of folate metabolism, see Tibbetts & Appling (2010).

#### 4) Current recommendations on folate intake

##### **Reference nutrient intakes for folate**

34. The reference nutrient intake (RNI) is the amount of a nutrient that is considered sufficient to meet the requirements of 97.5% of the population. For adults, the RNI for folate is 200 µg/d. For infants and children, the RNIs per day are: 0-12 months, 50 µg; 1-3y, 70 µg; 4-6y, 100 µg; 7-10y, 150 µg; for children 11y and above, the RNI is the same as that for adults.

##### **Recommended upper intake levels for folic acid**

35. Although folates occur naturally in a wide range of foods, they are present in relatively low amounts. This means that it is hard to achieve high folate intakes from consumption of naturally occurring folates alone. In addition, the absorption of naturally occurring folates is approximately 50% lower than that of folic acid. Concerns regarding the safety of high intakes are therefore restricted to folic acid.
36. In the USA and Europe, a Tolerable Upper Intake Level (UL) of 1 mg/d of folic acid was set for adults (Food and Nutrition Board, 1998; Scientific Committee on Food, 2000). The UL represents the highest level of a nutrient that is likely to pose no risk of adverse health effects to almost all individuals in the general population. It applies to long-term exposure on a daily basis. The UL was based on the risk of progression of neurological symptoms in vitamin B12 deficient patients. ULs for children in the USA<sup>11</sup> and Europe<sup>12</sup> were extrapolated from the UL for adults on the basis of relative body weight.
37. In the UK, safe levels of intake for vitamins and minerals in food supplements and fortified foods were set by the Expert Group on Vitamins and Minerals (2003). Safe Upper Levels (SULs) were set when supported by adequate data. SULs represent intakes that can be consumed over a lifetime without significant risk to health. A Guidance Level (GL) was set when there were insufficient data to determine an SUL. GLs represent an approximate indication of intakes that would not be expected to cause adverse effects. An SUL was not set for folic acid intake as the available evidence on adverse effects of folic acid was not considered to be sufficiently robust but a GL of 1 mg/d was set based on concerns that intakes above this level may mask signs of vitamin B12 deficiency. GLs were not set for children as there were no data reporting adverse effects in children.

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<sup>11</sup> ULs (µg/d) by age group: 1-3y, 300; 4-8y, 400; 9-13y, 600; 14-18y, 800.

<sup>12</sup> ULs (µg/d) by age group: 1-3y, 200; 4-6y, 300; 7-10y, 400; 11-14y, 600; 15-17y, 800.

## 5) Potential adverse effects of folic acid fortification

### Types of evidence considered

38. The range of evidence considered in this report covered three types of study: RCTs of folic acid supplementation (including those that had considered folic acid together with other B vitamins or multivitamins); observational studies of dietary folate intake (from foods), total folate intake (from diet and folic acid supplements) and folate status; and genetic association studies.
39. Genetic association studies are not subject to reverse causality and are less prone to potential confounding, both of which limit the causal interpretation of observational studies of nutrient intake and status. They have been likened to '*natural*' RCTs (with genotype corresponding to the dietary intervention) though with the advantage that the numbers of individuals studied are typically much larger and exposure time is much longer (lifelong) than can be achieved in an RCT. However, there are issues that may affect the interpretation of genetic association studies (see paragraphs 45-47).
40. The basis for genetic association studies is that an observed association between a polymorphism and a disease state or other trait is assumed to arise because the polymorphism has a causal role in determining the trait. This logic may be extended to the assumption that the pathway or process in which the gene is involved is causal and that the nutritional and environmental factors which influence the pathway or process may influence the disease state/trait. This approach has been termed '*mendelian randomisation*' (Davey Smith et al., 2005)<sup>13</sup>.
41. The enzyme methylenetetrahydrofolate reductase (MTHFR) converts 5,10-methylene-THF to 5-MTHF (see paragraph 31). A relatively common polymorphism of the gene encoding MTHFR, involving a C to T substitution at base 677 of the gene (677C→T; rs1801133), produces an enzyme with lower folate-processing capacity. Individuals with the TT genotype have significantly lower blood folate concentrations for the same dietary intake of folate (Molloy et al., 1997). A meta-analysis (Tsang et al., 2015) estimated that, compared to CC, the TT genotype confers a 16% lower red blood cell folate and a 13% lower serum (or plasma) folate measured using a microbiological assay and a serum (or plasma) difference of 20% when assessed using protein-binding assays. The validity of this genetic approach is supported by health outcomes such as NTD where it is known that the condition is influenced by low dietary folate intake and that mothers or infants with the TT genotype have significantly greater risk of an NTD-affected pregnancy than those with the CC genotype (Yan et al., 2012; Zhang et al., 2013).

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<sup>13</sup> The principle of mendelian randomisation is that "*if genetic variants either alter the level of or mirror the biological effects of a modifiable environmental exposure that itself alters disease risk, then these genetic variants should be related to disease risk to the extent predicted by their effect on exposure to the risk factor*" (Davey Smith et al., 2005).

### **Potential sources of confounding in studies of folate and health outcomes**

42. A common problem, particularly with the RCTs, was the statistical power. This was rarely reported in the reviews and no attempt was made here to do this retrospectively but, where the numbers were small, this was noted.
43. The three study types have different strengths and weaknesses and do not always measure exactly the same thing. RCTs typically use higher doses (mainly of folic acid) but are of shorter duration than observational studies. Observational studies of intake often do not distinguish between natural folates and folic acid and they may be subject to confounding. Blood folate status is also affected by genotypes such as MTHFR. Application of the mendelian randomisation approach to MTHFR genetic evidence also has problems (see paragraphs 45-47).
44. In addition to the general confounders in studies of diet and disease (such as smoking, alcohol intake and physical activity), a number of other factors need to be considered in the assessment of evidence on folate intakes/folate status and health outcomes. In studies of folate status, serum or plasma folate concentrations may not be comparable across different studies because of significant analytical variation between the different assay methods and between different laboratories using similar methods (see SACN 2006 report). Another important consideration is that serum or plasma folate concentrations reflect recent dietary intake rather than long term folate status which is better reflected by red cell folate concentration. Serum or plasma folate concentration is also influenced by genetic variation (see paragraph 41). In studies of dietary folate intake, estimated intakes based on different dietary assessment methods and different nutrient databases may not be comparable.
45. Genetic studies are not affected by some of the biases that affect other observational studies of folic acid intake and status (e.g., confounding and reverse causation) but, in common with other study types, they may be subject to publication bias. They also have their own specific problems of interpretation. They may be subject to bias due to population stratification and the inference of a nutritional effect may not be valid in all circumstances.
46. Gene products may have more than one role and it is possible that an association between the MTHFR 677 TT genotype and health may operate through a mechanism that is not related to the effect of the TT genotype on folate status. Also, genetic material is inherited in blocks and genetic variants are often linked to others in the same gene or other nearby genes. It is therefore possible that another variant within the MTHFR gene, or within another gene close by, may be influencing the health outcome and that the statistical association with the MTHFR C677T variant is not causal.
47. In cases where the MTHFR 677 TT genotype does accurately identify an effect of folate on health, the timing of that effect is generally not known. In the case of NTD the

developmental window within which the condition develops is relatively narrow (periconceptional to 12 weeks of gestation) therefore an association with the MTHFR C677T variant points to an effect of folate at a specific developmental stage. For diseases such as cancer, where the timing is not so clear, it may not be possible to specify the critical period of exposure as genotypes do not change across the life-course.

### **Review of the evidence**

#### ***Cognitive health: Masking or exacerbation of low vitamin B12 status; cognitive decline in older individuals***

48. Clinical symptoms associated with vitamin B12 deficiency include anaemia (identical to that of folate deficiency) and neurological impairment. Treatment with high doses of folic acid can alleviate the anaemia and, as a consequence, 'mask' the vitamin B12 deficiency. This could delay the diagnosis of vitamin B12 deficiency and may lead to irreversible neurological damage.
49. In 2006, SACN considered whether folic acid fortification could lead to a delay in the diagnosis of vitamin B12 deficiency and allow the neuropathy to progress. SACN concluded that folic acid intakes of up to 1 mg/d are not associated with neurological impairment in older people with low B12 status.

#### **Cognitive related outcomes**

50. Since 2005, several systematic reviews have evaluated the association of folate status with risk of dementia or changes in cognitive capabilities, as well as the effect of folic acid administration (alone or with other nutrients) on these outcomes. The results of these are summarised in Annex 2 (Tables 1-2).
51. The primary evidence in the reviews focuses on adults aged  $\geq 55$ y (mostly aged  $\geq 65$ y). These systematic reviews indicate that intervention studies with folic acid alone or in combination with (mainly) other B-vitamins report mixed results but overall no consistently significant effects on any general measures or specific domains of cognition. The systematic reviews of cohort studies also report either no significant relationships or that relatively higher folate status is associated with lower risks of cognitive decline and dementia.

#### **Masking or exacerbation of low vitamin B12 status**

52. No systematic reviews or meta-analyses, evaluating the risk of folic acid masking or exacerbating adverse effects of vitamin B12 deficiency, were identified.
53. Three narrative reviews (Reynolds, 2016; Selhub & Rosenberg, 2016; Smith & Refsum, 2016) discuss putative risks of folic acid fortification in relation to these outcomes. Masking by folic acid of the anaemia associated with vitamin B12 deficiency is often described in the clinical nutrition literature, but it is further suggested that folic acid

also causes or exacerbates long-term neurological degeneration associated with marginal vitamin B12 status.

54. A key issue is not whether these outcomes could occur, but the susceptible populations and the doses of folic acid where there might be a significant risk of these occurring. A study which examined nationally representative samples of adults aged  $\geq 50$ y in the US (Qi et al., 2014) reported that the prevalence of low vitamin B12 status (defined as serum B12 concentration  $< 148$  pmol/L) in the absence of megaloblastic anaemia or macrocytosis did not increase after fortification (140  $\mu$ g folic acid per 100 g flour). This is consistent with data from regional cohorts in the USA (Mills et al., 2003) and Canada (Liu et al., 2004) which reported no evidence of 'masking' of vitamin B12 deficiency after folic acid fortification, although Wyckoff & Ganji (2007) reported an increase after fortification in the proportion of individuals with low vitamin B12 status and no anaemia in another US cohort. These data are, however, difficult to interpret because they are likely to include some correction of anaemia associated with folate deficiency. In addition, the biochemical measures used to assess vitamin B12 deficiency are of limited reliability and there are no agreed criteria to define deficiency.
55. Much of the evidence reporting these adverse outcomes originates from interventions with folic acid doses in excess of 1 mg/d, initiated as part of the clinical management of small populations of older patients presenting with pernicious anaemia (Savage & Lindenbaum, 1995) and the relevance of these data is uncertain. At folic acid doses below 1 mg/d there is very limited and mixed evidence, largely presented as case studies in which causality cannot be confirmed (see Savage & Lindenbaum, 1995). There continues to be speculation and debate around the interpretation of these observations. Where some cross-sectional observational studies (reviewed by Selhub & Rosenberg, 2016) find associations between high folate status (plasma or red blood cell concentrations above the normal range) and cognitive impairments in older individuals with low vitamin B12 status, causality cannot be assumed. These same data also indicate an association of high folate status with relatively better cognitive function in individuals with normal vitamin B12 status.
56. High folate status may reflect a significant contribution from supplemental folic acid intake. In the USA, folic acid intakes exceeding 1 mg/d are strongly associated with use of supplements (Orozco et al., 2016) and this was also the case in previous UK modelling of individuals age 65y and above with low vitamin B12 status (SACN, 2006).
57. A single nucleotide polymorphism (776C $\rightarrow$ G) in the gene for transcobalamin (TCN2; rs1801198), which transports vitamin B12 around the body, affects the binding of transcobalamin to vitamin B12 and is associated with a lower concentration of holotranscobalamin (vitamin B12 attached to transcobalamin) (Miller et al., 2002; Afman et al., 2002). Therefore vitamin B12 availability to tissues may be lower in 776G carriers even when vitamin B12 intake is adequate. A study which examined the association of the TCN2 776C $\rightarrow$ G polymorphism and folate intake with peripheral

neuropathy in individuals (n=171; age, ≥ 60y) with normal vitamin B12 status (plasma vitamin B12 concentration >148 pmol/L) reported a significantly higher risk of neuropathy in GG compared to CC genotypes (OR, 3.33; 95% CI, 1.15-9.64) at folate intakes ≥ 800 µg/d (Sawaengsri et al., 2016). However, as with the MTHFR 677 TT genotype, there are uncertainties regarding the validity of inferring nutritional effects from genetic evidence (see paragraphs 45-47).

58. Intervention studies with folic acid supplementation (with or without vitamin B12), have generally reported no significant effects on cognitive performance and risk of dementia. However, almost all intervention trials were less than 1 year in duration and neither intervention nor observational analyses have been focused on or powered for assessment of effects in individuals with low vitamin B12 status specifically. As noted by other authorities, data are lacking with which to directly assess the risk of adverse neurological effects of higher folic acid intakes in individuals with low vitamin B12 status, particularly for folic acid intakes < 1 mg/d. Longitudinal studies have generally reported no association or a significant beneficial association of higher folate status with lower risk of dementia or cognitive decline.

*Cognitive health related outcomes in children*

59. Two systematic reviews were identified which examined the effects of folic acid supplementation on paediatric populations (Lohner et al., 2012; Skorka et al., 2012).
60. Lohner et al. (2012) reviewed RCTs of folic acid supplementation in infants, children or adolescents. The majority of studies were of premature infants, malnourished populations, or individuals with specific medical conditions; only 6 of the 21 included studies described results for healthy populations. In general, no adverse effects were reported for any outcomes including vitamin B12 status; however, the studies measuring vitamin B12 were of relatively short duration. Cognition was only reported as an outcome in two studies of children with Down syndrome.
61. Skorka et al. (2012) focused on RCTs of folic acid supplementation in mothers and in children aged up to 3y with child mental and psychomotor development as outcomes. However only two studies met the inclusion criteria, both of which involved periconceptual supplementation of mothers with multivitamin mixes including folic acid and both reported no significant effects on subsequent child development.
62. Another systematic review that examined the links between vitamin B12 and cognition in children (Venkatramanan et al., 2016) cited one RCT from India (Kvestad et al., 2015) in which children (aged 6 to 30 months) from low to middle socioeconomic class families were supplemented with combinations of folic acid and/or vitamin B12. Six months of supplementation with folic acid alone had no significant effects on measures of gross motor and problem-solving skills, regardless of initial vitamin B12 status.

### Summary and conclusions

63. Evidence from intervention studies suggests, overall, that folic acid had no significant effects on cognitive decline in older individuals. Observational studies have reported no significant relationship, or a lower risk, associated with higher folate status.
64. Concern has been expressed regarding possible adverse effects of high folate status in individuals with low vitamin B12 status. No systematic reviews have evaluated the risk of folic acid masking or exacerbating vitamin B12 deficiency in adults and the evidence for this outcome is largely from folic acid interventions in excess of 1 mg/d. Evidence from the US indicates that the prevalence of vitamin B12 deficiency with or without anaemia did not increase after mandatory fortification.
65. Evidence from intervention studies suggests no effect of folic acid on cognitive function or development in children.

### **Cancer**

66. In 2006, SACN concluded that there was insufficient evidence at that time for an adequate risk assessment of folic acid and cancer risk or of the intake levels that might be associated with risk. In 2009, the Committee agreed that there were still uncertainties regarding folic acid and cancer risk.
67. A limitation of RCTs that have assessed the relationship between folic acid and cancer risk is that most were not designed to do so and may, therefore, not have been adequately powered to detect an association. In addition, cancer usually develops over several years and most trials were of relatively short duration with limited follow-up time.

### Prostate cancer risk

#### *RCTs of folic acid supplementation*

68. Two meta-analyses of published results (Wien et al., 2012; Qin et al., 2013b) and one pooled analysis of individual participant data (Vollset et al., 2013) examined the effect of folic acid supplementation on prostate cancer risk (Table 3, Annex 2). The pooled analysis of Vollset et al. (2013), which included the largest number of trials (n=12) and cases (n=656), reported no significant difference in prostate cancer risk between participants randomised to receive folic acid (dose range, 0.5-40 mg/d; median, 2.0 mg/d) compared to placebo.

#### *Observational studies of folate intake*

69. Two meta-analyses of dietary folate and prostate cancer risk were identified (Tio et al., 2014a; Wang et al., 2014). Both included the same individual studies (n=5; 12,898 cases) and reported no association of dietary folate (177-444 µg/d) with prostate cancer risk (Table 4, Annex 2).
70. One meta-analysis of total folate intake (diet plus supplements) and prostate cancer risk was identified (Tio et al., 2014a). The meta-analysis, which included two individual

studies, reported no association of total folate intake (223-640 µg/d) with risk for prostate cancer (Table 5, Annex 2).

#### *Observational studies of serum or plasma folate concentration*

71. Three meta-analyses of published results (Collin et al., 2010; Tio et al., 2014a; Wang et al., 2014) and one pooled analysis of individual participant data (Price et al., 2016) investigated the prospective relationship between serum or plasma folate and prostate cancer risk (Table 6, Annex 2). The pooled analysis (Price et al., 2016) included the largest number of cases (n=6875). Study specific quintile cut-points (not reported) were used to categorise participants into fifths of serum/plasma folate concentration (mean concentrations ranged from 5.7 to 16.9 nmol/L). A significantly higher risk for prostate cancer in men with relatively high compared to relatively low serum or plasma folate was reported. Price et al. (2016) also conducted subgroup analyses according to tumour characteristics and reported significant heterogeneity by the histological grade of the tumour, with a high risk for high grade disease associated with high circulating folate concentrations.
72. In the next largest meta-analysis (Tio et al., 2014a) (n=5904 cases), which also reported a significantly higher risk of prostate cancer in men with relatively high compared to relatively low folate concentration, the median folate concentration was 17.1 (range 10.3-58.2) nmol/L in the high category and 6.5 (range 4.8-10.9) nmol/L in the low category.

#### *MTHFR genotype*

73. Five meta-analyses investigated the association between MTHFR genotype and prostate cancer risk (Table 7, Annex 2). Four are based only on published results (Zhang et al., 2014; Abedinzadeh et al., 2015; Chen et al., 2015; Guo et al., 2015) while one includes unpublished data (Collin et al., 2009). The studies and numbers of cases included varied, with the largest number of studies (n=23) and cases (n=11,348) in the meta-analysis by Guo et al. (2015) which reported a significantly lower risk in men with TT genotype (associated with lower serum folate) than in those with CC genotype.

#### Summary and conclusions

74. The data on folic acid/folate and prostate cancer risk, overall, are inconsistent.
75. Meta-analyses of RCTs of folic acid supplementation (median dose, 2.0 mg/d) show no effect of folic acid on prostate cancer risk but the number of cases is small suggesting low statistical power.
76. Observational studies of dietary (median intake in high category, 378 µg/d) or total (median intake in high category, 554 µg/d) folate intake do not suggest an association with prostate cancer risk. Observational studies of serum or plasma folate concentration suggest a higher risk of prostate cancer in men with relatively high (10.3-58.2 nmol/L; median, 17.1 nmol/L) serum or plasma folate concentration.

77. The genetic studies show a significantly lower prostate cancer risk in men with MTHFR TT genotype, which results in a lower blood folate concentration. This suggests that higher folate concentrations are associated with an increased risk of prostate cancer.

#### Breast cancer risk

##### *RCTs of folic acid supplementation*

78. Two meta-analyses examined the effect of folic acid supplementation (usually combined with vitamin B12 and sometimes other vitamins) on breast cancer risk (Vollset et al., 2013; Qin et al., 2013b) (Table 8, Annex 2). The largest number of cases (n=297) and trials were included in the pooled analysis by Vollset et al. (2013) which reported no significant difference in breast cancer risk between participants randomised to folic acid supplements (0.5-40 mg/d; median 2.0 mg/d) compared to placebo.

##### *Observational studies of folate intake*

79. Three meta-analyses of dietary folate intake and breast cancer risk were identified (Larsson et al., 2007; Chen et al., 2014; Liu et al., 2014) (Table 9, Annex 2). The two most recent (Chen et al., 2014; Liu et al., 2014), which include the same individual studies and almost the same number of cases, reported no evidence of an association of dietary folate (126-551 µg/d) with breast cancer risk. Four meta-analyses of total folate intake (diet plus supplements) were identified (Lewis et al., 2006; Larsson et al., 2007; Chen et al., 2014; Zhang et al., 2014) (Table 10, Annex 2). The meta-analysis by Zhang et al. (2014), which included the largest number of studies and cases (n=18,572), reported no evidence of an association of total folate intake (150-919 µg/d) with breast cancer risk.

##### *Observational studies of serum/plasma folate*

80. One meta-analysis (Larsson et al., 2007) reported no evidence of an association of circulating folate concentration (6.8-13.6 nmol/L) with breast cancer risk (Table 11, Annex 2).

##### *MTHFR genotype*

81. Four meta-analyses investigated the association between MTHFR genotype and breast cancer risk (Table 12, Annex 2). The most recent (Kumar et al., 2015) with the largest number of studies (n=75) and cases (31,315), observed a small but significantly higher risk in women with TT genotype (associated with relatively lower serum folate) than in those with CC genotype.

#### Summary and conclusions

82. The data overall do not suggest that folic acid/folate increases the risk for breast cancer.

83. Meta-analyses of RCTs of folic acid supplementation (median dose, 2.0 mg/d) show no effect of folic acid on breast cancer risk but they may not have had sufficient power to detect an effect.
84. Observational studies of dietary folate intake (median, >374 µg/d) and total folate (median, 489 µg/d) intake do not show an association with breast cancer risk. Observational studies of serum or plasma folate concentration (6.8-31.7 nmol/L) also show no association with breast cancer risk.
85. Findings from the MTHFR genetic studies suggest lower folate concentrations are associated with higher breast cancer risk.

### Colorectal cancer risk

#### *RCTs of folic acid supplementation*

86. Two meta-analyses (Cooper et al., 2010; Qin et al., 2015) and one pooled analysis (Vollset et al., 2013) assessed the relationship between folic acid supplementation and colorectal cancer risk (Table 13, Annex 2). The pooled analysis (Vollset et al., 2013), which included the largest number of cases (n=429), reported no effect of folic acid supplementation (0.5-40 mg/d; median dose, 2.0 mg/d) on colorectal cancer risk but the confidence intervals are large and, even when combined, the numbers studied are relatively small.
87. Five meta-analyses (Cooper et al., 2010; Ibrahim & Zekri, 2010; Fife et al., 2011; Figueiredo et al., 2011; van Dijk & Pot, 2016) examined adenoma recurrence in individuals with a history of adenomas (Table 14, Annex 2); one of these (Fife et al., 2011) reported that folic acid supplementation (0.5-2.5 mg/d; median, 1 mg/d) for over 3 years significantly increased the risk of an adenomatous lesion. The most recent meta-analysis (van Dijk & Pot, 2016) reported folic acid supplementation (0.5-5 mg/d; median dose 1 mg/d) had no significant effect overall on colorectal adenoma recurrence but the confidence intervals are large and the findings heterogeneous.

#### *Observational studies of folate intake*

88. One meta-analysis (Kennedy et al., 2011) and one pooled analysis (Kim et al., 2010) evaluated the association between dietary folate intake and colorectal cancer risk (Table 15, Annex 2). Both reported no association. One meta-analysis (Heine-Broring et al., 2015) evaluated the association between supplemental folic acid intake and colorectal cancer risk and reported inconsistent associations, though a comparison of highest (>143 to ≥ 560 µg/d; median, ≥400 µg/d) and lowest (<50 to <101 µg/d; median, <83 µg/d) categories suggests a significant protective effect of higher intakes (Table 16, Annex 2).
89. One meta-analysis (Liu et al., 2015) and one pooled analysis (Kim et al., 2010) investigated total folate intake and colorectal cancer risk (Table 17, Annex 2). The pooled analysis (Kim et al., 2010) (5720 cases) reported no significant association of folate intake with colorectal cancer risk in the continuous regression model but a

comparison of highest and lowest quintiles of intake suggested a significant protective effect of higher intakes. Folate intakes in the highest vs lowest quintiles were not specified but the median intake range across the included studies was 259-501 µg/d. The most recent meta-analysis (Liu et al., 2015) with the largest number of cases (n=24,816) reported a reduced colorectal cancer risk when comparing highest (median, > 441 µg/d) with lowest (median, 212 µg/d) folate intake.

*Observational studies of serum or plasma folate*

90. One meta-analysis (Chuang et al., 2013) assessed the association between serum or plasma folate concentration and colorectal cancer risk (Table 18, Annex 2). Overall, no association was found although there was heterogeneity when the studies were considered by assay method. In meta-analysis of studies which measured serum or plasma folate concentration using radioimmunoassay, a higher (median, 31.5 nmol/L) compared to lower (median, 6.1 nmol/L) serum or plasma folate concentration was significantly associated with a lower risk of colorectal cancer, while studies using microbiological assays reported no association.

MTHFR genotype

91. Six meta-analyses (Kennedy et al., 2012; Rai, 2015; Sheng et al., 2012; Taioli et al., 2009; Yang et al., 2012; Zhou et al., 2012) (based on 94 primary studies) investigated the association between the MTHFR genotype and colorectal cancer risk (Table 19, Annex 2). The meta-analysis with the largest number of cases (n=26,731) reported a significant association between the MTHFR 677TT genotype (which results in lower blood folate concentration) and lower colorectal cancer risk (Kennedy et al., 2011). A similar result was reported in the other five meta-analyses though there was overlap in the primary studies included in these.
92. The numbers required to detect a genetic association with a health outcome depend on the frequency of the MTHFR C677T genotype in the population studied with greater numbers being required when the TT genotype frequency is lower. In European white populations the frequency of the TT genotype is around 10% but has been reported to be as low as 2% in West African and African American populations and less than 1% in the northern Chinese and individuals of Mexican descent (Tsang et al., 2015). Therefore in non-European non-white populations, larger numbers are required to detect effects of the same magnitude.
93. A subgroup analysis in Asians by Sheng et al. (2012) indicated a lower colorectal cancer risk in those with the TT genotype. Other studies have shown the same significant association in Asian populations (Yang et al., 2012; Zhou et al., 2012) though Rai (2015) reported a similar odds ratio but the association was not significant. Taioli et al. (2009) conducted a meta-analysis of 29 studies (11,936 cases, 18,714 controls) and a pooled analysis of 14 studies (5068 cases, 7876 controls), with stratification by racial/ethnic group. The TT genotype was significantly associated with a reduced colorectal cancer risk in the whole population and in whites and Asians separately.

### Summary and conclusions

94. The data on folic acid/folate and colorectal cancer risk, overall, are heterogeneous within all but the genetic association study designs and the findings are inconsistent between study designs.
95. The meta-analyses of RCTs of folic acid supplementation (median dose, 2.0 mg/d) on colorectal cancer risk report no significant effect but the numbers studied are relatively small.
96. The observational studies also have a high degree of heterogeneity though the largest suggests a protective association of folate intakes above about 400 µg/d. There is also evidence of a protective association of high intakes when comparing the highest and lowest categories of intake for total folate and folic acid as a supplement. Observational studies of serum or plasma folate concentration provide no clear evidence of a beneficial or detrimental association with colorectal cancer risk.
97. The evidence from the MTHFR genetic studies indicates a consistently lower risk of colorectal cancer in individuals with the TT genotype compared to those with the CC genotype in both white and Asian populations. This is generally assumed to be indicative of a decreased risk of colorectal cancer in individuals with lower blood folate concentrations associated with the TT genotype.

### Overall cancer risk

98. Overall cancer risk represents an average of the different types of cancers and will depend on population and the prevalence of many cancer risk factors.

### RCTs of folic acid supplementation

99. Three meta-analyses of published results (Wien et al., 2012; Baggott et al., 2012; Qin et al., 2013b) and one pooled analysis of individual participant data (Vollset et al., 2013) examined the effect of folic acid supplementation on overall cancer risk (Table 20, Annex 2). The meta-analysis with the largest number of trials (n=13) and cases (n=3741) (Qin et al., 2013a) reported no significant difference in cancer risk between participants randomised to receive folic acid supplements (range, 0.5-40 mg/d; median dose, 2 mg/d) compared to placebo. There was also no association between intervention duration and cancer incidence risk. The pooled analysis of individual participant data (Vollset et al., 2013), which included the same number of trials and almost as many cases (n=3713), also reported no significant effect of folic acid on cancer risk. Daily dose of folic acid or treatment duration had no effect.

### MTHFR genotype

100. One meta-analysis of studies (n=134) investigating the association between the MTHFR polymorphism and overall cancer risk (Tang et al., 2014) (Table 21, Annex 2) reported a significantly higher risk of all cancers in people with TT genotype (lower serum folate concentration) than in those with CC genotype.

### Summary and conclusions

101. The data on folic acid/folate and overall cancer risk are inconsistent.
102. Evidence from RCTs shows no effect of folic acid supplementation (at doses ranging from 0.5-40 mg/d; median, 2.0 mg/d) on overall cancer risk but they may not have had sufficient power to detect an effect.
103. Findings from the MTHFR genetic studies suggest lower folate concentrations are associated with higher overall cancer risk.

### ***Unmetabolised folic acid***

104. The appearance of UMFA in the systemic circulation has raised concerns regarding potential long term effects of high folic acid intakes.
105. In 2006, SACN noted that "*unmetabolised folic acid has been detected in the systemic circulation following oral doses of folic acid above 260 µg*" but that there were "*insufficient data in humans to assess the long-term effects of exposure to unmetabolised folic acid in the systemic circulation*". Since then, a number of new studies on UMFA have been published and improved detection methods (LC-MS/MS) have been applied in national surveys such as the NDNS in the UK and National Health and Nutrition Examination Survey (NHANES) in the USA.
106. Studies on UMFA are summarised in Tables 22-25 (Annex 2).

### Measurement of serum/plasma UMFA in the systemic circulation

#### *Intervention studies following folic acid supplementation*

107. Seven intervention studies (from USA, Ireland and Germany) measured serum UMFA following folic acid supplementation (Table 22, Annex 2). Sample sizes were very small in all studies (n=20-74) and duration ranged from 3-30 weeks<sup>14</sup>. The intervention dose ranged from 100 µg to 5 mg/d but, in most studies, was 400 µg/d. Fasted blood samples were used to measure UMFA in five studies; non-fasted blood samples were used in one study; fasting status was not reported in one study.
108. The proportion of individuals with detectable UMFA ranged between 0 and 68% at baseline and 33 to 97% post intervention. UMFA as a proportion of total serum folate was 1-3% with folic acid doses of 400 µg/d. One study reported that UMFA was 15% of total plasma folate following a supplementation dose of 5 mg/d (Obeid et al., 2011).
109. In one study (Houghton et al., 2009), which measured the effect of three interventions (folic acid, 400 µg/d; 5-MTHF, 416 µg/d; or placebo) on milk folate concentrations of lactating women, UMFA comprised 8% of total breast milk folate concentration regardless of treatment group. Another study that compared the effect of folic acid supplementation (400 µg/d) or placebo during pregnancy on cord blood UMFA concentration reported that UMFA was detected in 15% of the cord samples but there

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<sup>14</sup> With the exception of one study with a duration of 1 year.

was no difference between the two groups in the proportion of cord samples with detectable UMFA (Pentieva et al., 2016).

110. One small study (n=20) which examined 3 folic acid doses (100, 200 or 400 µg/d) reported that only the highest (400 µg/d) led to the appearance of UMFA in serum (Sweeney et al., 2007). A study (Tam et al., 2012) which compared the effect of two higher doses of folic acid (1.1 vs 5 mg/d for 30 weeks) on plasma UMFA concentration of women of reproductive age (n=40), reported no significant differences between the two doses.

#### *Observational studies*

111. Seven observational studies (1 prospective; 6 cross-sectional) examined associations between folic acid intake and UMFA (Table 23, Annex 2). Sample sizes ranged from n=11 to n=368 and the majority of studies measured UMFA in fasted blood samples.
112. Four studies reported UMFA during pregnancy and in newborns. In three studies (Obeid et al., 2010; Sweeney et al., 2005; Sweeney et al., 2009) from Germany and Ireland (where there is voluntary but not mandatory fortification) the proportion of mothers with detectable UMFA during pregnancy ranged from 44 to 90% (UMFA as % of total folate ranged from 0.43 to 1.3%); the proportion of umbilical cord samples with detectable UMFA ranged from 53 to 100%. In one study from Canada (Plumptre et al., 2015) (where there is mandatory fortification) UMFA was detected in 97% of women (median UMFA as % of total folate = 3.1%) and 93% of cord samples (median UMFA as % of total folate = 1.3%). There was no significant difference in the proportion of maternal or umbilical cord samples with detectable UMFA according to maternal supplement use during pregnancy. UMFA as proportion of total folate was significantly lower in cord than in maternal serum.
113. Out of three population-based studies (2 cross-sectional; 1 prospective cohort) in Ireland, two analysed fasted samples (Vaish et al., 2016; Boilson et al., 2012) and reported detectable UMFA in 10% of children ≤ 16y (1.9% of total folate) and in 94% of adults aged 60-86y (1.3% of total folate). In the study which used non-fasting samples (Sweeney et al., 2009), UMFA was detected in 98% of adults aged 26-39y (2.3% of total folate).
114. One cross-sectional study examined the effects of a polymorphism in the DHFR<sup>15</sup> gene (19 bp deletion in intron-1; rs70991108) on UMFA concentration (Kalmbach et al., 2008). This polymorphism is relatively common with 23% homozygosity in the US population (Philip et al., 2015). Kalmbach et al. (2008) reported that the polymorphism was associated with higher plasma UMFA concentration and lower red blood cell folate concentration. The proportion of individuals with serum UMFA concentration >1.35 nmol/L was higher in those homozygous for the polymorphism (47%), who were

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<sup>15</sup> DHFR catalyses the reduction of folic acid to THF (see paragraph 32).

consuming > 500 µg/d of folic acid, compared with those with one copy of the deletion (21%) or none (24%).

#### *National monitoring programmes*

115. Three studies in the USA reported findings from NHANES (2000-2001; 2007-2008; 2011-12) (Table 24, Annex 2). In NHANES 2000-2001 (Bailey et al., 2010), which measured fasted samples, UMFA was detected in 38% of the population and accounted for 2.3% of total serum folate. In NHANES 2007-08 (Pfeiffer et al., 2015b) & 2011-12 (Pfeiffer et al., 2015a), which included fasted & non-fasted samples, UMFA was detected in over 95% of the population and accounted for 4% of total serum folate.
116. Data on UMFA concentrations of individuals from the NDNS in the UK (see Annex 4) indicate that UMFA comprises a relatively constant proportion (2-3%) of total blood folate (Bates et al., 2015). The median value is slightly lower in children aged under 11y but, overall, the distribution of the proportion of UMFA appears to be relatively constant across different age groups. The median UMFA as a proportion of total folate by age group are: 1.9%, 1.3-3y; 2.1%, 4-10y; 2.9%, 11-18y; 2.8%, 19-64y & 65+y. For the group as a whole, 82% of individuals had a UMFA concentration < 5% of total blood folate and 98% had a UMFA concentration < 10% of total blood folate. The percentage of individuals with UMFA concentrations below the limit for detection was: 7.5%, 1.5-3y; 19.2%, 4-10y; 30.1%, 11-18y; 32.6%, 19-64y; and 28.5%, 65+y.
117. It has been suggested that UMFA, rather than reflecting an intake of folic acid which has exceeded the body's capacity for metabolic conversion, may be produced endogenously from natural folates (Obeid et al., 2010). This could explain the significant positive correlation observed between UMFA and 5-MTHF and total folate concentrations (Obeid et al., 2011; Pfeiffer et al., 2015b) and the observations that UMFA is routinely detected in samples collected from fasting individuals, and that the concentration of UMFA comprises a relatively constant proportion of total blood folate regardless of age and intake.
118. There appear to be two processes that result in UMFA appearing in the blood. Ingestion of a bolus dose of folic acid can exceed the capacity of the intestinal mucosa to metabolise it to circulating plasma folate (5-MTHF) before entering the liver and the wider systemic blood supply, resulting in the transient appearance of UMFA in the circulation (Patanwala et al., 2014). It is possible that this could explain some of the UMFA detected in fasting NDNS samples. However, the proportions of UMFA in fasting samples in the USA are of the same order as those in the UK, although folic acid intakes are considerably higher in the USA, and, as in the UK, UMFA makes up a relatively constant proportion of total folate regardless of age. It is likely that there is a natural equilibrium point between total folate and UMFA (possibly involving endogenous UMFA synthesis). This complicates the interpretation of UMFA concentrations but it also suggests that the generation of UMFA is a natural process and that concentrations

may be determined by the total intake of folates (natural and synthetic) rather than intake of folic acid *per se*.

#### Health outcomes

119. Three observational studies examined associations between potential adverse effects of UMFA on health outcomes (cancer & cognitive test performance) (Table 25, Annex 2).
120. One prospective cohort study (Cho et al., 2015) reported that, overall, prediagnostic UMFA was not associated with colorectal cancer risk; however blood samples were collected before mandatory folic acid fortification so UMFA concentrations were not reflective of those after fortification. One prospective cohort study (Hu et al., 2016) reported no associations between UMFA & overall cancer risk. One cross-sectional study (Morris et al., 2010) reported that in a subgroup analysis of participants with low vitamin B12 status (serum B12 < 148 nmol/L or methylmalonic acid ≥ 210 nmol/L) the presence compared with the absence of detectable UMFA was associated with lower cognitive test score.

#### Summary and conclusions

121. In intervention studies, the proportion of individuals with detectable UMFA ranged between 33 and 97% post intervention. UMFA as a proportion of total folate was 1-3% at folic acid doses of 400 µg/d. The presence of UMFA in umbilical cord blood and breast milk was unrelated to maternal FA supplement intake.
122. There is no clear dose-response relationship between folic acid intake and the appearance of UMFA in the systemic circulation.
123. UMFA comprises a relatively constant proportion of total folate in the population regardless of age and it is commonly detected in fasted samples. It is unlikely that the fasting UMFA concentration only reflects an intake of folic acid which has exceeded the body's capacity for metabolic conversion. This is supported by findings from national monitoring programmes in the USA and UK which show similar proportions of UMFA in fasting samples from both countries although folic acid intakes are considerably higher in the USA.
124. The concentration of UMFA in individuals carrying a relatively common polymorphism within the DHFR gene is likely to be higher, for at least part of the day, than in those without the polymorphism or with fewer copies.
125. There are insufficient data to assess whether the presence of UMFA in the systemic circulation is related to any adverse health outcomes.

## 6) The potential impact of mandatory folic acid fortification

126. In its 2006 report, SACN assessed the potential impact of fortifying wheat flour<sup>16</sup> (including and excluding wholemeal flour) with different doses of folic acid (100-450 µg folic acid/100 g flour) on the total folate intake of different population age groups in the UK. Dietary intake data from the NDNS series was modelled to explore the effect of mandatory folic acid fortification on:
- average intakes of folic acid;
  - proportion of the population with folate intakes below the RNI;
  - risk of NTD affected pregnancies;
  - numbers in the population who might be exposed to folic acid doses above the UL<sup>17</sup> for folic acid;
  - numbers in the population aged ≥ 65y with low vitamin B12 status who might be exposed to folic acid doses above 1 mg/d.
127. The effects of mandatory folic acid fortification were considered with and without the contribution of folic acid intakes from voluntary fortification and/or supplement consumption. It was estimated that, if no foods were voluntarily fortified, the optimum balance between benefits and possible risks would be mandatory fortification at a level of 300 µg of folic acid per 100 g of flour (excluding wholemeal flour). Mandatory fortification at this level would increase average folic acid intakes of the UK population by about 80 µg/day and be effective in reducing NTD risk (by about 11-18%) without increasing numbers of individuals with intakes above the UL/d.
128. In 2007/8 the Food Standards Agency remodelled updated folate consumption data using the same methodology as the previous modelling (SACN, 2006) but as an alternative to all wheat flour also considered fortification of bread flour only and included scenarios where folic acid from voluntarily fortified foods and supplements were capped rather than excluded.
129. In 2016, FSS commissioned an update of the 2006 and 2007/8 modelling to explore the potential impact of fortification of bread or wheat flour with folic acid (100-450 µg/100 g flour) on intakes of total folate (natural and folic acid) in the UK. This was undertaken to estimate the efficacy and safety of different possible options for adding folic acid to the diet for the purpose of reducing NTDs. The updated modelling followed a strategy similar to the previous modelling. Current intakes of total folate (natural and folic acid) were obtained from the NDNS rolling programme, years 1-6 (2008/9-2013/14).
130. SACN advised FSS on the information that would be useful and possible approaches to the modelling and commented on the results at a draft stage. The Committee's

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<sup>16</sup> Includes bread flour.

<sup>17</sup> As GLs were not set for children in the UK, ULs were used for the purpose of the modelling exercise.

comments were taken into account, together with those from peer reviewers, before finalisation and publication of the updated modelling.

131. The results of the updated modelling indicate that there are combinations of mandatory folic acid fortification with capping of voluntary fortification and supplements that can achieve reductions in NTD risk, whilst also decreasing the prevalence of both low intakes and intakes above the UL/d. The increase in mean population intakes of folic acid in these scenarios is similar to that previously suggested by SACN (see paragraph 127).
132. The updated modelling with full details of the fortification scenarios considered, the methods, assumptions and results, is published separately by FSS<sup>18</sup>.

## 7) Overall summary and conclusions

### Background

133. Conclusive evidence from RCTs has shown that folic acid supplementation during the early stages of pregnancy can reduce the risk of the fetus developing NTDs. All women planning a pregnancy are therefore advised to take a daily supplement of folic acid (400 µg) prior to conception and until the 12th week of pregnancy. Women with a previous pregnancy affected by NTDs or women with spina bifida themselves are advised to take folic acid supplements of 5 mg/d<sup>19</sup>.
134. Evidence indicates that this advice has not been followed. It has been estimated that the proportion of women who reported taking folic acid supplements prior to pregnancy has declined from 35% in 1999-2001 to 31% in 2011-12y. Another limitation to the value of recommending folic acid supplementation prior to conception is that only about half of all pregnancies in Britain are planned. Importantly, significant reductions in NTD prevalence have been reported in countries where mandatory folic acid fortification has been introduced. For example, in the USA, where mandatory fortification was introduced in 1998, there was a corresponding 28% reduction in prevalence of anencephaly and spina bifida post-fortification (1999-2011).
135. In 2006, SACN recommended mandatory fortification of flour with folic acid to improve the folate status of women most at risk of NTD-affected pregnancies in the UK (SACN, 2006). It stipulated, however, that it should only be introduced alongside restrictions on voluntary fortification of foods with folic acid. This was to ensure no increase in the numbers of people with intakes above the GL/UL and no substantial increase in mean folic acid intakes or folate status of the UK population.
136. In 2007, following publication of two studies suggesting potential adverse effects of folic acid on colorectal cancer risk, SACN was requested by the Chief Medical Officer to

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<sup>18</sup> Available at <http://www.foodstandards.gov.scot/publications-and-research/stochastic-modelling-estimate-folic-acid-uk>

<sup>19</sup> Diabetes UK recommends that all women with diabetes planning a pregnancy should take a folic acid daily dose of 5 mg.

conduct a detailed review of these data. In 2009, the Committee concluded that there were uncertainties regarding folic acid and cancer risk but reiterated its previous recommendation for mandatory folic acid fortification together with controls on voluntary fortification, guidance on supplement use and appropriate population monitoring procedures. In addition, people aged over 50y and those with a previous history of colorectal adenomas were advised not to consume supplements containing folic acid above the RNI for folate (200 µg/d).

137. In February 2016, FSS informed SACN that in the absence of progress regarding mandatory folic acid fortification in the UK, Scottish Ministers were considering whether to proceed unilaterally with mandatory folic acid fortification of flour in Scotland. FSS requested advice on whether SACN's 2006 and 2009 recommendations on mandatory folic acid fortification remained applicable. In response, SACN agreed to conduct a review of evidence published since its previous risk assessments.

#### **Terms of reference**

138. The terms of reference were to:
- Conduct a review of major new evidence (with an emphasis on systematic reviews and meta-analyses) published since SACN's 2006 and 2009 reports on folate and folic acid, to assess whether its previous advice stands.
  - Provide comments in relation to the modelling exercise carried out by the FSA for SACN's 2006 report and any updated modelling exercise undertaken by FSS.

#### **Review of the evidence**

139. SACN's review of the evidence published since its previous risk assessments in 2006 and 2009 was restricted to potential adverse effects of folic acid. These were: masking or exacerbation of low vitamin B12 status; cognitive decline in older individuals; and cancer (prostate, breast, colorectal and overall). The implications for health of the presence of unmetabolised folic acid (UMFA) in the systemic circulation was also considered.
140. Only systematic reviews and meta-analyses were considered in the assessment of evidence relating to masking or exacerbation of low vitamin B12 status, cognitive decline, and cancer risk. Narrative reviews were considered for context where appropriate, where systematic reviews were unavailable. Primary studies were considered in relation to UMFA because the evidence base was less extensive.

### Cognitive decline related outcomes

141. The SACN 2006 report highlighted uncertainties regarding evidence relating to potential cognitive and vitamin B12 related adverse outcomes of folic acid (masking of vitamin B12 deficiency & acceleration/aggravation of cognitive decline). It concluded that folic acid intakes up to 1 mg/d are not associated with masking anaemia associated with vitamin B12 deficiency. It noted a lack of data on trends in clinical incidence of vitamin B12 deficiency or any related neurological damage but limited data (from national hospital discharge surveys) from countries with mandatory fortification had not suggested an increase post-fortification.
142. Systematic reviews of RCTs published since the 2006 SACN report indicate no effect of folic acid supplementation on cognitive decline in older individuals while observational studies report no relationship or a lower risk associated with higher folate status. In relation to possible adverse effects of high folate status in individuals with low vitamin B12 status, evidence is inconsistent and largely derived from folic acid interventions above 1 mg/d and cross-sectional associations for which causality cannot be assumed. In the US, the prevalence of vitamin B12 deficiency with or without anaemia did not increase after mandatory fortification.
143. Evidence published since the 2006 SACN report does not provide a substantive basis to change the conclusions of the previous risk assessment with regard to these outcomes, nor to propose changes to the UL for folic acid of 1 mg/d.

### Cancer

144. *Prostate cancer:* RCTs of folic acid supplementation have not reported an effect on prostate cancer risk but it is unclear whether the numbers were sufficient to establish that there was no effect. Observational studies on dietary folate intake show no association with prostate cancer risk. Observational studies of serum or plasma folate and genetic studies of the MTHFR polymorphism suggest that higher concentrations of folate may be associated with increased risk. The results from the different types of study are inconsistent and overall the evidence is inconclusive.
145. *Breast cancer:* RCTs of folic acid supplementation have not reported an effect on breast cancer risk but it is unclear whether the numbers were sufficient to establish that there was no effect. Observational studies on dietary folate intake and observational studies of serum or plasma folate concentration show no association with breast cancer risk. The genetic studies of the MTHFR polymorphism suggest that lower folate concentrations are associated with a higher risk of breast cancer. The results from the different types of study are inconsistent but overall do not suggest an adverse association between folic acid and breast cancer risk.
146. *Colorectal cancer:* RCTs of folic acid supplementation have not reported an effect on colorectal cancer risk but it is unclear whether the numbers were sufficient to establish that there was no effect. Observational studies of serum or plasma folate

concentration provide no clear evidence of a beneficial or detrimental association with colorectal cancer risk. The observational studies of folate intake are heterogeneous but suggest a protective association at intakes above 400 µg/d. The genetic studies of the MTHFR polymorphism suggest that higher folate concentrations are associated with a higher risk of colorectal cancer. The results from the different types of study are inconsistent and overall the evidence is inconclusive.

147. *Overall cancer risk:* RCTs of folic acid supplementation show no significant effect on overall cancer risk but it is unclear whether the numbers were sufficient to establish that there was no effect. The genetic studies of the MTHFR polymorphism suggest lower blood folate concentrations are associated with increased cancer risk. The results from the different types of study are inconsistent but overall do not suggest an adverse association between folic acid and overall cancer risk.
148. The evidence base for each outcome is characterised by inconsistencies in the findings of the different study types considered (RCTs, observational studies of folate and folic acid intake, observational studies of folate status, and the indirect inference of folate effects based on genetic MTHFR polymorphism studies).
149. It is difficult to draw firm conclusions on folate and cancer risk on the basis of evidence from nutritional studies (RCTs and observational). Overall the evidence from these studies is no more certain, in either direction, than it was when SACN previously considered the issue (2006 and 2009). Even within a study type the data are heterogeneous and overall do not suggest a detrimental effect of folic acid/folate on cancer risk. However statistical power is generally low, particularly for the RCTs. In addition, cancer usually develops over a number of years but most trials were of short duration with limited follow-up time. Interpretation of the observational data on folate intake was complicated by the large variation between studies in the range of folate intakes. There was also inconsistency in categorisation of 'high' and 'low' intakes, which made it difficult to specify folate intakes considered to be *high* and *low*.
150. Evidence from genetic studies is relatively consistent within a cancer type but the apparent associations go in different directions for different cancers. The inference from genetic studies is that high blood folate concentrations may be associated with increased risk of prostate and colorectal cancer but reduced risk of breast and overall cancer. The usual interpretation of such genetic evidence is that the effect on cancer operates via folate status, but it is possible that the MTHFR 677 TT genotype may have another parallel mode of action that is not currently understood. In addition, although the genetic studies do not suffer from some of the biases that affect other observational studies, they are potentially subject to other biases and uncertainties in interpretation.
151. Although there are still uncertainties relating to folate and cancer risk, it is important to note that the folic acid doses (0.5-40 mg/d; median, 2.0 mg/d) used in the trials

were much larger than the amounts being considered for fortification. In the observational nutritional studies where there were significant associations it is not possible to identify any threshold effect. Genetic studies are not designed to identify threshold effects.

#### Unmetabolised folic acid

152. SACN's earlier risk assessment (2006) concluded that, overall, there were insufficient data to assess the long-term effects of exposure to UMFA in the systemic circulation. Although more primary studies are now available, most relate to measurement of UMFA in the systemic circulation. The widespread use of fasting samples for these measurements, and uncertainties relating to the nature of the dose-response and the origin and metabolic fate of UMFA in the systemic circulation, make it difficult to interpret the findings.
153. The evidence is insufficient to assess whether the presence of UMFA in the systemic circulation has any long-term adverse consequences on health.

#### **The potential impact of mandatory folic acid fortification**

154. A modelling exercise commissioned by FSS explored the effect of mandatory folic acid fortification of bread or wheat flour (100-450 µg/100 g flour) on: average intakes of folic acid; the proportion of the population with folate intakes below the RNI; risk of NTD affected pregnancies; numbers who might be exposed to folic acid doses above the UL<sup>20</sup> for folic acid; and numbers aged ≥ 65y with low vitamin B12 status who might be exposed to folic acid doses above 1 mg/d. The updated modelling followed a similar strategy as the previous SACN modelling (2006).
155. The results of the modelling indicated that various combinations of mandatory folic acid fortification, with capping of voluntary fortification and supplements, can achieve reductions in NTD risk whilst reducing the numbers with low folate intakes and not increasing the numbers with intakes above the UL. The increase in mean population intakes of folic acid in the fortification scenarios is similar to that previously proposed by SACN (2006).

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<sup>20</sup> As GLs were not set for children in the UK, ULs were used for the purpose of the modelling exercise.

## **8) Recommendations**

156. SACN's previous recommendation (2006 and 2009) for mandatory folic acid fortification to improve the folate status of women most at risk of NTD-affected pregnancies remains unchanged. The evidence published since SACN's previous reports (2006 and 2009), on potential adverse effects of folic acid, does not provide a substantial basis for changing this recommendation.
157. SACN previous recommendations stipulated that mandatory fortification should only be introduced alongside restrictions on voluntary dietary fortification with folic acid and clear guidance on the use of folic acid supplements. This was to ensure no increase in the numbers of people with intakes above the GL/UL. These recommendations remain unchanged.
158. In keeping with SACN's previous recommendation, implementation of mandatory folic acid fortification should be accompanied by measures for monitoring folic acid intakes and blood folate concentrations of the population. This is to ensure mandatory folic acid fortification does not lead to an increase in the proportion of the population with folic acid intakes above the GL/UL.
159. Current government advice for all women who could become pregnant is to take 400 µg/d of folic acid prior to conception and until the twelfth week of pregnancy. Women with a history of a previous NTD-affected pregnancy are advised to take 5 mg/d of folic acid prior to conception and until the twelfth week of pregnancy (Department of Health, 2000)<sup>21</sup>. This recommendation was endorsed by SACN in 2006 and 2009 and remains unchanged.

## **9) Research recommendations**

160. Evidence on folate/folic acid and prostate and colorectal cancer risk remains inconclusive and further research is required. Most of the available RCTs have been of relatively short duration, with limited follow-up time, and unspecified statistical power. Since cancer develops over a number of years, future studies should be of longer duration, with lengthier follow-up periods, and provide sufficient statistical power.
161. Evidence from genetic studies did not always agree with that from nutritional studies. Further research is needed on the validity of using genetic evidence to infer nutritional effects on disease outcomes.
162. Further research is needed on the effect of folic acid fortification on the folic acid intakes of groups whose patterns of consumption or relative exposure may differ from that of the general population.

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<sup>21</sup> Diabetes UK recommends that all women with diabetes, who are planning a pregnancy, should also take a daily folic acid dose of 5 mg.

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## Annexes

### ANNEX 1

#### Summary of reports on folic acid published since SACN's previous risk assessment (2006)

Since SACN's full risk assessment in 2006, five reports on folic acid have been published by the following organisations: European Food Safety Authority (EFSA) (2014), the Food and Drug Administration (FDA) (2016), Food Safety Authority of Ireland (FSAI) (2016), National Toxicology Program (NTP) (2015); and the Norwegian Scientific Committee for Food Safety (VKM) (2015). The conclusions relating to potential adverse effects are summarised below and the overall findings and conclusions are tabulated.

#### **POTENTIAL ADVERSE EFFECTS OF FOLIC ACID**

##### ***Cognitive health related outcomes: masking of vitamin B12 deficiency in older adults; aggravation or acceleration of cognitive decline in older individuals with low vitamin B12 status***

The NTP (2015) concluded that evidence suggesting high folic acid intake in the presence of low B12 exacerbates neuropathy is based on early case reports and only supported by limited data from observational studies. In relation to risks for other neurological outcomes (e.g., dementia, depression) it observed that the large volume of literature is indicative of no adverse effects. The FDA (2016) concluded that a folic acid intake up to 1 mg/d is unlikely to mask vitamin B12 deficiency or have adverse effects on cognitive decline in older people. The Food Safety Authority of Ireland (FSAI) (2016) cited the NTP report which concluded that high folic acid intake did not increase risk of cognitive impairment. The VKM (2015) and EFSA did not reconsider the evidence on whether folic acid has adverse effects in relation to cognition.

##### ***Cancer***

The NTP (2015) concluded that there was a consistent enough suggestion in human studies of an adverse effect on cancer growth from supplemental folic acid to justify further research.

The VKM (2015) did not find new evidence for increased risk of cancer related to folic acid in the reviewed literature and concluded that studies examining cancer published after 2009 until 15 October 2014 did not provide support to alter the existing UL for folic acid.

EFSA noted that clarification of the relationship between folic acid and cancer required studies designed with sufficiently long follow-up addressing biological hypotheses for the dual effect of folic acid on cancer development. It concluded that the possible adverse effect of folic acid related to intakes at or above the UL of 1 mg/d.

The FSAI (2016) cited the conclusions of the NTP (2015). It noted that since the introduction of mandatory fortification in the US, rates of all cancers, colorectal cancer and prostate cancer had not significantly increased.

The FDA concluded that there was insufficient evidence to support an association between high folic acid intake and increased risk of colorectal cancer. In relation to breast cancer it recommended further study regarding potential tumour growth-promoting effects in susceptible populations (breast cancer patients and survivors). For prostate cancer, it noted that increased risk was reported

in 2 RCTs with folic acid doses of 1 mg/d (Cole et al, 2007; Figueiredo et al, 2009) but not in a trial with 0.8 mg/d (Ebbing et al, 2009). It concluded that it was not possible to rule out the possibility that folic acid may be associated with increased risk of certain cancer subtypes.

#### **Unmetabolised folic acid (UMFA)**

The VKM (2015) concluded that the impact of UMFA in the circulation & extent to which it contributes to development of cancer or other undesirable health effects is still of concern. The FSAI (2015) concluded that at low concentrations the balance of evidence shows it is unlikely that any adverse health effects are associated with the presence of UMFA in the circulation. EFSA (2015) concluded that the metabolic and biological consequences of UMFA in the circulation are, as yet, uncertain. The NTP and FDA did not consider UMFA.

## OVERALL SUMMARY

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| <p><b>National Toxicity Programme Monograph</b> (US Department of Health and Human Services):</p> <p><i>Identifying research needs for assessing safe use of high intakes of folic acid (2015)</i></p> | <p><u>Purpose</u> – To inform development of a research agenda for evaluating safe use of high intakes of folic acid.</p> <p><u>Outcomes considered</u> - 4 high priority outcomes identified based on adverse reports in studies of intakes &gt; 400 µg/d, serum folate &gt; 10 nmol/L or RBC folate &gt; 340 nmol/L:</p> <ul style="list-style-type: none"> <li>• Cancer – 43 pooled &amp; meta-analyses of 12 cancer subtypes (~600 primary studies identified)</li> <li>• Cognition &amp; vitamin B12 – 28 primary studies &amp; 2 meta-analyses</li> <li>• Hypersensitivity-related outcomes – 43 studies</li> <li>• Thyroid &amp; diabetes-related disorders – 72 studies</li> </ul> <p><u>Conclusions</u> (cancer and cognition &amp; B12 only)</p> <p><i>Cancer</i></p> <ul style="list-style-type: none"> <li>• Although inadequate dietary folate intake increases colorectal cancer risk in humans, no benefit for cancer reduction from supplements among people whose baseline folate status is adequate.</li> <li>• Consistent enough suggestion in human studies of an adverse effect on cancer growth from supplemental FA to justify further research.</li> <li>• Need to clarify whether existing evidence from trials suggesting increased risk is driven by effects in specific subgroups (e.g. age, pre-existing neoplasia, genetics, other factors) &amp; to assess long-term outcomes from prior folic acid trials.</li> </ul> <p><i>Cognition &amp; vitamin B12</i></p> <ul style="list-style-type: none"> <li>• Hypothesis that high folic acid/folate in presence of low B12 exacerbates neurological problems based on early case reports is supported by evidence from observational studies but data are limited.</li> <li>• Data from epidemiological studies hard to interpret because of heterogeneity in vitamin status cut points, cognitive outcomes &amp; omission of other neurological outcomes. Existing intervention studies not designed to answer this question.</li> </ul> |
| <p><b>Food Safety Authority of Ireland:</b></p> <p><i>Update report on folic acid and the prevention of birth defects in Ireland (2016)</i></p>  | <p><u>Purpose</u> - Update on data relevant to prevention of pregnancies affected by NTDs in Ireland; recommendations on best practice monitoring systems necessary to generate these data into the future; update on latest scientific developments relevant to safe &amp; effective dietary intakes of folic acid; recommendations on suitable options for prevention of NTDs in Ireland.</p> <p><u>Outcomes considered:</u></p> <ul style="list-style-type: none"> <li>• Cognitive performance</li> <li>• Unmetabolised folic acid</li> <li>• Growth of colorectal adenomas</li> <li>• Diabetes</li> </ul> <p><u>Conclusions</u> (cognitive performance, unmetabolised folic acid &amp; colorectal adenomas only)</p> <p><i>Cognitive performance</i></p> <ul style="list-style-type: none"> <li>• Cite NTP report which concluded available data are limited and no RCTs designed to address this question.</li> </ul> <p><i>Unmetabolised folic acid</i></p> <ul style="list-style-type: none"> <li>• No definitive studies that have found adverse health effects from exposure to UMFA.</li> <li>• Expert international panel concluded ‘it was not aware of any toxic or abnormal effects of circulating folic acid’ even from much higher exposures than those typically obtained through food fortification.</li> <li>• At generally low concentrations arising through food fortification, unlikely that any adverse health effects associated with presence of unmetabolised folic acid in circulation.</li> </ul>  |

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|--|---|
|  | <p><i>Growth of undiagnosed colorectal adenomas</i></p> <ul style="list-style-type: none"> <li>• Cite SACN review (2009) – concluded insufficient data to support concerns that mandatory fortification would promote cancer.</li> <li>• Cite NTP – concluded that although numerous studies of high folic acid intake across multiple cancer types in various populations, results inconsistent in relation to folic acid exposure &amp; cancer risk. However consistent enough suggestion in human studies of an adverse effect on cancer growth from FA supplements to justify further research.</li> <li>• Cite Vollset <i>et al</i> (2013) meta-analysis of RCTs - concluded FA supplements neither increased/decreased site-specific cancer within first 5 years of treatment &amp; noted that this finding supported by 2 other meta-analyses (Qin <i>et al</i>, 2013; Mackerras <i>et al</i>, 2014).</li> <li>• Since introduction of mandatory fortification in the US (1996), rates of all cancer, colorectal cancer and prostate cancer have not significantly increased (National Cancer Institute, 2015)</li> </ul>  |
| <p><b>FDA Memorandum for food additive petition:</b></p> <p><i>Folic acid in corn masa flour</i> (2016).</p> | <p><u>Purpose</u> - Perform safety evaluation in response to Food Additive Petition (FAP 2A4796) by 6 organisations to amend the food additive regulation by allowing addition of folic acid to corn masa flour (CMF)</p> <p><u>Outcomes considered</u></p> <ul style="list-style-type: none"> <li>• Masking effect of folic acid on vitamin B12 deficiency</li> <li>• Direct effects of FA on B12 deficiency related neurological complications</li> <li>• Effects of prenatal FA on childhood health outcomes</li> <li>• Potential dual actions of FA on carcinogenesis</li> <li>• Asthma &amp; other respiratory problems</li> <li>• Reproduction</li> <li>• Folic acid drug interaction</li> </ul> <p><u>Conclusions</u></p> <p><i>Masking effect of folic acid on vitamin B12 deficiency</i></p> <ul style="list-style-type: none"> <li>• No info found on lowest level of FA associated with masking effect.</li> <li>• Study (Qi <i>et al</i>, 2014) which compared data from NHANES 1991-94 (prefortification) and 2001-2006 (postfortification), prevalence of low B12 status in absence of megaloblastic anaemia or macrocytosis in adults &gt;50 y did not increase after fortification.</li> <li>• Agreed with conclusions SACN, FSANZ, FSAI, Health Council Netherlands -FA up to 1 mg/d not likely to mask B12 deficiency.</li> </ul> <p><i>Direct effects of FA on B12 deficiency related neurological complications</i></p> <ul style="list-style-type: none"> <li>• Neurological complications – rate of neuropathy progression varied significantly among B12 deficient patients regardless of folic acid treatment. Could not reach definitive conclusion on whether FA enhances or worsens B12 related neuropathy.</li> <li>• Cognitive decline – several cross-sectional studies but cognitive tests used not consistent &amp; different cut-offs used to define <i>high</i> &amp; <i>low</i> B12 status. Concluded FA &lt; 1 mg/d will not pose immediate health risk for cognitive decline in older people.</li> </ul> <p><i>Colorectal adenoma (CRA) &amp; colorectal cancer (CRC)</i></p> <ul style="list-style-type: none"> <li>• 6 RCTs in patients with history of CRA. 5 showed no or protective effect on CRA or CRC; 1 suggested positive relationship between FA &amp; recurrence of CRA (Cole <i>et al</i>, 2007).</li> <li>• Observational evidence – temporal studies do not provide strong evidence for causative relationship between FA &amp; increased CRC risk. Cohort &amp; case-control studies investigated combined effect of natural folate &amp; synthetic FA, used different cut-offs, generating inconsistent results.</li> <li>• Overall, scientific evidence not sufficient to support association between high folic acid intake &amp; increased risk of CRA or CRC.</li> <li>• Could not confirm if FA associated with increased risk of CRC progression in those with cancerous or pre-cancerous lesions.</li> </ul> <p><i>Breast cancer</i></p> |

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>• No RCTs on effects of FA alone on breast cancer risk.</li> <li>• 2 RCTs of mixed B vitamins (which incl 2.5 mg FA) did not have higher risk of breast cancer.</li> <li>• Potential tumour growth-promoting effects in susceptible populations (breast cancer patients &amp; survivors) warrant further study.</li> </ul> <p><i>Prostate cancer</i></p> <ul style="list-style-type: none"> <li>• Increased risk reported in 2 RCTs using 1 mg/d FA (Cole et al, 2007; Figueiredo et al, 2009) but not in trial using 0.8 mg/d (Ebbing et al, 2009).</li> <li>• Cohort/case-control studies suggest no or protective effect of folate/folic acid &amp; many did not differentiate between natural folate &amp; synthetic FA exposure.</li> </ul> <p><i>Other types of cancer</i></p> <ul style="list-style-type: none"> <li>• Insufficient evidence to support or refute hypothesis that high folic acid intake promotes other types of cancers.</li> <li>• Not possible to rule out possibility that FA may be associated with increased risk of certain cancer subtypes.</li> </ul> <p>Overall conclusions:</p> <ul style="list-style-type: none"> <li>• Evidence linking 2 potential adverse health outcomes with high folic acid intake in adults: <ol style="list-style-type: none"> <li>1. Masking vitamin B12 deficiency</li> <li>2. Accelerating or exacerbating neurological complications &amp; cognitive decline among those who are vitamin B12 deficient</li> </ol> </li> <li>• For other potential adverse outcomes (such as promoting progression of established neoplasms, childhood hypersensitivity &amp; reproductive outcomes evidence not clear.</li> </ul> <p>No safety/toxicological concerns regarding request to amend food additive regulation to allow addition of folic acid to CMF.</p>  |
| <p><b>Norwegian Scientific Committee for Food Safety (VKM):</b></p> <p><i>Risk assessment of folic acid in food supplements (2015)</i></p> | <p><u>Purpose</u> – To assess whether the UL of folic acid should be amended in light of new scientific evidence suggesting possible link between high folic acid intakes and cancer risk. (Norwegian Food Safety Authority currently evaluating national maximum limit for folic acid.)</p> <p>Considered articles published from 2009-15/10/2014. Literature search for studies addressing high intakes of folic acid in food supplements.</p> <p><u>Publication selection:</u></p> <ul style="list-style-type: none"> <li>• Systematic reviews &amp; meta-analyses of human studies; RCTs &amp; prospective studies with data on FA supplementation in at least 1 gp.</li> <li>• Inclusion criteria - results for FA supplementation could be separated from other interventions &amp; could be compared to placebo gp.</li> </ul> <p><u>Outcomes considered</u></p> <ul style="list-style-type: none"> <li>• Cancer development (identified 8 meta-analyse, 3 RCTs, 2 case-control studies)</li> <li>• Unmetabolised folic acid (identified 6 studies)</li> </ul> <p><u>Conclusions</u></p> <p><i>Cancer</i></p> <ul style="list-style-type: none"> <li>• Most studies investigated adenomas &amp; colorectal cancer but also breast cancer &amp; total cancer.</li> <li>• None of the studies regarding cancer published after 2009 provide significant support to alter the existing UL for folic acid supplementation.</li> </ul> <p><i>Unmetabolised folic acid</i></p> <ul style="list-style-type: none"> <li>• Impact of UMFA in circulation &amp; extent to which it contributes to development of cancer or other undesirable health effects, still of concern.</li> <li>• Reviewed studies do not contribute with evidence useful in terms of potential modification of current UL for folic acid.</li> </ul> <p><i>Overall conclusion</i></p> <ul style="list-style-type: none"> <li>• At this time, no new arguments for increasing or decreasing UL for folic acid in relation to cancer.</li> </ul> |
| <p><b>EFSA:</b></p> <p><i>Scientific opinion on dietary reference</i></p>  | <p><u>Purpose</u> – To deliver a scientific opinion on Dietary Reference Values for the European population, including folate.</p> <p><u>Outcomes considered</u> - series of health outcomes to use as a basis for deriving the requirement for folate. Under health consequences of excess, considered:</p> <ul style="list-style-type: none"> <li>• Masking of B12 deficiency</li> </ul>   |

|                                  |  |
|----------------------------------|--|
| <p>values for folate (2015).</p> | <ul style="list-style-type: none"> <li>• Cancer</li> <li>• Unmetabolised folic acid.</li> </ul> <p><i>Masking of B12 deficiency – allowing neurological dysfunction to progress to irreversible subacute combined degeneration of the spinal; cord.</i></p> <ul style="list-style-type: none"> <li>• Accepted UL of 1mg/day set by SCF (2000) (200µg/d for 1-3y; 800µg/day 15-17 y).</li> </ul> <p><i>Cancer</i></p> <ul style="list-style-type: none"> <li>• Refer to studies by Cole <i>et al</i> (2007), Figueiredo <i>et al</i> (2009) and meta-analyses by Vollset <i>et al</i> (2013) &amp; Mackerras <i>et al</i> (2014).</li> <li>• Noted that follow-up period of trials included in meta-analyses rather short considering development of cancer</li> <li>• Whether or not there is a relationship between folic acid and cancer needs to be clarified by studies designed with sufficiently long follow-up addressing biological hypothesis for the dual effect of folic acid on cancer development.</li> <li>• Noted that possible adverse effect of folic acid related to intakes at or above currently accepted UL.</li> </ul> <p><i>Unmetabolised folic acid</i></p> <ul style="list-style-type: none"> <li>• Metabolic and biological consequences of unmetabolised folic acid in the circulation are, as yet, uncertain.</li> </ul> |
|----------------------------------|--|

## Studies considered in relation to folic acid/folate and potential adverse health outcomes

### Summary of systematic reviews & meta-analyses on folic acid/folate and risk of adverse cognition-related outcome

**Table 1. Randomised controlled trials of folic acid supplementation and risk of adverse cognition-related outcomes**

| First author/date                | Design/model   | Studies (n)   | Participants  | Comparison                   | Results/RR   | Comments   |
|----------------------------------|--|---|---|------------------------------|--|--|
| Balk et al. (2007) <sup>22</sup> | SR of RCTs of B6 and/or B12 and/or folic acid supplementation<br><br>Model: SR; no MA                  | 3 RCTs FA alone   | n=75<br>Mean age: 74-80y<br>n=862                                   | Placebo                      | 19 outcome measures. Significant benefit in 4 outcomes (all in 1 trial). All others, NS  | 2 out of 3 trials - participants with dementia or cognitive impairment.  |
|                                  |  | 6 RCTs FA; 7 other B-vits   | Mean age: 73-76y  | Placebo                      | Total – 37 tests. Placebo better for some tests (in 2 studies). All other NS.  | Limited evidence of benefit or no effect. Doses highly variable.   |
| Dangour et al. (2010)            | SR of RCTs of dietary factors in prevention & treatment of AD % dementia<br><br>Model: SR; no MA       | 4 RCTs FA alone   | n=1066<br>Age: 20-92y   | Placebo                      | 3 out of 4 studies found FA significantly improved memory & cognitive function for some outcomes.  | Limited or no evidence of benefit.<br><br>Participants included people with cognitive impairment/decline             |
|                                  |  | 6 RCTs FA + other B vits  | n=958<br>Age: 65+y  |                              | No trials reported increased cognitive performance with FA + other B vitamins.<br>3 trials reported trend for increased performance/slower decline in placebo compared to vitamin groups.  |  |
| Ford & Almeida (2012)            | SR & MA<br>RCTs of homocysteine lowering treatment on cognitive function<br><br>Model - random effects | 19 RCTs (4 FA alone)<br><br>6 RCTs - included participants with cognitive impairment.<br><br>13 RCTs – participants without cognitive impairment. | n=5398<br>Mean age: >70y (except 1 study, mean age, 60y)            | Placebo                      | Summary effect (all cognitive scores combined) - B vits vs placebo:<br>Trials of people with cognitive impairment: SMD = 0.10 (95% CI, -0.08 to 0.28)<br>Trials of people without cognitive impairment: SMD= -0.03 (95% CI, -0.1 to 0.04)                      | Conclude FA alone or in combination does not improve cognitive function in those with or without cognitive function. |
| Malouf & Grimley Evans (2008)    | SR + MA<br>TCTs FA +/- B12<br><br>Model: Fixed-effects unless evidence of heterogeneity                | 8 trials:<br>4 in older healthy people<br>4 in cognitive impaired or demented people  | n=1523<br>Age: 65+y in 6 studies and 56-89y and 50-70y in 2 others. | Placebo (or FA vs FA + B-12) | Did not pool data because of heterogeneity in sample selections, outcomes, trial duration, and dosage.<br><br>Some evidence of benefit in individual measures and studies but overall no consistent evidence of effect FA w/ or w/o B12 on cognitive function. |  |

FA, folic acid; MA, meta-analysis; SMD, standardised mean difference; SR, systematic review

<sup>22</sup> Balk et al mark results of p<0.10 as statistically significant. For consistency across papers in this assessment, a p<0.05 criterion has been applied to the results they report.

**Table 2. Prospective studies of serum or plasma folate and risk of adverse cognition-related outcomes**

| First author/date         | Design/model   | Studies (n)  | Cases (n)  | Comparison   | Results/RR  | Comments   |
|---------------------------|--|--|--|--|---|--|
| Cooper et al. (2015)      | SR & MA of longitudinal studies of incident dementia in people with mild cognitive impairment.<br>Model: no MA   | 3  | 301  | n/a  | Higher serum folate predicts less risk of conversion from mild cognitive impairment to dementia in 2 studies, NS in 1 study (smallest, shortest).   |  |
| Dangour et al. (2010)     | SR prospective cohort studies on association of dietary factors with dementia.<br>Model: no MA   | 11<br>(10 with other B vits; 1 of folate alone)  | 410 (dietary intake)<br>902 (blood folate)                         | 3 studies reported dietary intake.<br>6 studies examined folate blood concentrations   | 2 studies reported significantly decreased risk of developing AD with increased folate intake.<br>Serum folate: low folate increased risk of developing dementia & AD in 1 study & increased risk of conversion from MCI to dementia in 1 study. 4 studies reported no association between folate status & dementia or AD risk. | Higher folate intakes or status either NS or associated with lower risk of dementia.   |
| (Michelakos et al., 2013) | SR & MA of observational studies on the association of serum folate and B12 levels with cognitive impairment in older adults<br>Model: Fixed effects where heterogeneity not significant; otherwise random effects | 13 of which 10 were cross-sectional and 3 prospective  | 9,747  | High vs low 7 studies<br>Quantiles – 6 studies   | In total sample OR = 1.66 (95% CI 1.40, 1.96; p < 0.01) for association of low folate levels with cognitive impairment.<br>The 3 prospective trials reported NS association of low folate levels with cognitive impairment.   | Threshold for defining low folate ranged from 7.3 to 14 nmol/L.  |
| Raman et al. (2007)       | SR of longitudinal and case-control studies on association between folate, B6, B12 & cognitive function and risk of AD in the elderly.<br>Model: no MA.  | 10 – serum folate & CTP<br>(8 PCS; 1 RC; 1 case-control)<br>9 cohorts for AD risk (11 studies) | 2910 for folate conc & cognitive function<br>3886 total, 935 cases | High vs low 4 studies<br>Quantiles – 5 studies<br>Qualitative data – 1 study<br>High vs low - 3 studies<br>Quantiles – 5 studies<br>Qualitative data – 2 studies | Low blood folate concentration associated with poorer outcome<br>Association with high FA intake 'equivocal' (2 studies)<br>Low folate increased risk in 3 cohorts with 384 cases, NS in 6 studies  | Threshold for defining low blood folate concentration ranged from 3.6 to 27 nmol/L.  |
| Vogel et al. (2009)       | SR of longitudinal & cross-sectional studies on serum folate concentration & cognitive impairment.<br>Model: no MA.  | Exact numbers of studies & participants not stated.  | Not provided   | Not provided.  | Narrative and subjective description of literature precludes objective characterisation   | Authors conclude majority of data associates low folate with increased risk of cognitive decline & dementia, but direction of cause-effect is not clear. |

AD, Alzheimer's disease; CTP, cognitive test performance, MA, meta-analysis; MCI, mild cognitive impairment; NS, not significant; PCS, prospective cohort study; RC, retrospective cohort; SR, systematic review

## Summary of systematic reviews and meta-analyses on folic acid/folate and risk of cancer

### Prostate cancer

**Table 3. RCTs of folic acid supplementation and prostate cancer risk.**

| Author/Date           | Design          | Model          | Trials (n)/<br>Dose (mg/d)                        | Cases (n) | Comparison               | RR (95% CI)      | Comments |
|-----------------------|-----------------|----------------|---|-----------|--------------------------|------------------|----------|
| Wien et al. (2012)    | Meta-analysis   | Random effects | 6<br><u>Dose</u><br>Range: 0.8-2.5<br>Median: 1   | 632       | FA ≥0.4 g/day vs placebo | 1.24 (1.03-1.49) |          |
| Qin et al. (2013a)    | Meta-analysis   | Random effects | 5<br><u>Dose</u><br>Range: 1-2.5<br>Median: 2     | 508       | Treatment vs placebo     | 1.17 (0.84-1.62) |          |
| Vollset et al. (2013) | Pooled analysis | Fixed effects  | 13<br><u>Dose</u><br>Range: 0.5-40<br>Median: 2.0 | 656       | Treatment vs placebo     | 1.15 (0.99-1.34) |          |

**Table 4. Prospective studies of dietary folate intake and prostate cancer risk**

| Author/Date        | Design        | Model          | Studies (n)/<br>Folate intake (µg/d)  | Cases (n) | Comparison  | RR (95% CI)      | Comments                          |
|--------------------|---------------|----------------|---|-----------|-------------|------------------|-----------------------------------|
| Tio et al. (2014a) | Meta-analysis | Random effects | 5<br><u>Intake</u><br>High: 259-444; median: 378<br>Low: 177-283; median: 215   | 12,898    | High vs low | 1.00 (0.96-1.05) |                                   |
| Wang et al. (2014) | Meta-analysis | Random effects | 5<br><u>Intake</u><br>High: >259-444; median: 378<br>Low: <177-283; median: 215 | 12,898    | High vs low | 1.02 (0.95-1.09) | RR, 1.01 (0.99-1.02) per 100 µg/d |

**Table 5. Prospective studies of total folate intake (diet plus supplements) & prostate cancer risk**

| Author/date         | Design        | Model          | Studies (n)/<br>Folate intake (µg/d)           | Cases (n) | Comparison  | RR (95% CI)      | Comments  |
|---------------------|---------------|----------------|--|-----------|-------------|------------------|---|
| (Tio et al., 2014a) | Meta-analysis | Random effects | 2<br>High: 468; 640 µg/d<br>Low: 223; 300 µg/d | 6,729     | High vs low | 1.00 (0.79-1.27) | Typo in upper CI, assumed 0.1.27 should be 1.27 |

**Table 6. Prospective studies of serum or plasma folate and prostate cancer risk**

| First author         | Design          | Model          | Studies (n)<br>Folate conc. (nmol/L)                             | Cases (n) | Comparison                                  | RR (95% CI)      | Comments  |
|----------------------|-----------------|----------------|--|-----------|---|------------------|---|
| Collin et al. (2010) | Meta-analysis   | Fixed effects  | 6  | 1,807     | Various <sup>1</sup>                        | 1.19 (1.03-1.37) |   |
| Tio et al. (2014a)   | Meta-analysis   | Random effects | 6<br>High: 10.3-58.2; median, 17.1<br>Low: 4.8-10.9; median, 6.5 | 5,904     | High vs low                                 | 1.14 (1.02-1.28) |   |
| Wang et al. (2014)   | Meta-analysis   | Random effects | 5<br>High: 10.3-58.2; median, 16.6<br>Low: <4.8-10.9; median, 6  | 4,451     | High vs low                                 | 1.21 (1.05-1.39) | Dose response – RR=1.04 (1.00-1.07) per 5 nmol/L increment serum folate |
| Price et al. (2016)  | Pooled analysis | Fixed effects  | 6<br>Geometric mean range 5.7-16.9                               | 6,875     | High vs low (top v bottom 5 <sup>th</sup> ) | 1.13 (1.02-1.24) | Significant heterogeneity by grade, RR for high grade=2.30 (1.28-4.12)  |

<sup>1</sup> Quartiles, quintiles, per 4.5 nmol/l, per 18 nmol/l

**Table 7. Genetic studies of MTHFR C677T polymorphism and prostate cancer risk**

| Author/date               | Design        | Model          | Studies (n) | Cases (n) | RR (95% CI) for TT* | Comments                  |
|---------------------------|---------------|----------------|-------------|-----------|---------------------|---------------------------|
| Collin et al. (2009)      | Meta-analysis | Random effects | 12          | 10,745    | 1.05 (0.89-1.23)    | Included unpublished data |
| Zhang et al. (2012)       | Meta-analysis | Fixed effects  | 15          | 7,306     | 0.96 (0.85-1.08)    |                           |
| Abedinzadeh et al. (2015) | Meta-analysis | Fixed effects  | 22          | 10,832    | 0.91 (0.83-1.01)    |                           |
| Chen et al. (2015)        | Meta-analysis | Fixed effects  | 21          | 10,529    | 0.82 (0.69-0.97)    |                           |
| Guo et al. (2015)         | Meta-analysis | Fixed effects  | 23          | 11,348    | 0.90 (0.82-1.00)    |                           |

\*Results are presented in terms of the OR/RR associated with the TT genotype relative to the CC genotype. The MTHFR TT genotype decreases the concentration of blood folate relative to CC genotype. The inference from an OR/RR > 1.0 is that a high level of folate is protective whilst an OR/RR < 1.0 suggests that a high level of folate increases risk.

## Breast cancer

**Table 8. RCTs of folic acid supplementation & breast cancer risk.**

| Author/Date           | Design          | Model          | Trials (n)  | Cases (n) | Comparison           | RR (95% CI)      | Comments  |
|-----------------------|-----------------|----------------|---|-----------|----------------------|------------------|---|
| Vollset et al. (2013) | Pooled analysis | Fixed effects  | 13<br><i>Dose</i><br>Range: 0.5-40<br>Median: 2.0 | 297       | Treatment vs placebo | 0.89 (0.66-1.20) | 99% CI, 95% not available                             |
| Qin et al. (2013a)    | Meta-analysis   | Random effects | 4<br>Range: 1-2.5<br>Median: 2.25                 | 213       | Treatment vs placebo | 0.82 (0.63-1.07) | Fixed effects only available for all cancers combined |

**Table 9. Prospective studies of dietary folate intake & breast cancer risk**

| Author/Date           | Design        | Model          | Studies (n) | Cases (n) | Comparison/<br>Folate intake ( $\mu\text{g}/\text{d}$ )  | RR (95% CI)      | Comments   |
|-----------------------|---------------|----------------|-------------|-----------|--|------------------|--|
| Larsson et al. (2007) | Meta-analysis | Random effects | 8           | 8367      | High vs low<br>High: >294-522*<br><i>Median: &gt;400</i><br>Low: <179-296<br><i>Median: &lt;225</i>  | 0.96 (0.87-1.05) | 200 $\mu\text{g}/\text{d}$ increments<br>RR, 0.97 (95% CI, 0.88-1.07)  |
| Chen et al. (2014)    | Meta-analysis | Fixed effects  | 15          | 24,422    | High vs low<br>High: 277-522<br><i>Median: &gt;388</i><br>Low: 153-296<br><i>Median: 217</i>   | 0.99 (0.94-1.04) | 100 $\mu\text{g}/\text{d}$ increments<br>RR, 1.0 (95% CI, 0.98-1.01).<br>U-shaped dose-effect relationship:<br>Significant decreased breast cancer risk with intakes<br>153-400 vs <153 $\mu\text{g}/\text{d}$<br>>400 vs <153 $\mu\text{g}/\text{d}$ – NS |
| Liu et al. (2014)     | Meta-analysis | Random effects | 15          | 24,083    | High vs low<br>High: 249-551 $\mu\text{g}/\text{d}$<br><i>Median: &gt;374</i><br>Low: 126-296 $\mu\text{g}/\text{d}$<br><i>Median: &lt;200</i> | 0.98 (0.90-1.05) | Increments of 220 $\mu\text{g}/\text{d}$ not associated with risk of breast cancer.<br>RR, 0.96 (95% CI, 0.95-1.05)  |

Tio et al. (2014b): Excluded because unable to extract full numbers for the prospective studies; Li et al (2015) excluded because endpoint breast cancer mortality. Did not include 1 study because per 100  $\mu\text{g}/\text{d}$

**Table 10. Prospective studies of total folate intake (diet + supplements) & breast cancer risk**

| Author/Date           | Design        | Model          | Studies (n) | Cases (n) | Comparison  | RR (95% CI)      | Comments  |
|-----------------------|---------------|----------------|-------------|-----------|---|------------------|---|
| Lewis et al. (2006)   | Meta-analysis | Random effects | 9           | 11,227    | 100 µg/d increment  | 0.99 (0.98-1.01) | Most but not all studies reported on diet & supplements   |
| Larsson et al. (2007) | Meta-analysis | Random effects | 6           | 8,165     | High vs low<br>High: >351 to >853<br><i>Median: 602</i><br>Low: 150 to <336<br><i>Median: 219</i> | 1.00 (0.87-1.14) | Increments of 200 µg/d<br>RR, 1.01 (95% CI, 0.97-1.05)  |
| Chen et al. (2014)    | Meta-analysis | Fixed effects  | 11          | 16,717    | High vs low<br>High: >351-3663<br><i>Median: 642</i><br>Low: 150-<472<br><i>Median: 237</i>       | 0.99 (0.94-1.04) | Per 100 µg/day increment:<br>RR, 1.00 (0.995-1.013)   |
| Zhang et al. (2014)   | Meta-analysis | Random effects | 14          | 18,572    | High vs low<br>High: 277-918.9<br><i>Median: 489</i><br>Low: 150-333.5<br><i>Median: 205</i>      | 0.97 (0.90-1.05) | Per 100 µg/day increment:<br>RR, 0.99 (0.98-1.01)<br>Intake of 200-320µg/d associated with reduced risk<br>Intakes >400µg/d associated with increased risk. |

**Table 11. Prospective studies of serum or plasma folate & breast cancer risk**

| Author/Date           | Design        | Model          | Studies (n) | Cases (n) | Comparison  | RR (95% CI)      | Comments |
|-----------------------|---------------|----------------|-------------|-----------|---|------------------|----------|
| Larsson et al. (2007) | Meta-analysis | Random effects | 3           | 970       | High vs low<br>High: 13.6-31.7 nmol/l<br>Low: 6.8-10.4 nmol/L | 0.81 (0.59-1.10) |          |

**Table 12. Genetic studies of MTHFR C677T polymorphism and breast cancer risk<sup>23</sup> (OR/RR presented in terms of TT genotype relative to the CC genotype)**

| First author/date    | Design        | Model          | Studies (n) | Cases (n) | RR (95% CI) for TT | Comments                        |
|----------------------|---------------|----------------|-------------|-----------|--------------------|---------------------------------|
| Lewis et al. (2006)  | Meta-analysis | Random effects | 17          | 6373      | 1.04 (0.94-1.16)   |                                 |
| Tang et al. (2014)   | Meta-analysis | Fixed effects  | 25          | 13,874    | 1.09 (0.93-1.28)   |                                 |
| (Rai, 2014b)         | Meta-analysis | Fixed effects  | 36          | 8040      | 1.24 (1.13-1.36)   | Restricted to Asian populations |
| (Kumar et al., 2015) | Meta-analysis | Fixed effects  | 75          | 31315     | 1.10 (1.04-1.16)   |                                 |

<sup>23</sup> (Macis et al., 2007) excluded because did not report TT relative to CC; (Rai, 2014a) excluded because MTHFR A1298C polymorphism; (Lissowska et al., 2007) excluded because MTHFR A222V and E429A

## Colorectal cancer

**Table 13. RCTs of folic acid supplementation and colorectal cancer risk**

| Reference/date        | Design / Model/dose (mg/d)  | Trials (n) | Cases (n) | Comparison             | OR/RR (95% CI)   |
|-----------------------|---|------------|-----------|------------------------|------------------|
| Cooper et al. (2010)  | Systematic review<br>Dose: 2.5-20; median, 2.5<br>Duration of treatment: 3y   | 3          | 128       | FA + B vits vs placebo | 1.13 (0.77-1.64) |
| Vollset et al. (2013) | Meta-analysis of individual data<br>Fixed effects<br>Dose:0.5-40; Median: 2.0 | 13         | 429       | FA vs placebo          | 1.07 (0.83-1.37) |
| Qin et al. (2015)     | Meta-analysis<br>Model: Fixed effects<br>Dose: 0.5-2.5; Median: 1.5           | 8          | 381       | FA vs placebo          | 1.00 (0.82-1.22) |

**Table 14. RCTs of folic acid supplementation and colorectal adenoma recurrence**

| Reference/date           | Design / Model  | Trials (n) | Cases (n)  | Comparison  | OR/RR (95% CI)                       |
|--------------------------|---|------------|------------|---|--------------------------------------|
| Cooper et al. (2010)     | Systematic review<br>Doses: 0.5 & 1.0; median, 0.75<br>Treatment duration: 3y           | 2          | 278        | FA vs placebo   | 1.16 (0.97-1.39)                     |
| Ibrahim & Zekri (2010)   | Meta-analysis<br>Random & fixed effects<br>Dose: 0.5-5<br>Median: 1                     | 5          | 564        | FA vs placebo<br>Recurrence (n=4); fixed effects model<br>By dose; random-effects model | 1.08 (0.87-1.33)<br>0.78 (0.49-1.24) |
| Fife et al. (2011)       | Systematic review<br>Dose: 0.5-2.5<br>Median: 1   | 3          | 850<br>383 | FA supplementation up to 3 y<br>FA supplementation over 3 y                             | 1.09 (0.93-1.28)<br>1.35 (1.06-1.70) |
| Figueiredo et al. (2011) | Meta-analysis<br>Model: Random-effects<br>Dose: 0.5-1<br>Median: 1                      | 3          | 682<br>202 | FA vs placebo<br>All adenomas<br>Advanced lesions                                       | 0.98 (0.82-1.17)<br>1.06 (0.81-1.39) |
| van Dijk & Pot (2016)    | Systematic review & meta-analysis.<br>Model: Random-effects<br>Dose: 0.5-5<br>Median: 1 | 4          | 444        | FA vs placebos.   | 0.93 (0.69-1.25)                     |

**Table 15. Prospective cohort studies of dietary folate intake and colorectal cancer risk**

| Reference/date        | Design / Model  | Studies (n) | Cases (n)   | Comparison  | OR/RR (95% CI)/comment                                    |
|-----------------------|---|-------------|-------------|---|---|
| Kennedy et al. (2011) | Meta-analysis<br>Dietary folate intake<br>Model: random effects               | 9           | Not stated. | High vs low<br>High: >212 to >634; median, 335.5<br>Low: 103.3 to <244; median, 184.4   | 0.92 (0.81-1.05)<br>No dose effect relationship detected. |
| Kim et al. (2010)     | Pooled analysis<br>Dietary<br>Model: random-effects                           | 13          | 5720        | Dietary folate: highest v. lowest quintile<br>Intake by highest/lowest categories not stated;<br>median intake range: 184-409<br>100 µg/d increment | 0.92 (0.84-1.00)<br><br>0.98 (0.95-1.01)                  |
| Hou et al. (2013)     | Excluded because reports results of other meta analyses already included here |             |             |   |   |

**Table 16. Prospective cohort studies of supplemental folate intake and colorectal cancer risk**

| Reference/date              | Design / Model                        | Studies (n) | Cases (n) | Comparison  | OR/RR (95% CI)/comment  |
|-----------------------------|---------------------------------------|-------------|-----------|---|---|
| Heine-Broring et al. (2015) | Meta-analysis<br>Model: Random-effect | 3           | 4066      | Highest vs lowest<br>Dose-response (increase of 100 µg/d)<br>High: >143 to ≥560; median, ≥400<br>Low: <50-<101; median, <83 | 0.88 (0.78-0.98)<br>0.98 (0.97-1.00)<br>Difficult to interpret (participants may have been consuming other supplements) |

**Table 17. Prospective cohort studies of total folate intake and colorectal cancer risk**

| Reference/date    | Design / Model                           | Studies (n) | Cases (n) | Comparison   | OR/RR (95% CI)/comment  |
|-------------------|--|-------------|-----------|--|---|
| Kim et al. (2010) | Pooled analysis<br>Model: random-effects | 10          | 4015      | Highest vs lowest quintile<br>median intake range: 259-501<br><br>100 µg/d increment | 0.85 (0.77-0.95)<br><br>0.99 (95% CI, 0.96-1.02)  |
| Liu et al. (2015) | Meta-analysis<br>Model: random-effects   | 19          | 24816     | Highest vs lowest<br>High: ≥212-≥1224; median, >441<br>Low: <103-422; median, 212    | 0.88 (0.81-0.95)<br>Objective of study was to consider association with FA supplement intake, authors stated that if results reported both dietary & total vitamins, they used result for 'total' in main analysis. |

**Table 18. Prospective studies of plasma/serum folate concentration and colorectal cancer risk**

| Reference/Date       | Design / Model  | Studies (n) | Cases (n) | Comparison   | OR/RR (95% CI)   |
|----------------------|---|-------------|-----------|--|--|
| Chuang et al. (2013) | Meta-analysis<br>Model: fixed-effect flexible meta-regression<br><br>Folate concentration<br>Upper: -10.8-709.3; median, 31.5<br>Lower: 4.2-23.8; median, 6.1 | 8           | 3477      | Serum/plasma folate concentration<br><br>Regression analysis (linear; risk per 10 nmol/L)<br>Regression analysis (non-linear; risk per 10 nmol/L)<br><br>Highest vs lowest (radioimmunoassay)<br>Highest vs lowest (microbiological assay) | <br><br>0.96 (0.91-1.02)<br>0.99 (0.96-1.02)<br><br>0.80 (0.61-0.99)<br>1.03 (0.83-1.22) |

**Table 19. Genetic studies of MTHFR C677T polymorphism & colorectal cancer risk**

| Reference and search date | Design / Model                                   | Studies (n)                              | Cases (n)                                       | Comparison   | OR (95% CI) <sup>1</sup>   |
|---------------------------|--|--|---|--|--|
| Kennedy et al. (2012)     | Meta-analysis<br>Random effects                  | 59                                       | 26,731  | All gender and ethnicity   | 0.88 (0.80-0.96)   |
| Rai (2015)                | Meta-analysis<br>Random effects                  | 34                                       | 9143  |  | 0.88 (0.74-1.04)   |
| Sheng et al. (2012)       | Meta-analysis<br>Random effects                  | 61                                       | 16111   | All ethnicities and gender<br>Asian only<br>Males only   | 0.89 (0.82-0.97)<br>0.82 (0.69-0.97)<br>0.82 (0.71-0.93)   |
| Taioli et al. (2009)      | Meta-analysis & pooled analysis<br>Fixed effects | Meta-analysis: 29<br>Pooled analysis: 14 | Meta-analysis: 11,936<br>Pooled analysis: 5,068 | <i>Meta-analysis</i><br>All<br>White<br>Asian<br><br><i>Pooled analysis</i><br>All<br>White<br>Asian | 0.83 (0.77-0.90)<br>0.83 (0.74-0.94)<br>0.80 (0.67-0.96)<br><br>0.85 (0.75-0.96)<br>0.91 (0.77-1.07)<br>0.68 (0.55-0.85) |
| Yang et al. (2012)        | Meta-analysis<br>Random effects                  | 21                                       | 6692  | All  | 0.84 (0.70-1.00)   |
| Zhou et al. (2012)        | Meta-analysis<br>Random & fixed effects          | 41                                       | 17552   | All groups (fixed effects)<br>Asians (fixed effects)<br>White (random effects)                       | 0.83 (0.77-0.88).<br>0.76 (0.68-0.86)<br>0.85 (0.72-1.01)  |

<sup>1</sup>Results are presented in terms of the odds ratio/relative risk associated with the TT genotype relative to the CC genotype. The MTHFR TT genotype decreases the concentration of blood folate relative to the CC genotype. The inference from an odds ratio greater than 1.0 is that a high level of folate is protective whilst an odds ratio less than 1.0 suggests that a high level of folate increases the risk of CRC.

## Overall cancer

**Table 20. RCTs of folic acid supplementation and overall cancer risk**

| Author/Date           | Design/duration   | Model          | Trials (n)/<br>Dose (mg/d)                         | Cases<br>(n) | Comparison                | RR (95% CI)      | Comments  |
|-----------------------|---|----------------|--|--------------|---------------------------|------------------|---|
| Wien et al. (2012)    | Meta-analysis<br>Included studies<br>FA ≥0.4 mg/d<br>FA +/- other B vitamins<br>Median duration: 38 m | Random effects | 10<br><u>Dose</u><br>Range: 0.5-40<br>Median: 2.25 | 3515         | FA ≥0.4 mg/d vs placebo   | 1.07 (1.00-1.14) | Increased risk in 4 studies with dose of 0.4-1 mg/d (RR, 1.21; 95% CI, 1.06-1.38) but not in those with doses > 1mg/d<br>Follow-up time>60m – RR, 1.09 (1.1-1.18) |
| Baggott et al. (2012) | Meta-analysis<br>Intervention duration ≥1y<br>Median duration - 4.2 y                                 | Fixed effects  | 6<br><u>Dose</u><br>Range: 0.5-2.5<br>Median: 0.9  | 2416         | 0.5-2.5 mg/day vs placebo | 1.21 (1.05-1.39) | Did not perform dose-dependent analysis because of narrow dose range  |
| Vollset et al. (2013) | Pooled analysis<br>Mean duration – 5 y  | Fixed effects  | 13<br><u>Dose</u><br>Range: 0.5-40<br>Median: 2.0  | 3713         | Treatment vs placebo      | 1.06 (0.99-1.13) | Risk did not increase with treatment duration or daily dose.  |
| Qin et al. (2013b)    | Meta-analysis   | Fixed effects  | 13<br><u>Dose</u><br>Range: 0.5-40<br>Median: 2.0  | 3741         | Treatment vs placebo      | 1.05 (0.99-1.11) | FA dose ≤ 1mg/d:<br>RR=1.23 (1.06-1.43)<br>No effect of FA dose or treatment duration on risk.  |

Mackerras et al. (2014): Excluded because unable to verify result in Figure 3 for Smith 2010

**Table 21. Genetic studies of *MTHFR* C677T polymorphism and overall cancer risk**

| Author/Date        | Design        | Model         | Studies (n) | Cases<br>(n) | Reference genotype | RR (95% CI) for TT | Comments |
|--------------------|---------------|---------------|-------------|--------------|--------------------|--------------------|----------|
| Tang et al. (2014) | Meta-analysis | Fixed effects | 134         | 46207        | 677 CC             | 1.08 (1.01-1.17)   |          |

## Unmetabolised folic acid

### Measurement of UMFA in plasma/serum

**Table 22. Intervention studies**

| Study  | Population  | Objective/Intervention/duration   | Results   | Conclusion/comments  |
|--|---|---|---|--|
| Pentieva et al. (2016)<br><br>Northern Ireland | Pregnant women at 14 wks gestation, who had taken FA supplements (400 µg/d) as recommended during 1 <sup>st</sup> trimester (n=67). | <p><b>Objective:</b> to investigate effect of FA during pregnancy on UMFA in maternal plasma &amp; newborn cord plasma.</p> <p><b>Intervention:</b> Start of 2<sup>nd</sup> trimester</p> <ol style="list-style-type: none"> <li>1. FA (400µg/d)</li> <li>2. Placebo</li> </ol> <p><b>Duration:</b> 22 weeks (until end of pregnancy).</p> <p><b>Blood collection:</b> <i>Non-fasting</i> blood samples collected at weeks 14 &amp; 36. Cord blood samples obtained at delivery.</p> <p><b>Folate measurement:</b> LC-tandem MS.</p> <p>LOD<sup>24</sup> for UMFA = 0.27 nmol/L</p> | <p><b>Baseline</b> (14 wks gestation):<br/>Proportion with detectable UMFA = 33%.</p> <p><b>Post intervention</b> (wk 14 to 36):<br/>Significant increase in plasma total folate &amp; 5MTHF but not in UMFA conc. or in % of UMFA relative to total plasma folate</p> <p>Proportion with detectable UMFA significantly greater in FA group (p=0.002)</p> <ol style="list-style-type: none"> <li>1. 42%</li> <li>2. 16%</li> </ol> <p>Mean plasma UMFA (nmol/L)</p> <ol style="list-style-type: none"> <li>1. 0.44 (± 0.80) (0.51 ± 1.41, <i>pre-intervention</i>)</li> <li>2. 0.13 (± 0.49) (0.46 ± 1.36, <i>pre-intervention</i>)</li> </ol> <p>Plasma UMFA as % of total folate</p> <ol style="list-style-type: none"> <li>1. 1.16 (± 2.07) (1.42 ± 3.7 <i>pre-intervention</i>)</li> <li>2. 0.38 (± 1.2) (1.13 ± 2.7 <i>pre-intervention</i>)</li> </ol> <p><b>Cord blood:</b> plasma folate &amp; 5-MTHF significantly higher in infants of FA supplemented mothers but no diff between groups in % of cord samples with detectable UMFA (20%, FA gp &amp; 11%, placebo gp; p=0.34).</p> | <p>FA dose of 400 µg/d throughout 2<sup>nd</sup> &amp; 3<sup>rd</sup> trimester increased maternal &amp; neonate folate status but did not increase circulating UMFA concentrations.</p> <p>Although significantly higher proportion in FA group had detectable FA in plasma (42% v 16% in placebo gp; p=0.002), this did not correspond to a significant increase in UMFA concentration in maternal circulation.</p> <p>Findings suggest FA metabolised to reduced folates in mother before transfer to placenta.</p> |

<sup>24</sup> Limit of detection.

| Study                            | Population  | Objective/Intervention/duration   | Results   | Conclusion/comments   |          |          |    |     |     |    |     |     |  |
|----------------------------------|---|---|---|---|----------|----------|----|-----|-----|----|-----|-----|--|
| Houghton et al. (2009)<br>Canada | Lactating women (36 wk gestation) intending to exclusively breast feed for >4m (n=69) < Mean age: 32 ± 4y | <p><b>Objective:</b> compare effects of folic acid &amp; 5-MTHF on total milk folate &amp; determine if UMFA present in breast milk.</p> <p><b>Intervention:</b> (within 1 wk after birth of infants)</p> <ol style="list-style-type: none"> <li>1. Folic acid (400µg/d)</li> <li>2. 5-MTHF (416 µg/d; equimolar dose)</li> <li>3. Placebo</li> </ol> <p>All received daily supplement of B6 (1 mg), B12 (3 µg), ferrous fumarate (4 mg)</p> <p><b>Duration:</b> 16 weeks</p> <p><b>Blood/milk collection:</b> Blood collected 16 wks postpartum (did not specify fasting status); milk samples collected between 1300 &amp; 1450 because of wide variation in milk folate conc. over 24 hrs.</p> <p><b>Folate measurement</b> – Plasma &amp; RBC folate &amp; total milk folate measured by microbiological assay; milk FA measured using HPLC.</p> <p>LOD for UMFA not specified.</p> | <p>All reported consumption of FA containing supplements during pregnancy (mean FA intake, 911 ± 251 µg/d).</p> <p><b>After 16 wks:</b></p> <p>Mean plasma folate con significantly greater in supplemented participants compared to placebo group (p&lt;0.0001)</p> <p>Milk folate concentration similar between all groups &amp; remained stable from 4-16 weeks postpartum.</p> <p>No significant correlation between maternal blood folate concentrations &amp; total milk folate concentrations.</p> <p>UMFA detected in 96% of milk samples &amp; represented ~ 8% of total milk folate concentration; no group differences in UMFA concentrations at 16 wk postpartum.</p>   | <p>Did not measure UMFA in lactating mothers.</p> <p>Milk folate concentrations similar to those reported before fortification.</p> |          |          |    |     |     |    |     |     |  |
| Tam et al. (2012)<br>Canada      | Women (n=40)<br>Age: 18-45 y  | <p><b>Objective:</b></p> <ol style="list-style-type: none"> <li>(1) Examine relationship between plasma UMFA concentration &amp; dietary FA &amp; total folate intake</li> <li>(2) examine effect of FA supplementation on fasting plasma concentrations of UMFA.</li> </ol> <p><b>Intervention:</b> Randomised open label trial</p> <ol style="list-style-type: none"> <li>1. FA (1.1 mg/d)</li> <li>2. FA (5 mg/d)</li> </ol> <p><b>Duration:</b> 30 weeks</p> <p><b>Blood collection:</b> <i>Fasting</i> sample (min 6h): baseline, 2, 4, 6, 12 &amp; 30 wks.</p> <p><b>Folate measurement:</b> total folate, microbiological assay; FA, affinity-HPLC.</p> <p>LOD for UMFA = 0.18 nmol/L</p>  | <p><i>Baseline % with detectable UMFA in plasma</i></p> <ol style="list-style-type: none"> <li>1. 63%</li> <li>2. 68%</li> </ol> <p>Significant change in % with detectable UMFA over time in both grps but no diff between grps.</p> <ol style="list-style-type: none"> <li>1. Out of 7 with undetectable UMFA at baseline, all had undetectable UMFA at 30 wks; out of 12 with detectable UMFA at baseline, 11 (58%) had detectable UMFA at 30wks.</li> <li>2. Out of 6 with undetectable UMFA at baseline, 5 had undetectable UMFA at 30 wks; out of 13 with detectable UMFA at baseline, 10 (53%) had detectable UMFA at 30wks.</li> </ol> <p><i>Median plasma UMFA concentration (nmol/L)</i></p> <table> <thead> <tr> <th></th> <th>Baseline</th> <th>30 weeks</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>4.8</td> <td>3.1</td> </tr> <tr> <td>2.</td> <td>3.7</td> <td>4.4</td> </tr> </tbody> </table> <p>No significant change over 30 wks in either grp. When data pooled from both grps, change in UMFA significant (p=0.019).</p> |   | Baseline | 30 weeks | 1. | 4.8 | 3.1 | 2. | 3.7 | 4.4 | <p>Significant decline in UMFA between weeks 12 &amp; 30 despite ongoing supplementation &amp; sustained total folate concentrations. Plasma UMFA at wk 30 not significantly different from baseline.</p> <p>Effect of supplementation small relative to natural variation in circulating UMFA.</p> <p>Data suggest homeostatic mechanisms that limit systemic exposure to UMFA, such as downregulation of carrier-mediated transport systems &amp; upregulation of FA metabolism.</p> |
|                                  | Baseline  | 30 weeks  |   |   |          |          |    |     |     |    |     |     |  |
| 1.                               | 4.8   | 3.1   |   |   |          |          |    |     |     |    |     |     |  |
| 2.                               | 3.7   | 4.4   |   |   |          |          |    |     |     |    |     |     |  |

| Study                            | Population   | Objective/Intervention/duration   | Results  | Conclusion/comments  |
|----------------------------------|--|---|--|--|
| Sweeney et al. (2007)<br>Ireland | Adults (n=20)<br>Age: 20-40y   | <p><b>Objective:</b> appearance of UMFA after consumption of FA for prolonged period.</p> <p><b>Intervention:</b> FA fortified bread (400, 200, 100 µg/d)</p> <p>Phase 1 – all, 400 µg/d FA for 14 wks.</p> <p>Phase 2 – 2 slices bread supplying total:<br/>Wk 1 - 400 µg/d FA.<br/>Wk 2 – 200 µg/d FA.<br/>Wk 3 - 100 µg/d FA.</p> <p>Between each wk consumed 400 µg/d FA supps for 7d to re-saturate total serum folate levels.</p> <p><b>Blood collection - fasted sample</b><br/>Phase 1: collected wks 10 &amp; 14, 6h post supplementation.<br/>Phase 2: Day 7 of each regimen; sample taken pre-prandially then after 1st slice, collected every hr for 4 hrs. 2<sup>nd</sup> slice then administered &amp; sample collected every hr for 3h.</p> <p><b>Folate measurement:</b> Microbiological assay used to measure total serum folate &amp; red cell folate; HPLC for UMFA.</p> <p>LOD for UMFA &gt;0.31 nmol/L</p> | <p><b>Baseline</b> - UMFA not detected in any samples.</p> <p><b>Intervention phase 1</b><br/>Serum &amp; red cell folate increased significantly (p&lt;0.001).<br/>At wk 14 – UMFA detected in 18/19 (95%) participants but only slightly elevated in 7 (37%) &amp; below level for accurate quantification.<br/>Mean UMFA = 0.048 nmol/L; as % of total serum folate = 1.4%</p> <p><b>Intervention phase 2</b><br/>UMFA present in 17/19 (89.5%) participants on day 7 of consuming 400 µg/d pre-prandially. UMFA increased post-prandially in all participants after consumption of slice 1 (200 µg) and slice 2 (200 µg) (p&lt;0.001).<br/>UMFA not detected in any participants on day 7 of regimen consuming 200 or 100 µg/d pre- or post-prandially.<br/>Total folate concentration – no significant change over 8 hrs after consuming bread containing 400, 200 or 100 µg/d.</p> | Out of the 3 fortified bread regimens, only the highest (400 µg/d) led to appearance of UMFA.  |
| Kirsch et al. (2015)<br>Germany  | Individuals invited to participate via local newspapers or during a stay in geriatric centre (n=59)<br>Mean age: 67y | <p><b>Objective:</b> measure changes of serum &amp; whole blood folate forms after 1 y supplementation with FA, B12 &amp; B6 in older adults.</p> <p><b>Intervention:</b> DBCRT; daily</p> <p>1. FA (500 µg), B12 (500 µg) B6 (50 mg), Ca (456 mg), vitamin D (30 µg)<br/>2. Ca (456 mg), vitamin D (30 µg)</p> <p><b>Duration:</b> 1 year.</p> <p><b>Blood collection:</b> Fasting samples (≥8hr) collected at baseline, 6 m &amp; 1y after supplementation.</p> <p><b>Folate measurement:</b> measured using Ultra Performance LC-MS/MS</p> <p>LOD for UMFA= 0.20 nmol/L</p>  | <p><b>5-MTHF</b><br/>Baseline: comparable between groups (85.6%).<br/>After 6m &amp; 1y, 5-MTHF ~. 2.2-2.6 x higher in gp 1</p> <p><b>UMFA:</b><br/>Baseline: 5% with detectable serum UMFA.<br/>6m: 29% gp 1 &amp; 7% gp 2 with detectable UMFA (p=0.031)<br/>1y:81% of gp 1 &amp; 11% in gp 2 had detectable UMFA (p&lt;0.001)</p> <p>Mean UMFA (nmol/L)<br/>Baseline: 0.05 (±0.08)<br/>6m: 0.15 (±0.13)<br/>1y: 0.45 (±0.09) (p&lt;0.05)</p> <p>UMFA concentration showed direct correlation with 5-MTHF at baseline (r=0.25; p=0.057) &amp; after 1y (r=0.35, p=0.089).</p>  | Mean UMFA after 1y similar to values reported in study in Ireland where FA fortification not mandatory (Boilson, 2012) suggesting 500 µg/d FA over 1y is effectively metabolised to other forms. UMFA correlated to serum 5-MTHF even in unsupplemented people (at baseline). Therefore, possible that 5-MTHF endogenous source of FA.<br><br>Co-supplementation with B6 & B12 could have impact on folate form distribution in serum. |

| Study                          | Population  | Objective/Intervention/duration   | Results   | Conclusion/comments   |
|--------------------------------|---|---|---|---|
| Obeid et al. (2016)<br>Germany | Residents in geriatric centre for recovery from bone fractures or other surgery (n=58)<br><br>Median age: 82y (range 69-96) | <u>Objective:</u> compare effect of short-term supplementation with FA or B-complex on serum UMFA.<br><u>Intervention</u> (daily) single blind, non-placebo controlled:<br>1. FA (400 µg)<br>2. FA (400 µg) + B12 (10 µg) +B6 (8 mg)<br><u>Duration:</u> median 23 days.<br><u>Blood collection:</u> Fasting samples (overnight) collected on 2 <sup>nd</sup> day of study and day before discharge.<br><u>Folate measurement:</u> Ultra Performance LC-MS/MS<br>LOD for UMFA = 0.20 nmol/L | Serum 5-MTHF <sup>25</sup> & UMFA increased significantly in both grps (p<0.001) with no difference between grps in extent of increase.<br><br>Serum UMFA increased significantly in both grps:<br>1. From <LOD at baseline to 0.61 nmol/L (p<0.001)<br>2. From <LOD at baseline to 0.17 nmol/L (p=0.002)<br><br>Proportion with detectable UMFA<br>1. From 20% at baseline to 76% (p<0.001)<br>2. From 7% at baseline to 33% (p=0.109)<br><br>UMFA as % of total 5MTHF (0% at baseline):<br>1. 3.26 (p<0.001) (3.3% total folate)<br>2. 0.77 (p=0.039) (1.1% total folate)     | Compared to FA alone group, serum UMFA lower in FA+B12 & B6 group.<br><br>Consuming FA together with vitamins that enhance its metabolism may lower prevalence of detectable UMFA.  |
| Obeid et al. (2011)<br>Germany | Older adults in geriatric health centre (n=74).<br><br>Median age = 82y   | <u>Objective:</u> examine concentrations of primary folate forms (5-MTHF, THF, FA) before & after high dose FA.<br><u>Intervention:</u> DBRCT<br>1. FA (5 mg), B12 (1 mg), B6 (40 mg)/day<br>2. Placebo<br><u>Duration:</u> 3 weeks<br><u>Blood collection:</u> Fasting samples (> 8h) collected on 3 <sup>rd</sup> day of admission & 3 weeks later before discharge.<br><u>Folate measurement:</u> Ultra Performance LC-MS/MS<br>LOD for UMFA = 0.20 nmol/L                               | At baseline: 26% with detectable plasma UMFA<br>After 3 wks<br>1. 97% with detectable UMFA; median plasma concentration, 15.3 nmol/L (0.07 nmol/L at baseline)<br>Median 5-MTHF & total folate significantly increased (p<0.001).<br>2. 41% with detectable UMFA; median plasma concentration, 0.17 nmol/L (0.08 nmol/L at baseline).<br>Median 5-MTHF & total folate concentrations slightly lower than those at start.<br><br>UMFA as % of total folate: 2.6% in placebo & 14.9% in FA grp.<br>UMFA concentration positively related to 5-MTHF & THF concentrations (p<0.05). | FA grp - substantial increase in UMFA - related to higher conc of THF & 5MTHF.<br>Increase in 5MTHF stronger than that of THF; suggests FA effectively reduced & further converted into active forms.<br>Wide range of interindividual variations in FA (144%), THF (58%), 5-MTHF (52%) in FA gp suggest factors other than folate intake might be responsible.<br>Differences in absorption, storage, or activities of folate cycle enzymes may account for such variations. |

<sup>25</sup> 6S)-5-methyltetrahydropteroylglutamate [(6S)-5-CH<sub>3</sub>-H<sub>4</sub>Pte]

**Table 23. Observational studies**

| Author (year)/Country           | Population  | Objective/study details  | Results   | Conclusion/Comments   |
|---------------------------------|---|--|---|---|
| Obeid et al. (2010)<br>Germany  | Pregnant women recruited from consecutive deliveries in hospital (n=87) including 24 mother-infant pairs<br><br>Newborns (n=29)<br><br>Non-pregnant women (n=25) not taking FA supplement<br><br><i>Cross-sectional</i> | <u>Objective:</u> - investigate primary folate forms in pregnant women and umbilical cord blood at delivery. Also tested effect of MTHFR polymorphism.<br><br><u>Methods</u><br>Blood sample (non-fasted) obtained from mothers 1-12h before birth.<br><br>Folate forms measured using Ultra Performance LC/MS.<br><br>LOD for UMFA = 0.20 nmol/L  | <u>Maternal</u> – n=25 consumed FA (400 µg/d) throughout pregnancy.<br>Higher total serum folate & 5-MTHF conc in supplemented pregnant women not associated with significant difference in UMFA compared with non-supp pregnant women.<br><br>No significant difference in % pregnant women with detectable UMFA according to FS supplement use (44% in both groups)<br><br><u>Umbilical cord blood</u><br>No difference in conc of folate forms by maternal FA use.<br>% with detectable UMFA did not significantly differ according to maternal supplement use: 52.6% from non-supplemented & 60% from supplemented.<br>UMFA as % of total folate did not differ by maternal supplement use: 0.54%, supplemented & 0.43%, non-supplemented.<br><br><u>Mother cord pairs</u><br>No significant diff in serum UMFA conc between maternal & cord.<br>UMFA as % of total folate significantly lower in cord than in maternal serum (0.49% vs 2.4%)<br>UMFA positively correlated to 5-MTHF in maternal & cord serum.<br><br><u>Genotype</u> – No difference in folate form conc. by MTHFR. | Detectable but small amounts UMFA observed in cord serum at birth.<br><br>Study might be underpowered to detect significant differences in cord blood UMFA according to maternal vitamin use.<br><br>Alternatively, speculate that FA might be produced in vivo from internal nonenzymatic oxidation of 5-MTHF or THF.<br><br>Maternal FA supplement use did not explain detection of UMFA in maternal or cord blood. |
| Plumtre et al. (2015)<br>Canada | Pregnant women between 12-16 wks gestation (n=368).<br><br>Mean age: 32.5 (5)y<br><br><i>Prospective</i>  | <u>Objective:</u> assess maternal & cord blood folate & UMFA in cohort of pregnant women & newborns & effect of maternal intakes of folate & FA supp on maternal & cord blood conc of folate & UMFA.<br>Effect of 4 variants in fetal MTHFR & DHFR genes on cord blood folate & UMFA.<br><br><u>Methods:</u><br>Maternal non-fasted blood drawn at wks 12-16 of pregnancy & at delivery. Mean time since food/supps consumed before blood draw = 5h. Umbilical cord blood obtained at delivery.<br>Serum & RBC folate concentrations measured using protein-binding immunoassays; UMFA measured using LC/MS.<br><br>Dietary intake - semi-quantitative FFQ.<br><br>LOD for UMFA = 0.2 nmol/L | <u>Maternal</u> early pregnancy - UMFA detected in 97% of women.<br>Median % of UMFA to total serum folate = 3.09% (IQR, 1.90-8.93%).<br>Maternal UMFA conc did not differ according to FA supplement use.<br><br><u>Cord blood</u> - UMFA detectable in 93% samples<br>Median % UMFA to total serum folate = 1.34% (IQR, 0.92-82.12%).<br>Cord plasma UMFA 72% lower than maternal plasma UMFA (p<0.0001)<br>Plasma UMFA not significantly higher in cord blood from mothers who supplemented in late pregnancy (p=0.07).<br>RBC folate & UMFA weakly correlated in maternal blood in early pregnancy (r=0.18; p=0009) but not in cord blood (r=0.08; p=0.23);<br>serum folate & UMFA strongly correlated in maternal blood (r=0.81; p<0.0001) & weakly correlated in cord blood (r=0.24; p=0.0002).<br><br><u>Genotype</u> - No significant associations between 3 fetal MTHFR & DHFR variants & serum & RBC folate or UMFA; fetal MTHFR 677TT genotype associated with significantly lower cord serum folate & higher cord RBC folate than wild type.                                  | Results suggest UMFA does not accumulate in the fetus even with a high folate status and detectable UMFA in mothers.<br><br>Fetus has limited folate storage in liver & must use what is immediately available via the placenta. Therefore the UMFA that reaches the fetus is likely metabolised to active folate forms in a more efficient manner.   |

| Author (year)/Country            | Population  | Objective/study details  | Results  | Conclusion/Comments  |
|----------------------------------|---|--|--|--|
| Sweeney et al. (2005)<br>Ireland | Newborn infants (n=11)<br><i>Cross-sectional</i>  | <u>Objective:</u> Examine UMFA in cord blood of newborns of mothers consuming normal diet & serum from 4d old infants post formula feeding.<br><u>Methods:</u> Blood collected from umbilical cord. Follow-up serum sample (n=9) collected 4d after birth (90 mins after last formula feed).<br>Serum UMFA: HPLC/microbiological assay.<br>LOD for UMFA = 0.31 nmol/L  | <u>Cord blood</u> - UMFA present in all samples<br>Mean UMFA concentration = 0.42 nmol/L<br>None of the mothers were consuming FA supplements.<br>At 4d (with formula feed) UMFA detected in 7 samples (78%)<br>Mean UMFA concentration = 1.06 nmol/L  | Since none of the mothers were consuming FA supplements, FA in cord blood must have arisen from FA intake from fortified foods.  |
| Sweeney et al. (2009)<br>Ireland | Mothers about to undergo caesarean section (n=20) & offspring immediately after delivery.<br>Age: 26-39y<br><i>Cross-sectional</i>              | <u>Objective:</u> examine whether infants <i>in utero</i> have UMFA in cord blood after period of maternal fasting.<br><u>Methods:</u> Blood collection: from mothers & umbilical cords immediately after caesarean section. All had fasted for ≥ 8h prior to surgery. None consuming FA at start of study.<br>Plasma folate & RCF: microbiological assay; UMFA: column switching HPLC.<br>LOD for UMFA – not reported | <u>Maternal</u> - UMFA present in 90%<br>Significant correlation between maternal plasma folate concentration & maternal plasma UMFA ( $r^2=0.300$ ; $p=0.007$ )<br>Mean total plasma folate mothers: 29.8 (19.6) nmol/L<br>Mean UMFA in mothers: 0.39 (0.325) nmol/L (1.3% of total folate)<br>Significant correlation between maternal FA & cord blood FA concentration ( $r=0.38$ ; $p=0.004$ )<br><u>Cord blood</u> – UMFA present in 85%<br>Mean UMFA in cord blood: 0.27 (0.15) nmol/L | Samples from fasting non-pregnant females were not included in study   |
| Vaish et al. (2016)<br>Ireland   | Healthy children attending routine minor surgery (n=68)<br>Age: ≤16y<br>0-5y – 23%<br>6-10y – 38.5%<br>11-16y – 38.5%<br><i>Cross-sectional</i> | <u>Objective:</u> Explore concentrations of fasting UMFA in circulation of children exposed to voluntary folic acid fortification in Ireland.<br><u>Methods:</u> Fasting blood samples (8h) collected from children before minor surgery.<br>Plasma folate & RCF measured using microbiological assay; UMFA: LC-MS.<br>Diet assessed using short dietary questionnaire for parents.<br>LOD for UMFA = 0.53 nmol/L      | UMFA detected in 10% of sample (95% CI, 4.2-20.1%)<br>Mean UMFA concentration: 0.07 (±0.23)<br>UMFA contributed 1.94% of plasma total folate.<br>Mean plasma folate: 35 nmol/L (range: 7-104 nmol/L)   | Limitation: small convenience sample not representative of the Irish population – difficult to say if findings can be translated to the population of children in Ireland. |

| Author (year)/Country            | Population  | Objective/study details   | Results   | Conclusion/Comments  |
|----------------------------------|---|---|---|--|
| Sweeney et al. (2009)<br>Ireland | Blood donors (n=50)<br>Age 27-60y<br><i>Cross-sectional</i>   | <b>Objective:</b> Explore if UMFA present in Irish people exposed to current range of vol fortified foods.<br><b>Methods:</b><br>Blood collection: unfasted samples collected from blood donors attending routine blood donation.<br>Plasma folate & RCF: microbiological assay; UMFA: column switching HPLC.<br>LOD for UMFA – not reported  | UMFA present in 98% of blood donors.<br>Plasma folate correlated with UMFA concentration (r=0.110; p=0.011)<br>Mean plasma folate – 32 (17.3) nmol/L<br>Mean UMFA: 0.72 (0.9) nmol/L (2.25% of total folate)  | Majority of population in Ireland now exposed to liberal voluntary fortification, appears to have circulating UMFA.<br><br>Samples from fasting males were not included. |
| Boilson et al. (2012)<br>Ireland | Participants ≥60y from the Lifeways Cross-Generation Cohort Study (n=135)<br>Mean age: 67.4y (±5.9)<br><i>Cross-sectional</i> | <b>Objective:</b> (i) Measure persistent UMFA conc. in non-institutionalised older people exposed to liberal voluntary fortification. (ii) Whether genes involved in folate metabolism are associated with plasma UMFA concentration.<br><b>Methods:</b><br>Blood collection – early morning fasting sample.<br>2 dietary intake questionnaires: semi-quantitative FFQ.<br>Plasma folate & RCF – microbiological assay; UMFA: column switching HPLC<br>LOD for UMFA = 0.07 nmol/L | UMFA detected in 94% of participants.<br>Mean UMFA concentration = 0.39 nmol/L (range 0.07-1.59), accounting for 1.3% of total folate<br>19% consumed FA supplements habitually; 8% had taken recently (within last 24h but not previous 8h).<br>UMFA significantly lower in those with no recent or habitual FA intake (0.11 ±3 compared with 0.43 ± 0.02; p<0.0005).<br>Habitual FA intake significantly related to UMFA (p<0.0005) but effect of recent FA intake not significant (p=0.108).<br>Dose-response between habitual FA intake & UMFA (regression analysis): doubling FA intake = 14.3% (95% CI, 9.7-18.8%) increase in UMFA.<br><b>Genotyping analysis:</b> No significant correlations with MTHFR 677C→T, DHFR 19-bp intron deletion, or MTHFDIL | UMFA in plasma of most of this older cohort even after overnight fast.<br><br>No threshold effect for habitual FA intake & UMFA.   |

| Author (year)/Country         | Population  | Objective/study details   | Results  | Conclusion/Comments  |
|-------------------------------|---|---|--|--|
| Kalmbach et al. (2008)<br>USA | Participants of 6 <sup>th</sup> examination of Framingham Offspring Study (Jan 1995-Aug 1998) (therefore includes people unexposed & exposed to mandatory FA fortification) (n=1258)<br><br>Mean age: 58y<br><br><i>Cross-sectional</i> | <b>Objective:</b> determine functional impact of DHFR polymorphism on UMFA, total folate, tHcy & RBC folate concentrations & evaluate possible interaction between FA intake & DHFR genotype with any measures of folate status.<br><br>Hypothesised DHFR polymorphism alters capacity to reduce dietary FA & thereby limits assimilation of FA into endogenous folate forms.<br><br><b>Methods:</b><br>Fasting blood samples.<br>Plasma total folate & RBC measured using microbiological assay. UMFA measured using updated affinity/HPLC method<br>Dietary intake assessed by semi-quantitative self-administered FFQ.<br><br>LOD for UMFA = not reported. | n=126, homozygous for deletion allele (del/del); n=646, heterozygous for deletion allele (WT/del); n=396, homozygous for wildtype allele (WT/WT).<br><br>Prevalence of high serum UMFA (defined as >1.35 nmol/L) higher in del/del homozygotes with FA intakes >500 µg/d (47%; 95% CI, 32-63%) compared with WT/del heterozygotes (21%; 95% CI, 14-29%) and WT/WT (24%; 95% CI, 14-35%).<br><br>Prevalence of high serum UMFA in those with intakes <500 µg/d unrelated to DHFR genotype.<br><br>Also interaction (p=0.01) between FA intake & DHFR genotype & RBC folate. In those with FA intakes <250 µg/d, mean RBC folate was 732.3 nmol/L (95% CI, 669.1-801.4) for del/del compared with 793 nmol/L (95% CI, 750.3-837.4) WT/del and 844.4 nmol/L (95% CI, 787.8-905.1) WT/WT. RBC folate in those consuming < 250 µg/d did not differ between the 3 genotypes.<br><br>No significant interaction between DHFR genotype & FA intake with plasma total folate. | Describes an effect of a 19-bp deletion allele in DHFR gene on measures of folate status that depends on FA intake.<br><br>Homozygotes for 19-bp deletion in DHFR consuming >500 µg/d FA had increased prevalence of high UMFA compared with WT/WT & WT/del genotypes.<br><br>Homozygotes who consume < 250 µg/d of FA had lower RBC folate compared with WT/WT genotype.<br><br>Results suggest DHFR polymorphism directly impairs FA metabolism at both low & high FA intakes. |

**Table 24. National Monitoring Programmes (NHANES)**

| Author (year)/Country       | Population  | Objective/study details  | Results  | Conclusion/Comments  |
|-----------------------------|---|--|--|--|
| Bailey et al. (2010)<br>USA | NHANES 2000-2001 (surplus sera project analysed UMFA conc of individuals ≥ 60y) (n=1121)<br><br>Mean age: 70y<br><br><i>Cross-sectional</i> | <b>Objective</b> – to examine UMFA concentrations in relation to dietary & supplemental folate & status biomarkers in NHANES 2001-2002<br><br><b>Methods:</b><br>Blood sample – Obtained details on fasting before blood draw.<br><br>UMFA & 5-MTHF measured using affinity/HPLC method.<br><br>Dietary data obtained from one 24-hour recall.<br><br>LOD for UMFA = 0.18 nmol/L | UMFA detected in 38% of population (fasted for mean of 10h).<br>UMFA concentration: mean = 4.4 (0.6) nmol/L; median = 1.2 (0.2) nmol/L<br><br>UMFA represented ~2.25% of total serum folate in population. In those with detectable UMFA, it represented ~6% of total serum folate.<br><br>In those with detectable UMFA, % contribution of UMFA did not vary by 5-MTHF quartile (5.5-7.5%) however mean UMFA concentration significantly higher in those in highest 5-MTHF quartile.<br><br>47% of population reported use of FA containing supplements.<br><br>Significantly higher % of FA dietary supplement users in those with detectable UMFA.<br><br>Total FA intakes (food & supplements) significantly higher in detectable UMFA grp but relation between UMFA & total FA intake not strong when examined in whole population. | Could not identify specific amount of FA leading to UMFA appearing in serum.<br><br>Although supp intake higher in detectable UMFA gp (235 µg/d) than undetectable UMFA grp (140 µg/d), 40% of undetectable UMFA gp were supp users and 39% of detectable UMFA grp not supp users. Supp use alone is insufficient factor in determining UMFA.<br><br>Suggest detectable UMFA gp represents sensitive subpopulation with altered FA metabolism – genetic differences may be contributing determinant in FA variability. |

| Author (year)/Country          | Population   | Objective/study details  | Results   | Conclusion/Comments   |
|--------------------------------|--|--|---|---|
| Pfeiffer et al. (2015b)<br>USA | NHANES 2007-2008 (population aged ≥1y) (n=2676)<br><br>26% children (1-11y)<br>12% adolescents (12-19y)<br>62% adults (≥20y)<br><br><i>Cross-sectional</i> | <u>Objective:</u> describe distributions of serum 5-MTHF & UMFA concentrations in US population & assess how they correlate with dietary folate intake. Also evaluate factors associated with UMFA concentrations > 1 nmol/L.<br><br><u>Methods:</u><br>Blood samples included fasting & non-fasting<br>5-MTHF & UMFA measured using HPLC-MS/MS.<br>Dietary intake assessed by two 24-hour recalls.<br><br>LOD for UMFA = 0.3 nmol/L | 38% <u>fasted</u> ≥8h; 27% reported using FA supplements in previous 30d.<br>UMFA detected in >95% of population.<br><br>When samples grouped according to weighted 5-MTHF quartiles, mean UMFA significantly higher in Q4 (5.6 nmol/L) than in Qs 1-3 (1.8, 1.4, 3.4 nmol/L respectively) but relative UMFA contribution to sum of 5-MTHF & UMFA, fairly constant across quartiles (3.1-5%).<br>In fasting samples (≥8h) relative UMFA conc. appeared lower (2.2-3.5%).<br>Mean UMFA concentration significantly higher (p<0.05) in supplement users vs non-users (1.5 & 0.79 nmol/L respectively).<br>Fasting status significantly associated with lower UMFA conc in SUP+ & SUP- gps with larger concentration diffs between nonfasting (<3h) & fasting (≥8h) in SUP+ gp (1.17 nmol/L) than SUP- gp (0.269 nmol/L)<br>Prevalence of UMFA >1 nmol/L: 33% overall & 21% in fasting (≥8h) adults.<br>UMFA > 1 nmol/L associated with being older, non-Hispanic black, nonfasting (<8h), smaller body surface area, higher total FA intake (diet & supps) & higher RBC concentrations. | UMFA concentration >1 nmol/L mainly associated with nonfasting & higher FA intake from diet & supplements.<br><br>Findings raise possibility that UMFA concentration may be an indicator of a mismatch between supply (i.e., intakes) and cellular demand (i.e., requirements) but some common genetic polymorphisms may also have an impact. |
| Pfeiffer et al. (2015a)<br>USA | NHANES 2011-12 (population aged ≥1y) (n=7462)<br><br>27% children (1-11y)<br>14% adolescents (12-19y)<br>59% adults (≥20y)<br><br><i>Cross-sectional</i>   | <u>Objective:</u> describe serum concentrations of several folate forms in the US population ≥1 y (NHANES 2011-12).<br><br><u>Methods:</u><br>Blood samples included fasting & non-fasting<br>Serum folate forms measured using HPLC-MS/MS; whole blood folate measured by microbiologic assay.<br><br>LOD for UMFA = 0.14 nmol/L  | UMFA detected in 99.9% of samples.<br>Mean UMFA: 1.21 nmol/L (95% CI, 1.15-1.92); range: 0.14-282 nmol/L<br>UMFA contributed 4% to serum total folate.<br>Correlation between UMFA & 5-MTHF (r=0.44) & total serum folate (r=0.5).<br>Mean UMFA (nmol/L) according to fasting time (h):<br><3 1.52 (95% CI, 1.44-1.61)<br>3 - <8 1.40 (95% CI, 1.29-1.52)<br>≥8 0.98 (95% CI, 0.92-1.04) p=0.01<br>Mean UMFA (nmol/L) according to FA sup use (last 24h)<br>Yes 2.10 (95% CI, 1.92-2.29)<br>No 1.02 (95% CI, 0.96-1.09) p<0.0001  | UMFA significantly higher in persons who reported consuming FA containing supplements during previous 24h.<br><br>Focus seems to be on MeFox (an oxidation product of 5-MTHF).<br><br>Patterns observed for MeFox suggest altered folate metabolism dependent on biological characteristics.  |

**Table 25. Studies examining the association between UMFA and adverse health outcomes**

| Author (year)        | Health outcome/objective/study type  | Population/Methods   | Results   | Conclusions/comments  |
|----------------------|--|--|---|---|
| Cho et al. (2015)    | <p>Colorectal cancer</p> <p><b>Objective:</b> Evaluate association between prediagnostic plasma UMFA and CRC risk</p> <p><i>Prospective cohort</i></p>   | <p><b>Population:</b> Nurses Health Study (NHS)/Health Professionals Follow-up Study (HPFS)</p> <p><b>Methods:</b> Participants grouped into 3 categories:</p> <ol style="list-style-type: none"> <li>3. Undetectable</li> <li>4. &lt; 0.5 nmol/L</li> <li>5. &gt;0.5 nmol/L</li> </ol> <p>Adjusted for multiple risk factors</p> <p>UMFA measurement: LC/MS/MS</p> <p>LOD for UMFA = 0.25 nmol/L</p>                            | <p>Follow-up time: NHS, 20-21y; HPFS, 15-17y.</p> <p>Cases, 618; controls, 1207</p> <p>UMFA detected in 21.4% of controls &amp; 22% of cases.</p> <p>Those with detectable UMFA: median conc = 0.61 nmol/L</p> <p>Overall, prediagnostic UMFA not associated with CRC risk</p> <p>Compared to those with undetectable UMFA:</p> <p>RR=1.03 (95% CI = 0.73-1.46) for less than 0.5 nmol/L.</p> <p>RR = 1.12 (95% CI, 0.81-1.55) for ≥0.5 nmol/L.</p>   | <p>Blood samples collected prior to mandatory folic acid fortification so concentrations not reflective of those after fortification which occurred during follow-up.</p> <p>Study suggests prediagnostic UMFA plasma concentrations from prefortification period in US not associated with CRC risk.</p> |
| Hu et al. (2016)     | <p>Cancer</p> <p><b>Objective:</b> Examine associations of folate intake, folate biomarkers, &amp; presence of UMFA with overall cancer incidence among adults ≥57y in NHANES 1999-2002.</p> <p><i>Prospective cohort</i></p>            | <p><b>Population:</b> Adults ≥57y to 85y (n=3997)</p> <p><b>Methods:</b> Data from NHANES 1999-2002 participants linked to Medicare data &amp; National Death Index.</p> <p>Folate &amp; FA intake assessed from 24h recall.</p> <p>RBC folate &amp; serum folate measured by radioassay; UMFA: revised affinity/HPLC.</p> <p>LOD for UMFA = 0.18 nmol/L</p>   | <p>Median follow-up time 6.3y; 125 cancer cases.</p> <p>No associations observed between presence of UMFA &amp; risk of cancer incidence (data were not shown).</p> <p>Significant inverse association between highest quartile of RBC folate (956 nmol/L) vs reference group (539 to &lt;721 nmol/L) with overall cancer incidence.</p> <p>Adjusted HR = 0.54 (95% CI, 0.31-0.93).</p>   | <p>Absence of relationship between UMFA &amp; cancer incidence may be due to insufficient power.</p> <p>Examined association between presence vs absence of UMFA rather than amount of UMFA &amp; risk of cancer incidence.</p>   |
| Morris et al. (2010) | <p>Cognitive test performance</p> <p><b>Objective:</b> examined associations between 5-MTHF &amp; UMFA in blood samples obtained from NHANES (1999-2002) participants with cognitive test performance.</p> <p><i>Cross-sectional</i></p> | <p><b>Population:</b> Adults ≥60y from NHANES (1999-2002); n=1430; mean age, 70y;</p> <p><b>Methods:</b> combined data from 2 surveys in which cognitive data were collected into single dataset</p> <p>Dietary data assessed from 24h recall.</p> <p>Fasted blood sample collected (6-9h fasting time)</p> <p>Plasma folate measured using radioassay; UMFA measured using affinity/HPLC</p> <p>LOD for UMFA = 0.027 nmol/L</p> | <p>UMFA detected in 32% – on average UMFA 6% of total serum folate (IQR: 1-8%).</p> <p>UMFA concentrations up to 111 nmol/L but 90% &lt;1.78 nmol/L.</p> <p>Presence vs absence of detectable UMFA related to increased odds of anaemia in alcohol users: OR=3.37 (95% CI, 1.42-8.01).</p> <p>In participants with low B12 status (serum B12 &lt;148 pmol/L or MMA ≥210 nmol/L) mean DSST score for those with detectable UMFA almost 5 points lower than that of unexposed participants: -4.86 (-9.09 to -0.63); p=0.03.</p> | <p>UMFA linked to increased odds of haematologic &amp; cognitive problems in combination with low B12 status.</p>   |

### Literature search methodology

1. Literature searches were conducted to identify relevant research on folic acid and health outcomes, which had been published since SACN's *folate and disease prevention report* (SACN, 2006) and SACN's *report to the Chief Medical Officer on folic acid and colorectal cancer risk* (SACN, 2009).

#### **Search**

##### Folic acid

2. Structured searches of Embase, MEDLINE, Scopus and the Cochrane Library were undertaken between April and June 2016. Three consecutive searches were conducted as follows: the first search (07/04/16) was limited to meta-analyses and systematic reviews; the second search (03/06/16) was limited to pooled analyses; the third search (28/06/16) combined the previous searches of MEDLINE and Embase and removed a database review filter which had resulted in a number of important studies not being identified. The results of all three searches were then combined.
3. The search was restricted to studies since 2005. Recently published reviews from international organisations (European Food Safety Authority, 2014; Administration, 2016; Food Safety Authority of Ireland, 2016; National Toxicology Program, 2015; Norwegian Scientific Committee for Food Safety, 2015) were also hand searched for relevant citations.
4. The Embase search strategy used on 28/06/16 is provided in the Appendix.

##### *Inclusion and exclusion criteria*

5. Meta-analyses, systematic reviews and pooled analyses of randomized controlled trials and prospective cohort studies in humans were included. Meta-analyses of case-control studies were included only for polymorphism publications as case-control studies are most often used to assess the relationship between polymorphisms and disease risk. All other study types were excluded. Only studies in healthy populations were considered; studies that investigated folic acid as a treatment for people with a disease or medical condition were excluded. Foreign language publications were excluded.
6. All health outcomes associated positively or adversely with folic acid supplementation were initially included. Due to the limited time available for completing the review, it was subsequently agreed to focus on the following potential adverse outcomes: i) cancer (prostate, breast, colorectal and total); ii) masking of vitamin B12 deficiency and iii) acceleration of cognitive decline in older individuals with low vitamin B12 status. It was also agreed that methylenetetrahydrofolate reductase polymorphism studies related to these outcomes would be included.
7. Publications which combined folic acid with other vitamins or minerals were initially excluded. As this would result in the exclusion of many important meta-analyses, it was subsequently

agreed to include those that assessed folic acid + B12 or other B vitamins. Publications that assessed the association between folate status and health outcomes were also included.

### *Screening*

8. The search results were screened in duplicate by a member of the SACN secretariat and a colleague in Food Standards Scotland. Publications were screened in two phases: i) the combined first and second search results ii) any new publications identified in the third search. Studies identified from each screening phase were then combined.
9. Publications were initially screened based on title and abstract; the full article was reviewed if there was any uncertainty about whether it should be included. Any differences were resolved by discussion before the list of publications to be considered by the working group was agreed. The working group agreed the final list of publications to be included in the review.

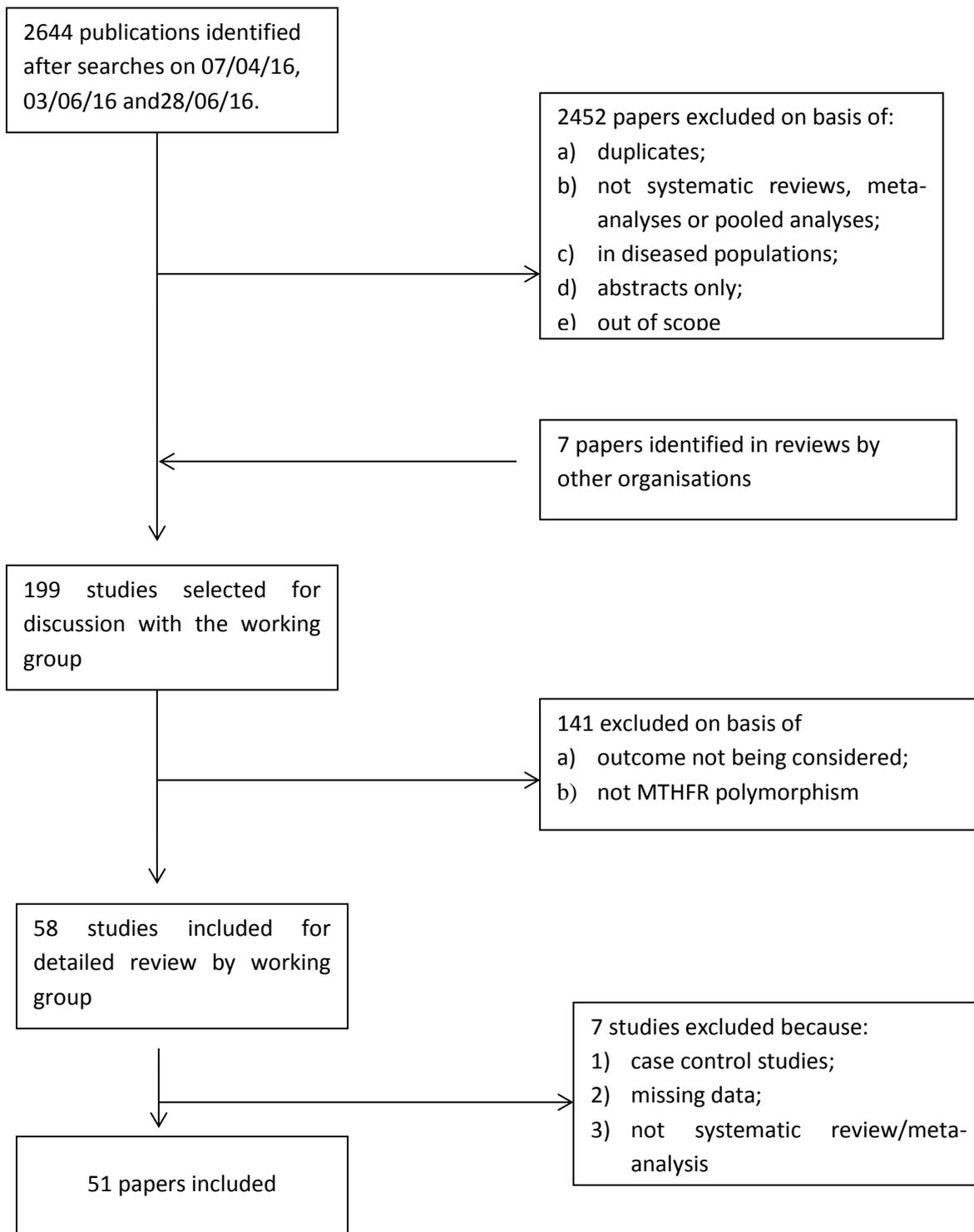
### Unmetabolised folic acid

10. A separate search of primary literature was undertaken on 3 May 2016 to identify studies that investigated: i) the effect of folic acid supplementation on plasma or serum unmetabolised folic acid (UMFA); ii) the metabolism of folic acid; iii) the relationship between UMFA and health outcomes. It was agreed to search for primary research studies as there is still limited research in this area. Four databases were searched: Embase, MEDLINE, Scopus and the Cochrane Library. The Embase search strategy is shown in the Appendix.

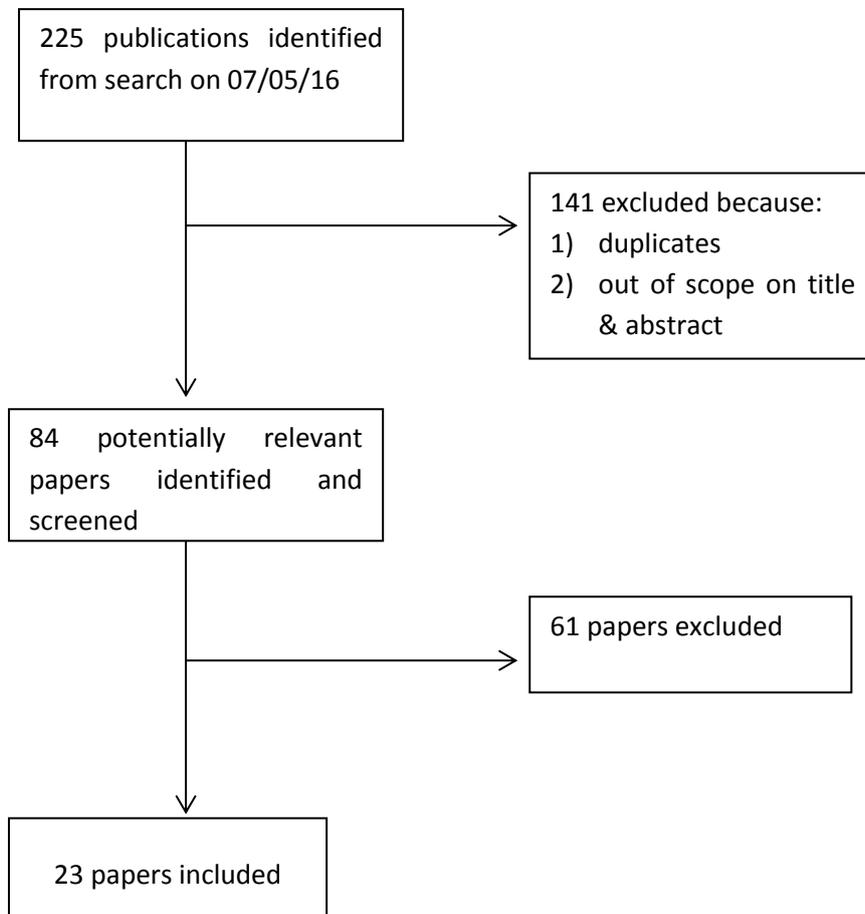
### **Search Results**

11. The combined literature search of folic acid and health outcomes identified 2644 citations of which 51 were included in the review (Figure 1). Although it did not meet the inclusion criteria for study type, it was agreed that one cross-sectional study by Qi et al (2014) should be included that provided evidence on the masking of B12 deficiency as there is very limited evidence in this area.
12. For the literature search on unmetabolised folic acid, 225 studies were identified, of which 23 were included in the review (Figure 2).

**Figure 1: Flow chart of search and selection process of meta-analyses, systematic reviews and pooled analyses included in update**



**Figure 2: Flowchart of search and selection process for studies on unmetabolised folic acid included in update**



**Embase search strategy**

**Folic acid**

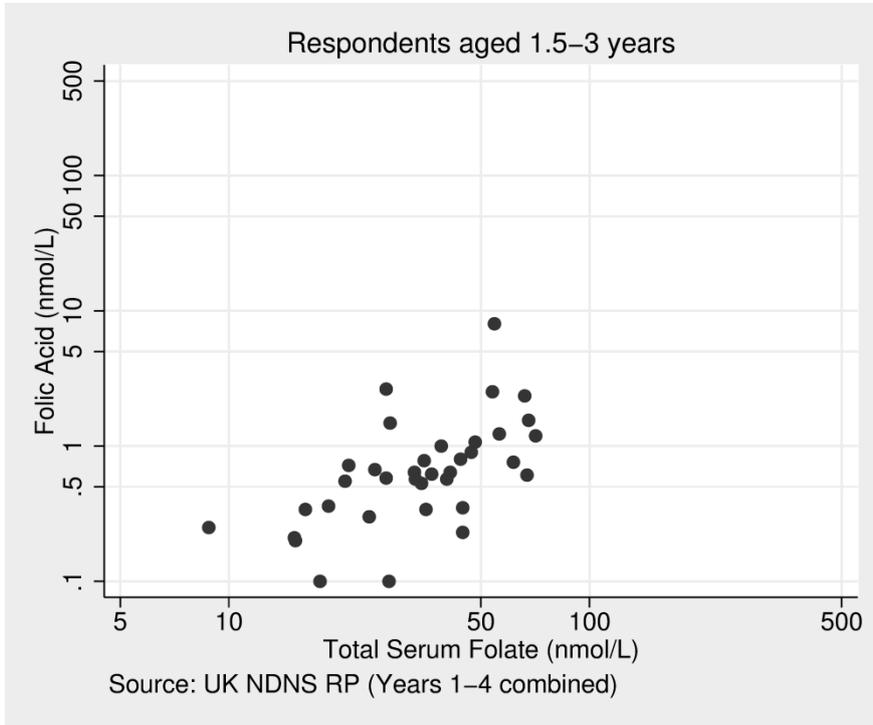
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2. "folic acid " OR folate\*
3. exp SYSTEMATIC REVIEW/
4. exp META ANALYSIS/
5. ("systematic review\*" OR meta-analys\* OR "meta analys\*").ti,ab
6. (pooled ADJ (analys\* OR mean OR estimate\*)).ti,ab
7. 1 OR 2
8. 3 OR 4 OR 5
9. 7 AND 8
10. 1 AND 6
11. 9 [Limit to: Publication Year 2000-2016 and (Publication Types Review)]
12. 10 [Limit to: Publication Year 2000-2016 and (Publication Types Review)]

**Unmetabolised folic acid**

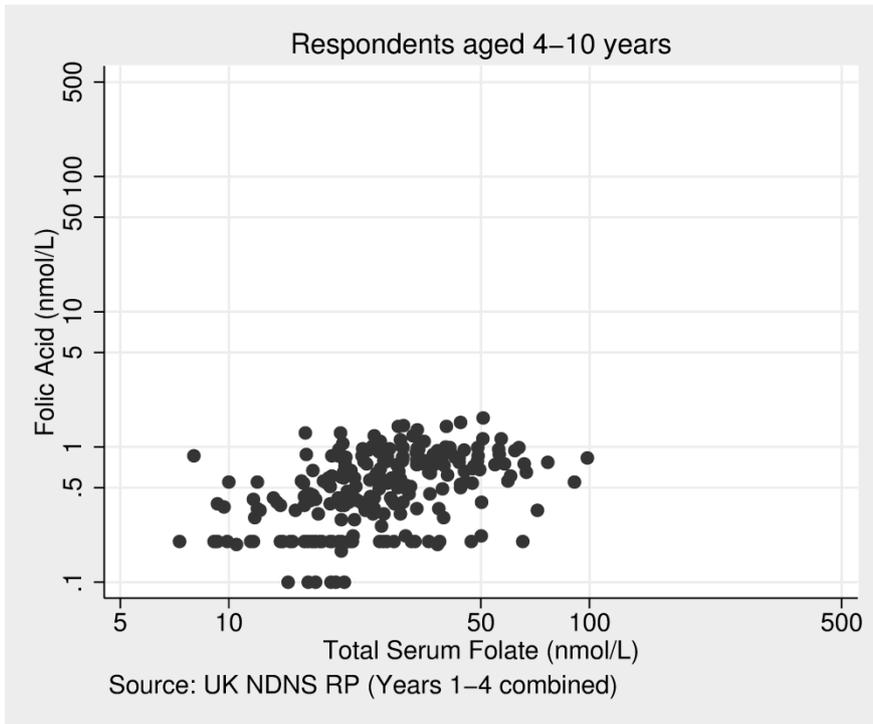
1. exp FOLIC ACID/
2. FOLIC ACID DEFICIENCY/
3. ("folic acid " OR folate\*).ti,ab
4. (unmetaboli?ed OR un-metaboli?ed OR metaboli?ation).ti,ab
5. 1 OR 2 OR 3
6. 4 AND 5

**Unmetabolised folic acid concentration in the NDNS (years 1-4), UK**

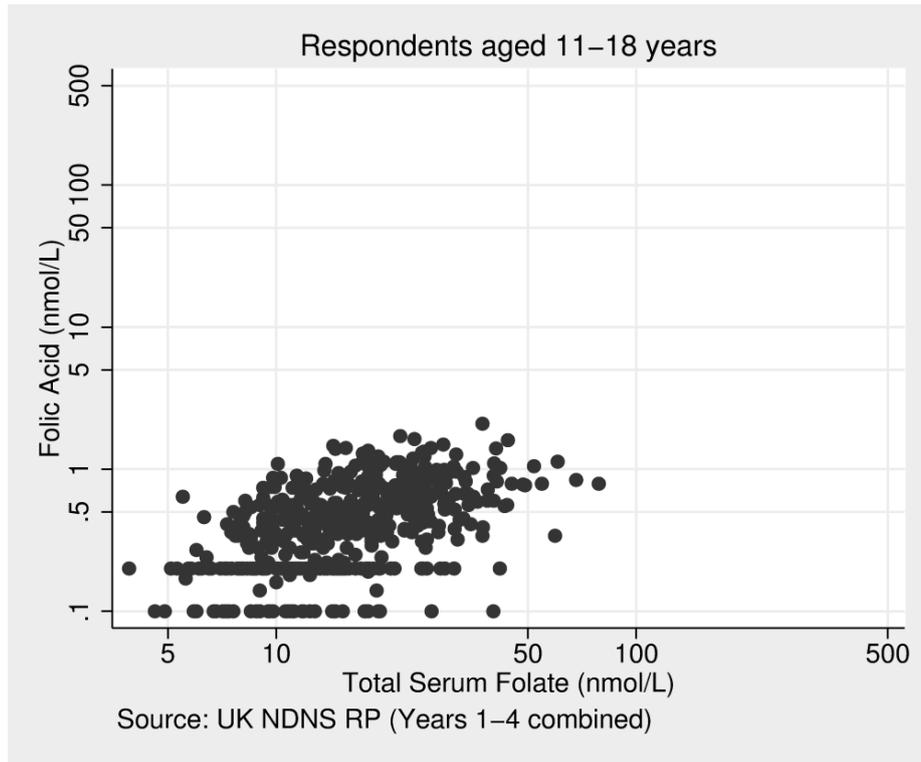
**Figure 1: UMFA concentration in participants aged 1.5-3y**



**Figure 2: UMFA concentration in participants aged 4-10y**



**Figure 3: UMFA concentration in participants aged 11-18y**



**Figure 4: UMFA concentration in participants aged 19-64y**

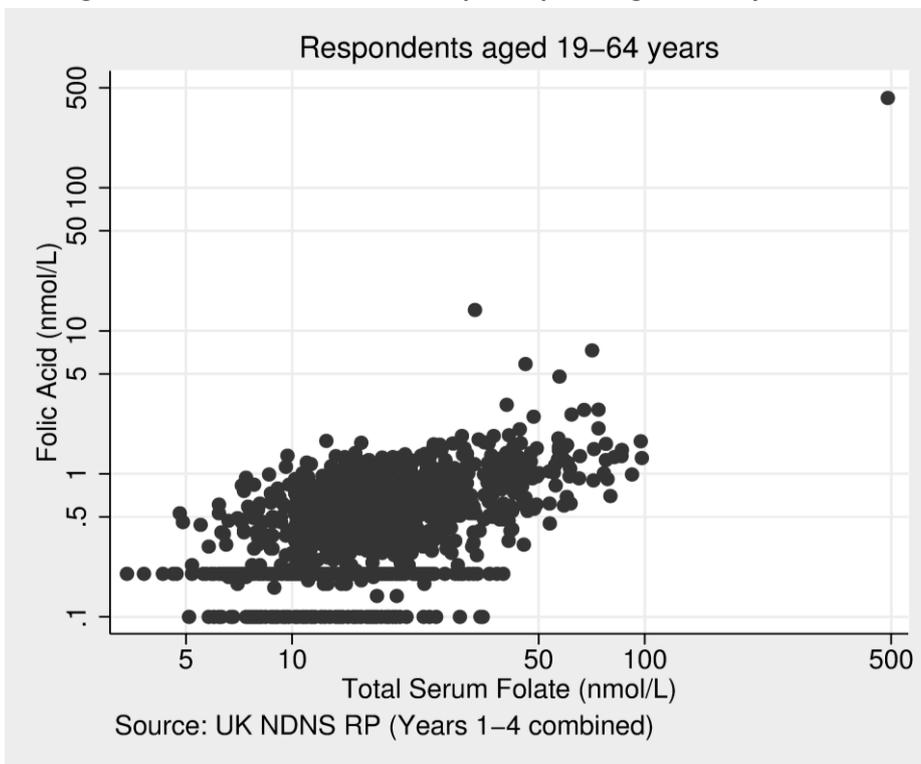
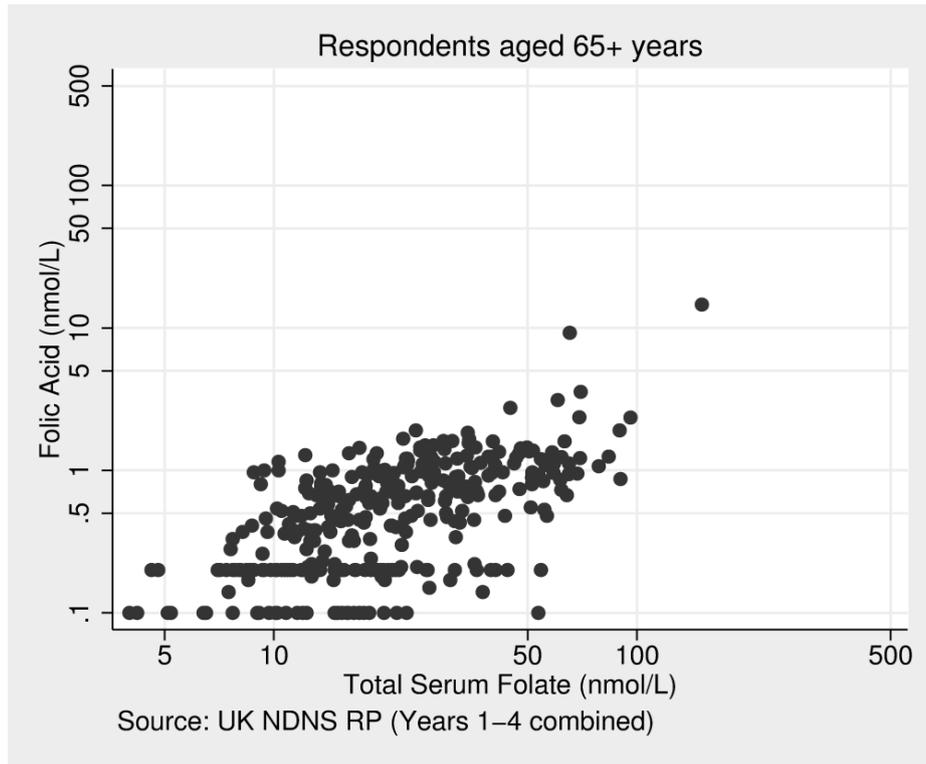
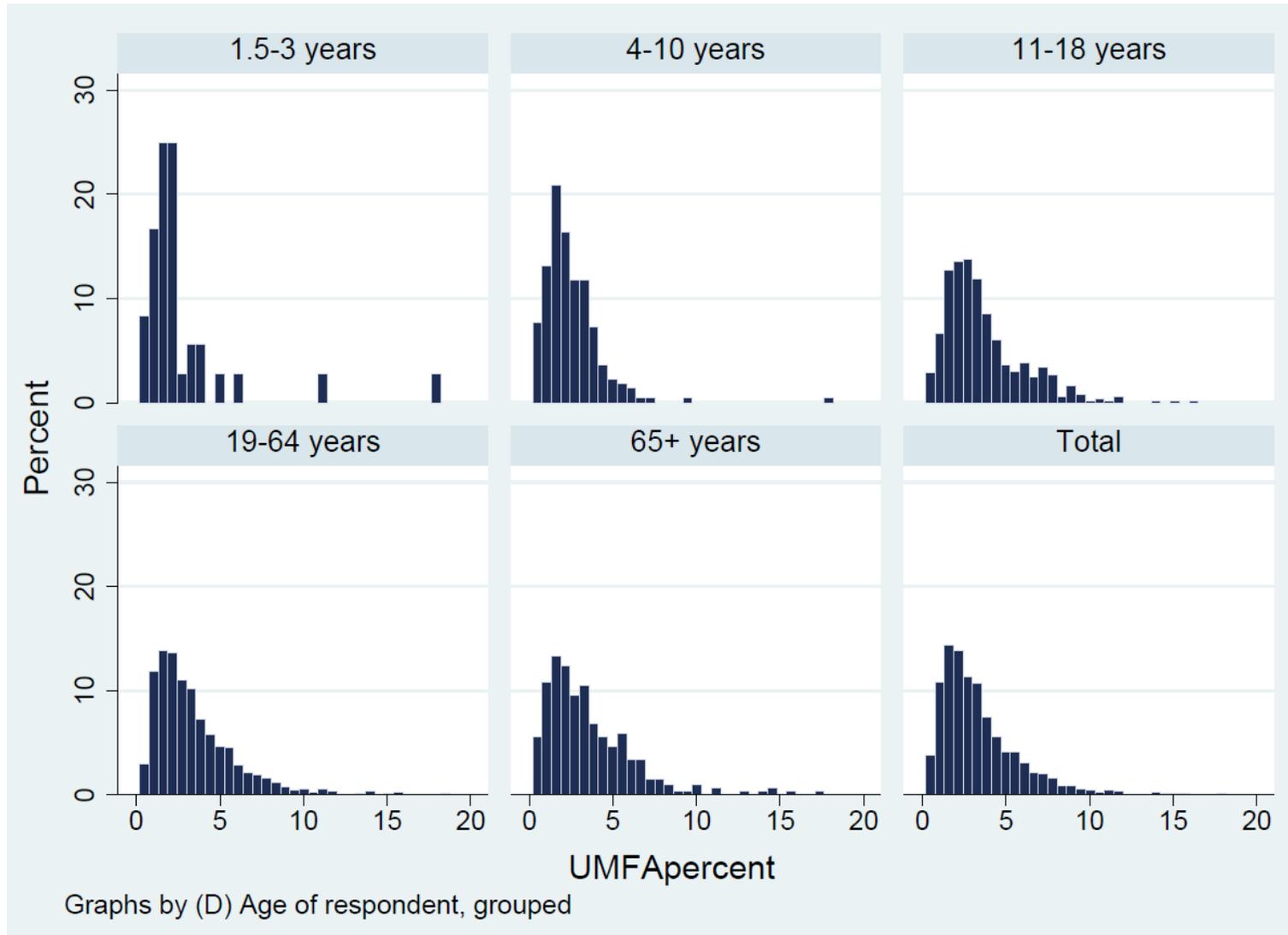


Figure 5: UMFA concentration in participants aged 65+y



**Figure 6: UMFA as a proportion of total folate**



## **SACN's recommendations on mandatory fortification of flour with folic acid** **(2009)**

1. As previously recommended by the Committee on Medical Aspects of Food and Nutrition Policy (Department of Health, 2000<sup>26</sup>), all women who could become pregnant should take 400 µg/day folic acid as a medicinal or food supplement prior to conception and until the twelfth week of pregnancy. Women with a previous pregnancy affected by a neural tube defect (NTD) are advised to take 5 mg/day of folic acid prior to conception and until the twelfth week of pregnancy.
2. Individual long-term intakes of folic acid from fortified foods and supplements above the Guidance/Tolerable Upper Level (GL/UL)<sup>27</sup> per day for folic acid (1 mg/day for adults; lower amounts for children<sup>28</sup>) should be avoided. A proportion of the UK population<sup>29</sup> is currently exceeding the GL/UL per day due to consumption of foods fortified with folic acid on a voluntary basis and supplement use. The current risk posed by voluntary fortification of food with folic acid and supplement use in contributing to intakes above the GL/UL per day for folic acid needs to be addressed.
3. Mandatory fortification of flour with folic acid would improve the folate status of women most at risk of pregnancies affected by NTDs. It would also improve the folate status of other population groups in the UK. However, mandatory fortification, combined with the current practice of voluntary fortification of foods with folic acid and inappropriate supplement use, would increase the numbers in the population consuming levels of folic acid above the GL/UL per day. Therefore, mandatory fortification should only be introduced in the UK if it is accompanied by:
  - action to restrict voluntary fortification of foods with folic acid;
  - measures for careful monitoring of emerging evidence on any adverse effects of long-term exposure to intakes of folic acid above the GL/UL per day; and
  - guidance on supplement use for particular population groups.
4. Mandatory fortification of flour<sup>30</sup> alongside restrictions on voluntary fortification will confer a more even distribution of folic acid intakes across the population compared to current voluntary fortification and supplement use. It will not lead to a substantial increase in the average population intake of folic acid but will reduce the risk of intakes exceeding the GL/UL and increase intakes of those currently consuming the lowest total folate intakes (from foods containing naturally occurring folates and foods fortified with folic acid).
5. The introduction of mandatory fortification will require: acquisition of new baseline data on folic acid intakes and blood folate concentration to ensure that mandatory fortification does not lead to an increase in folic acid intakes above the GL/UL and to permit monitoring of trends in future surveillance programmes; adoption of a sufficiently robust common standard analytical method for

<sup>26</sup> Department of Health. *Folic acid and the prevention of disease*. Report on health and social subjects 50. London: TSO, 2000.

<sup>27</sup> In the UK, the Expert Group on Vitamins and Minerals set a GL of 1 mg/day of folic acid for adults. The GL is based on limited data and is an approximate indication of intakes that would not be expected to cause adverse effects. In the USA and Europe, a UL of 1 mg/d of folic acid was set for adults; the UL represents the highest level of daily nutrient that is likely to pose no risk to health.

<sup>28</sup> GLs were not set for children in the UK. ULs were set for children in the USA and Europe based on body weight. ULs for children, Europe: 4-6y, 300 µg/d; 7-10y, 400 µg/d; 11-14y, 600 µg/d; 15-17y, 800 µg/d. ULs for children, USA: 1-3y, 300 µg/d; 4-8y, 400 µg/d; 9-13y, 600 µg/d; 14-18y, 800 µg/d.

<sup>29</sup> Approximately 106,000 people.

<sup>30</sup> Careful consideration would need to be given to the issue of overage.

measurement of folate status at baseline and in all future surveillance studies; and establishment of suitable reference ranges to predict folate adequacy and deficiency.

6. If mandatory fortification were introduced, all women who could become pregnant and those with a history of a previous NTD-affected pregnancy should continue to supplement their diet with 400 µg and 5 mg per day of folic acid respectively prior to conception and until the twelfth week of pregnancy.
7. There are no specific recommendations on folic acid supplementation for other population groups (i.e., children, women above child bearing age, and men) except on medical advice. For people who choose to take supplements, as a precaution, it would be advisable for those aged over 50 years not to consume supplements containing folic acid above the recommended nutrient intake (RNI)<sup>31</sup> for folate of 200 µg/day since the risk of developing colorectal adenomas/colorectal cancer increases after this age (Winawer *et al.*, 1997<sup>32</sup>; American Cancer Society, 2008<sup>33</sup>). For people with a previous history of colorectal adenomas, folic acid supplementation should also not exceed 200 µg/day without medical guidance. This recommendation is relevant to current consumption patterns and those which would prevail if mandatory fortification were introduced.
8. Evidence on the benefits and hypothesised risks of folic acid should be reviewed after an appropriate period of time which should be no later than five years.
9. There are a number of uncertainties regarding the GL/UL per day set for folic acid which is based on limited data and relates to concerns regarding vitamin B<sub>12</sub> deficiency. Further research is required on safe upper levels of folic acid intake in relation to other postulated risks, such as cancer.
10. More reliable diagnostic indices to identify vitamin B<sub>12</sub> deficiency should be developed. The development of a clinical strategy to manage issues related to vitamin B<sub>12</sub> is necessary irrespective of a decision on future mandatory fortification of flour with folic acid.
11. The prevalence of poor vitamin B<sub>2</sub> (riboflavin) status in the UK population needs to be addressed.

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<sup>31</sup> The RNI represents the amount of a nutrient that is sufficient to meet the requirements of 97.5% of the population.

<sup>32</sup> Winawer SJ *et al.* Colorectal cancer screening: clinical guidelines and rationale. *Gastroenterology*. 1997; 112:1060 and 1998; 114:625.

<sup>33</sup> American Cancer Society. *Cancer Facts & Figures 2008*. Atlanta: American Cancer Society; 2008.