

1 **Title**

2 Dietary intake of 20 polyphenol subclasses in a cohort of UK women

3 **Authors**

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11

12 **Short running title**

13 Polyphenol intake of UK women

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18

19 **Abstract**

20 *Background* Establishing and linking the proposed health benefits of dietary polyphenols to their consumption
21 requires measurement of polyphenol intake in appropriate samples and an understanding of factors that
22 influence their intake in the general population.

23 *Methods* This study examined polyphenol intake estimated from 3 day and 7 day food diaries in a sample of 246
24 UK women aged 18-50 years. Estimation of the intake of 20 polyphenol subclasses commonly present in foods
25 consumed by the sample studied was done using Phenol-Explorer® and USDA polyphenol databases. Women
26 were potential participants in the Leeds Women's Wellbeing Study (LWW) (N= 143), a dietary intervention
27 study aimed at overweight women (mean age: 37.2 ± 9.4 years; mean BMI: 30.8 ± 3.1 kg/m²) and the Diet and
28 Health Study (DH) (N = 103) which aimed to examine the relationship between polyphenol intake and cognitive
29 function (mean age: 25.0 ± 9.0 years; mean BMI: 24.5 ± 4.6 kg/m²).

30 *Results* The estimated intake of polyphenol subclasses was significantly difference between the two samples
31 (p<0.01) with consumption of 1292 ± 844 and 808 ± 680 mg/day for the LWW and DH groups respectively.
32 Flavanols and hydroxycinnamic acids were the most important contributors to the polyphenols consumed by
33 both groups, owing to tea and coffee consumption. Other major polyphenol food sources included fruits,
34 vegetables and processed foods.

35 *Conclusion* Older women consumed more polyphenol-containing foods and beverages, which was due to the
36 higher coffee and tea consumption amongst the LWW participants.

37

38 **Keywords** Polyphenols. flavonoids. phenolic acids. food diary. Phenol-Explorer

39

40 **Introduction**

41 Dietary assessment is an important technique for estimating food intake. This process first requires a reliable
42 collection of food intake data, followed by accurate and appropriate analysis of food intake using available
43 comprehensive databases which provide details of the nutrient content of foods. Two polyphenol databases that
44 are widely used in the estimation of polyphenol intake are the United States Department of Agriculture (USDA)
45 [1] and the Phenol-Explorer® [2] databases.

46 Several studies have estimated polyphenol intake and their association with health benefits in various
47 parts of the world. For example, a recent study identified an association between daily flavonoid and stilbene
48 intake and lipid profiles amongst Chinese adults [3]. The emphasis in this study was on fruit, vegetables and
49 nuts which are commonly consumed by the Chinese population. A study of Iranian adults reported a lower
50 prevalence of metabolic syndrome in participants with higher dietary intake of selected polyphenols estimated
51 using Phenol-Explorer® [4]. Another study from Spain which also used Phenol-Explorer® found a reduction in
52 cardiovascular disease risk amongst participants with greater intake of dietary polyphenols [5]. The European
53 Prospective Investigation into Cancer and Nutrition (EPIC) study estimated intake of particular flavonoids
54 (flavonols, flavanones and flavones), anthocyanins, phytoestrogens, lignans and phenolic acids in ten European
55 countries using 24 hour dietary recall methods [6-10]. Within the EPIC study, the UK “health conscious” cohort,
56 which includes fish eaters, vegans and lacto-ovo vegetarians, consumed higher amounts of flavanones [6],
57 anthocyanins [7], and phytoestrogens [8], but lower total phenolic acids [10] as compared to the general
58 population. However, no comparison could be made for total flavonoids because only total flavonoid intake data
59 of the general population from EPIC participating countries were presented [11]. In the EPIC study, tea and fruit
60 were the major flavonoid contributors for the UK sample [11] but non-flavonoid phenolics were not considered,
61 nor was the impact of body weight and age on polyphenol source or consumption.

62 In this study, we took advantage of two existing samples, potential participants in the Leeds Women’s
63 Wellbeing Study (LWW) and the Diet and Health Study (DH), since both studies required potential participants
64 to complete 3 or 7 day food diaries, but polyphenol intake was not emphasized and therefore these data provide
65 incidental assessment of the polyphenol intake of UK women. The different study aims – LWW was a dietary
66 intervention study targeted women who wanted to make dietary changes to improve their health and wellbeing
67 and maintain a healthy body weight and DH examined the relationship between habitual polyphenol intake and
68 cognitive function targeted young, healthy women – attracted different samples of women. Together these

69 studies allowed us to estimate the effect of age and BMI on the intake of a wide range of polyphenols in the UK
70 population.

71

72 **Materials and methods**

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74 **Participants and study design**

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76 This investigation employed a cross sectional design where habitual polyphenol intake was assessed using food
77 diaries. The diaries were collected from two different studies, namely the Leeds Women's Wellbeing Study
78 (LWW) (NHS ethics reference number: 10/H1305/6) and the Diet and Health Study (DH) (Ref No: 12-0020).
79 The LWW data were collected between 20/04/2010 and 10/08/2011 while DH study was collected between
80 01/06/2012 and 30/06/2013. Both studies were conducted in the Human Appetite Research Unit (HARU) at the
81 Institute of Psychological Sciences, University of Leeds. LWW study was intended to facilitate weight loss
82 through two approaches; healthy eating advice alone or healthy eating with extra advice to increase fibre intake
83 to a minimum of 25 g/day amongst overweight and obese women. Data taken from the LWW study were socio-
84 demographic information and 7 day food diaries collected during the screening phase of the study. The inclusion
85 criteria for the DH study were; women aged 18 to 50 years, not pregnant, non-smoker, normal body mass index
86 (BMI) and above (≥ 18.5 kg/m²) and English as their first language.

87

88 **Dietary assessment**

89

90 Food intake was assessed using a self-completed food diary. 7-Day food diaries were collected from LWW
91 participants during the screening phase prior to entering a weight loss intervention trial. For the DH study, a 3-
92 day food diary in which all food consumed for 2 weekdays and 1 weekend day was given to participants during
93 their first visit and was returned on their second visit at least one week later, so that the diary was completed
94 between visit one and visit two. Participants were encouraged to record their food intake using household
95 measures and to include the food packaging within the diary where possible. The participants were informed
96 how to fill in the food diary and were shown examples of good dietary recording from example diaries. Food
97 intake data from the food diaries were analysed using WinDiets®. This software comprised of two food
98 databases; namely UK Food Tables 2008 and USA Food Tables 2008. The data were inputted in gram (g) of

99 foods consumed by the participants. To facilitate the approximation of portion size, the latest food portion
100 guideline book for selected UK foods was used in the study [12]. Basal metabolic rate (BMR) was calculated
101 using Schofield equations [13]. The BMR value was used to verify accuracy of dietary recording of the
102 participants and was divided by energy intake (EI/BMR) to identify incidences of underreporting.
103 Underreporting is assumed when the EI/BMR is less than <1.14, normal is in the range 1.14 to 2.4 and over
104 reporting is >2.4 [14].

105

106 Estimation of polyphenol intake

107

108 Foods which did not contain any polyphenols such as meat-based products were omitted from the estimation of
109 polyphenols. Ingredients of processed foods such as canned foods and pre-packaged meals were checked for
110 polyphenol-containing ingredients. Foods that contained more than 1 mg per serving of any polyphenol were
111 identified using the Phenol-Explorer[®] database [2] when possible, and in combination with the USDA database
112 [1] on selected flavonoids to enable examination of the polyphenol content of as many foods as possible. Only
113 ingredients with a polyphenol content of ≥ 1 mg per serving were included in the calculation of polyphenol
114 intake. Data for polyphenol content obtained from Phenol-Explorer[®] was selected from mean content obtained
115 from methods involving chromatography. Missing data from fruit, such as citrus fruits and sultanas, were
116 estimated based on tangerine and raisin data from USDA and Phenol-Explorer[®] respectively. For other food
117 groups which are mainly comprised of processed foods, the estimation was made according to the percentages
118 of ingredients in the food products. Data for thearubigins from the USDA database was added to the existing
119 data in Phenol-Explorer[®] because this compound is a major contributor to the flavanol content of tea [15]. Data
120 for proanthocyanidins obtained from Phenol-Explorer[®] in the form of dimers and trimers were added together
121 and presented in the flavanols group. Twenty polyphenol subclasses were selected for the estimation on the
122 basis that these compounds are commonly present in foods consumed by the sample studied. The cut off used
123 for foods to be included in the polyphenol estimation was based on a previous study which referred to foods that
124 contributed less than 1 mg/day as minor contributors to polyphenol intake [16]. Thus, foods that contained less
125 than 1 mg of polyphenols as consumed in a usual portion were excluded from the analysis. Polyphenol intake
126 was presented based on average intake per day.

127

128 Statistical analysis

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130 Statistical analyses were performed using the Statistical Package for Social Science (SPSS, version 19). All data
131 were examined for outliers using boxplots and the normality assumptions were checked for each inferential
132 analysis. There was no significant deviation from normality and sample size was sufficient to retain all data with
133 no outliers excluded from the analysis. Data from continuous variables are presented as mean \pm standard
134 deviation. Percentages are used for categorical variables. Polyphenol intake data from LWW and DH samples
135 were combined to provide a better estimation and representativity of the polyphenol intake amongst UK women.
136 The results are presented in two ways; namely, a comparison between study groups (LWW vs DH) to identify
137 differences between 3 days and 7 days food recording and between beverage consumption groups. Chi-squared
138 tests were used to identify the association between two categorical variables. Independent t-tests and analysis of
139 variance (ANOVA) models were used to test differences in polyphenol intakes between study group and
140 beverage consumption group. In order to examine the influence of age and BMI, these continuous variables
141 were included in an ANCOVA with study group as a between-subjects factor and polyphenol intake as the
142 dependent variable. Data which were not normally distributed were analysed using non-parametric tests of
143 differences between groups; namely Mann-Whitney U-test for two groups and Kruskal-Wallis test for more
144 than two groups. In all analyses, p values of <0.05 or <0.01 were considered statistically significant.

145

146 **Results**

147 Table 1 presents the characteristics of participants according to the two study samples (LWW and DH). There
148 was a significant difference in age and BMI between the two study groups ($p<0.01$). LWW participants were
149 older and heavier than DH participants since the former were recruited specifically because they were
150 overweight and intended to participate in a weight loss intervention. Furthermore, higher BMI is associated with
151 increasing age [17]. More of the DH participants performed regular exercise ($p<0.05$) and were students
152 ($p<0.01$) than the LWW participants. There was no significant difference between the two study samples in the
153 frequency of participants in the EI/BMR categories. Under reporters were more frequent amongst DH
154 participants (45.1%) as compared to LWW participants (38.5%) and none over reported energy intake.

155 Table 2 represents the polyphenol food sources and the polyphenols contained in each food, commonly
156 consumed by the participants. In this study, coffee and tea were the major beverages consumed. Various types
157 of tea including black, green, camomile, and fruit tea were consumed by the participants. Onion, potato and
158 tomato were the most important vegetables contributing to polyphenol intake. Commonly consumed fruits were

159 bananas and apples, while processed foods, such as milk chocolate, baked beans, hummus, ready to cook sauces
160 and soups, were the most important sources of polyphenol intake.

161 A comparison between the LWW and the DH studies was made for specific polyphenol intake (Table
162 3) based on the average intake per day derived from the 3 day and 7 day diaries respectively. Overall, the intake
163 of polyphenols for the LWW group was higher than DH except for dihydrochalcones and lignans. These
164 differences might be due to the higher coffee and tea consumption and the greater diversity of food sources
165 consumed by the LWW participants. The daily intake of all major polyphenol groups was significantly different
166 between the two studies ($p < 0.01$), whereby LWW participants' intakes were higher. Moreover, the daily intake
167 of polyphenol subclasses also showed a significant difference between the two studies ($p < 0.01$) with mean
168 intakes of 1292 ± 844 and 808 ± 680 mg/day for LWW and DH participants respectively. This finding can be
169 explained by higher energy (kcal) intake of LWW participants in addition to positive association found between
170 energy (kcal) intake and polyphenol subclasses intake ($r = 0.237$, $p < 0.0001$). Moreover, when age and BMI
171 were included as covariates in an ANCOVA to compare polyphenol intake between LWW and DH participants,
172 both age ($F_{1, 242} = 117.18$, $p < 0.001$) and BMI ($F_{1, 242} = 4.203$, $p < 0.05$) were significant covariates and were
173 positively related to total polyphenol intake per day but the difference in polyphenol intake between the LWW
174 and DH samples was no longer significant suggesting that differences can be accounted for by age and BMI.

175
176 In order to identify the contribution of polyphenol sources other than coffee and tea, a comparison was
177 made between intake of total polyphenol subclasses (Total dataset) and intake excluding coffee and tea (NoCorT
178 dataset) (Table 4). The average intakes of polyphenol subclasses were 1089 ± 814 and 213 ± 129 mg/day for
179 Total and NoCorT datasets respectively. Clearly some polyphenols are only present in coffee or tea, or in fruit
180 and vegetables, but others are present in more than one group. The relative percentages of NoCorT to Total
181 datasets were calculated to identify the contribution of coffee and tea polyphenols to polyphenol intake. A value
182 of 100% indicates that all polyphenols are derived from fruit and vegetable sources, whereas a value of 0%
183 indicates that beverages provide all the polyphenols in the category. The alkylmethoxyphenol and flavanol
184 content of the diets came almost entirely from coffee and tea intake. Hydroxybenzoic acids and
185 hydroxycinnamic acids were also mainly derived from the beverage sources. Overall, the intake of polyphenols
186 after the addition of total flavonoids, total phenolic acids and total all other polyphenols was ~5-fold greater for
187 the Total dataset as compared to the dataset excluding coffee and tea (NoCorT). The major polyphenol food
188 sources for participants who did not consume coffee and tea mainly came from vegetables (e.g. onions, potatoes,

189 broccoli, beans), fruits (e.g: strawberries, blueberries, apples), wholemeal bread, chocolate and chocolate drink.
190 These foods were frequently consumed by the participants, however, no quantification was made to determine
191 the percentage of contribution of the foods to the intake of polyphenol subclasses.

192

193 **Discussion**

194 This study focused on the habitual polyphenol intake of women in the UK. Women have an important role in
195 food selection and consumption within the family [18]. In addition, women reportedly perceive themselves to be
196 more conscious about food, more likely to read nutritional labels, practise healthy eating and be more
197 knowledgeable about health and nutrition as compared to men [19]. The higher number of under reporters in the
198 DH study may be related to age and practising certain dietary restrictions for weight maintenance. A previous
199 study has suggested that young women tend to perceive themselves as overweight, thus efforts to lose weight
200 are becoming more common [20]. However, this might also reflect underreporting of actual intake rather than
201 lower intake per se. Underestimation of 37 % was previously reported in a study that used food recording as tool
202 for measurement of total energy intake when compared to the doubly labelled water method [21]. In an effort to
203 minimise underreporting, participants were advised to be honest about their intake, especially with respect to the
204 intake of foods which might be perceived as “unhealthy” such as confectionery or snacks.

205 A comparison of polyphenol subclasses intake was made between under and normal reporters, and no
206 significant difference was found. This finding can partly be explained by the perception that coffee and tea
207 drinking are not considered unhealthy habits therefore, participants are more likely to have reported their
208 consumption honestly. Furthermore, as tea and coffee dominate as sources of polyphenol subclasses intake but
209 contribute few, if any, calories there would be little impact on energy intake. Furthermore, flavonoids and
210 phenolic acids which are widely present in fruit and vegetables would be less likely to be under reported by the
211 participants because these foods are considered healthy. Moreover, participants from the DH study were
212 informed that the objectives of the study were to examine the effects of polyphenols and the major sources of
213 polyphenols were briefly explained in the participant information sheet which should encourage rather than
214 discourage reporting of these foods. Knowing the purpose of a study can encourage socially desirable responses.
215 DH participants were expected to over report their polyphenol intake as compared to LWW participants.
216 However, the opposite finding was demonstrated in this study. In relation to food intake, this is often reflected
217 by over reporting of foods perceived to be healthy and underreporting of foods perceived to be unhealthy.
218 Previous research has reported that participants believed that the consumption of foods perceived to be ‘good’ in

219 larger quantities would promote less weight gain [22]. To overcome this problem, surreptitious recording of
220 food intake or disguising the purpose of the study is recommended so that emphasis is drawn away from the
221 particular food groups under study.

222 In this study, it was apparent that there were more participants from both groups who consumed both
223 coffee and tea (39 %) or consumed tea only (32.5 %) than just coffee (11.8 %) or neither tea nor coffee (16.7
224 %). The average volume of coffee and tea consumed was 160 ± 239 and 328 ± 377 ml/day respectively. Higher
225 daily tea consumption (814 ± 450 ml/day) was reported from a longitudinal study amongst men in South Wales
226 [23]. The men were older than the current sample and were mainly working class in an industrial town, where
227 tea would be a routine part of their daily lives. Thus they represent a very different group to the average UK
228 population and to the samples considered in our study. From our data, consumers of both coffee and tea were
229 shown to drink more tea than coffee in terms of volume consumed daily. A similar finding was reported in a
230 study amongst Scottish adults, whereby high tea consumers were likely to drink less coffee [24].

231 The determination of major polyphenol food sources can be made by assessing the amount of
232 polyphenols present in food and the quantity of food consumed [25]. In addition, the determination of
233 polyphenol food sources relies on two aspects. Firstly, whether the foods have a high polyphenol content, so
234 even if a small amount is consumed the contribution to polyphenol intake is significant. Secondly, some foods
235 are consumed in large quantities however, because of their low polyphenol content, their contribution to intake
236 of individual subclasses is not significant. An example of the first situation is spinach and onions which have a
237 high polyphenol content, while the second is pineapple and cabbage which have a low polyphenol content.
238 Conversely, coffee and tea fulfil both aspects whereby these beverages are consumed in high amounts and have
239 a high polyphenol content and this is why they dominate the Total dataset.

240 The total polyphenol intake as reported from other studies ranges from 800 to 1200 mg/day [5, 16, 26,
241 27]. The value of total polyphenols estimated in this study by summing 20 polyphenols is within a reasonable
242 range when compared to the other studies. The main polyphenol food sources for the studies with total
243 polyphenol intake above 1 g per day are beverages such as coffee, tea and fruit juices as reported by study from
244 France and Poland [16, 27]. The other polyphenol food sources include fruit, vegetables, legumes and cereal
245 products. The disparity between all these studies in the estimation of total polyphenols can partly be explained
246 by the different number of polyphenol subclasses included in the estimation of polyphenol intake. The different

247 databases used to estimate polyphenol intake also can contribute to the differences in total polyphenol
248 estimation between countries.

249 In terms of food intake, data from the food diaries demonstrates that the major polyphenol food
250 sources consumed by the studied samples, such as tea, coffee, potatoes and apples are similar to those reported
251 from previous studies [16, 27]. An Australian study also identified black and green tea as major flavonoid food
252 sources along with wine, apples and oranges [28]. A recent study has estimated the total flavonoid intake
253 amongst the non-Mediterranean countries in Europe including Germany, the Netherlands, UK, Sweden and
254 Norway [11]. This study reported two major contributors to flavonoid intake of the non-Mediterranean countries
255 namely tea and fruits, with the UK population showing the highest intake of total flavonoids (average of 549
256 mg/d in men and 502 mg/d in women). Tea was also the major contributor to flavonoid intake in our study. An
257 implication of this is the possibility that health promotion to increase the serving size of fruit and vegetables as a
258 good source of polyphenol foods can also emphasize the point that these two food sources are also significant
259 contributors to polyphenol intake.

260 In addition, the inclusion of thearubigins in the estimation of flavanols was demonstrated to be an
261 important approach for a better estimation of polyphenol content in tea. The importance of this compound was
262 reported by the EPIC study which focused on thearubigin intake in several European countries [29]. This study
263 has reported that the UK general population were the highest tea consumers, with 48 % of total flavonoids being
264 contributed by thearubigins. **However, there is a possible limitation in the usage of data on thearubigins from**
265 **USDA.**

266 The current study was limited by its small sample size with a large age range (18 – 50 years). In
267 addition, being health-conscious might be a possible motivating factor for the participants to volunteer for these
268 two studies, and might influence the foods consumed (or reported) by the participants during the dietary
269 recording. Thus, the representativeness of this sample to the general female population of the UK may be
270 somewhat limited. Finally, there is a substantial lack of available information on the polyphenol content of
271 processed foods. Food recording can possibly cause some alterations in the habitual food intake of the
272 participants. However, to deal with this possibility, participants were encouraged to bring all food packaging
273 along with them in case they had difficulties in explaining the food portion size. The estimation of certain foods
274 was made based on the percentage of polyphenol-containing ingredients in the food products.

275 The average polyphenol intake of the whole sample, estimated from 20 polyphenol subclasses present
276 in commonly consumed foods, exceeded 1 g per day. The intake of polyphenol subclasses was higher amongst
277 LWW participants, whilst DH participants had 37.5% lower polyphenol subclasses intake than the LWW
278 participants, despite being aware of the polyphenol focus of the study. In addition, 56% of LWW participants
279 consumed more than 1 g polyphenols/day compared to DH (36 %). These effects can be explained by the
280 significant differences in age and BMI between the two study samples which account for the difference in
281 polyphenol intake. The major polyphenol food sources of the women studied in this study were tea and coffee,
282 thus women who did not consume tea or coffee had much lower average polyphenol intake.

283 Future studies should be longitudinal in design, and include samples which vary in socio-economic
284 status, age and BMI. In addition, the effect of food processing on the polyphenol content of foods should be
285 taken into consideration in subsequent research in order to better estimate polyphenol intake.

286

287 **Acknowledgments**

288

289 The authors thank all the women who participated in this study.

290

291 **Financial support**

292

293 This work was supported by funding from the Ministry of Education Malaysia and Universiti Kebangsaan
294 Malaysia. The Leeds Women's Wellbeing Study was funded by Kellogg's Sales and Marketing UK.

295

296 **Conflict of interest**

297

298 The authors declare that they have no conflicts of interest.

299

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