ABSTRACT

Background: The long-term longitudinal evidence for a relation between coffee intake and hypertension is relatively scarce.

Objective: The objective was to assess whether coffee intake is associated with the incidence of hypertension.

Design: This study was conducted on a cohort of 2985 men and 3383 women who had a baseline visit and follow-up visits after 6 and 11 y. Baseline coffee intake was ascertained with questionnaires and categorized into 0, >0–3, >3–6, and >6 cups/d. Hypertension was defined as a mean systolic blood pressure (SBP) ≥140 mm Hg over both follow-up measurements, a mean diastolic blood pressure (DBP) ≥90 mm Hg over both follow-up measurements, or the use of antihypertensive medication at any follow-up measurement.

Results: Coffee abstainers at baseline had a lower risk of hypertension than did those with a coffee intake of >0–3 cups/d [odds ratio (OR): 0.54; 95% CI: 0.31, 0.92]. Women who drank >6 cups/d had a lower risk than did women who drank >0–3 cups/d (OR: 0.67; 95% CI: 0.46, 0.98). Subjects aged ≥39 y at baseline had 0.35 mm Hg (95% CI: –0.59, –0.11 mm Hg) lower SBP per cup intake/d and 0.11 mm Hg lower DBP (95% CI: –0.26, 0.03 mm Hg) than did those aged <39 y at baseline, although the difference in DBP was not statistically significant.

Conclusions: Coffee abstinence is associated with a lower hypertension risk than is low coffee consumption. An inverse U-shaped relation between coffee intake and risk of hypertension was observed in the women.  

KEY WORDS  Coffee, hypertension, cohort study

INTRODUCTION

Coffee consumption has long been a suspected cause of hypertension, but the available evidence from various study designs is inconsistent. Many randomized experiments have been performed but with different coffee or caffeine intakes. In a recent meta-analysis of 16 trials with both coffee and caffeine interventions, we showed that for coffee trials with a median intake of 725 mL coffee/d there was a rise of 1.2 mm Hg in systolic blood pressure and of 0.5 mm Hg in diastolic blood pressure (1). These trials were designed for a short follow-up duration.

Most evidence on the relation between coffee and blood pressure stems from cross-sectional studies. This evidence, however, is inconsistent. Some of these studies showed a positive relation (2), no relation (3), or even an inverse relation (4). Such cross-sectional studies have important limitations with respect to causal inference.

Conclusive information about coffee as a cause for hypertension cannot be expected to come from randomized trials, because those would require unrealistically long-term interventions. Rather, long-term observational cohort studies will have to provide such information. There have been few follow-up studies on the relation between coffee intake and blood pressure or risk of hypertension (5, 6, 7). In 1017 young men, a small positive association between coffee intake and blood pressure rise over many years of follow-up was indicated to play a small role in the development of hypertension (6). In women participating in the Nurse’s Health Studies, an inverse U-shaped relation was recently found between hypertension and caffeine consumption, but no association was found with decaffeinated coffee consumption (7).

Because the long-term longitudinal evidence for a relation between coffee intake and hypertension is relatively scarce, we used a Dutch cohort study to address that issue. This cohort allowed for studying the relation of baseline coffee intake to the incidence of persistent hypertension on the basis of repeatedly measured blood pressure levels in subjects at 5 y intervals during a follow-up of 11 y. Our specific research question was whether coffee intake in subjects who are not hypertensive is associated with the incidence of hypertension.

SUBJECTS AND METHODS

The design of the Doetinchem Cohort Study is described in detail elsewhere (8). Briefly, the subjects were inhabitants of the Dutch city of Doetinchem who had participated in 2 subsequent general population screening projects for chronic disease risk

1 From the Julius Center for Health Sciences and Primary Care, University Medical Center, Utrecht, Netherlands (CSPMU, PHMP, and DEG); the Centers for Prevention and Health Services Research (WMMV), for Nutrition and Health (HBBdM, MO, and EJMF), and for Information Technology and Methodology (HCB), National Institute of Public Health and the Environment, Bilthoven, Netherlands; and the Division of Human Nutrition, Wageningen University, Wageningen, Netherlands (JMG).

2 The Doetinchem Cohort Study was financially supported by the Ministry of Public Health, Welfare, and Sports of the Netherlands and The National Institute of Public Health and the Environment, Bilthoven, Netherlands; and the Division of Human Nutrition, Wageningen University, Wageningen, Netherlands (JMG).

3 Reprints not available. Address correspondence to CSPM Uiterwaal, Julius Center for Health Sciences and Primary Care, University Medical Center, PO Box 85500, 3508 GA Utrecht, Netherlands. E-mail: c.s.p.m.uiterwaal@umcutrecht.nl.

Received September 18, 2006.
Accepted for publication October 11, 2006.
factors: the Monitoring Project on Cardiovascular Disease Risk Factors [Peilstationsproject Hart- en Vaatziekten (PPHV)] (9) conducted between 1987 and 1991, and the Monitoring Project on Risk Factors for Chronic Diseases—European Prospective Investigation into Cancer and Nutrition (MORGEN-EPIC) (10) conducted between 1993 and 1997. The subjects were invited for a third separate visit between 1998 and 2002. The response rate was 62% at baseline, 78% at the first follow-up, and again 78% at the third follow-up. Respondents who attended the baseline and at least one of the follow-up examinations were included in the present analysis (n = 6368). The median follow-up time was 11 y. The study was approved by the Medical Ethics Committee of the Organization for Applied Scientific Research-Zeist, Netherlands. All subjects signed an informed consent form.

Dietary variables and exposure categories

Coffee intake at baseline of PPHV was estimated by the question “How many cups of coffee do you drink per day?,” a question on the type of coffee used (regular, decaffeinated, or other), and a question about the use of additives (none, milk, sugar, etc). In MORGEN-EPIC, the subjects were asked to indicate how frequently they usually drank coffee, the type of coffee [regular (instant), decaffeinated, or other], use of additives (sugar, milk, and type of milk) with color photographs to indicate the strength of coffee and the standard size of a cup equaling 125 g. In a food-frequency questionnaire, the respondents were instructed to record what, on average, they had eaten and drunk in the past year. The MORGEN-EPIC food-frequency questionnaire was also used in the third follow-up (11). Similar questions were asked about tea intake. Coffee intake at baseline was divided into 4 categories: 0 cups/d, >0–3 cups/d, >3–6 cups/d, and >6 cups/d. The category of >0–3 cups/d was chosen as the reference category rather than the non-coffee drinking category because it contained larger numbers of subjects and yielded more stable estimates.

At baseline of PPHV, the subjects filled out a mailed questionnaire about demography, family history of cardiovascular disease, other chronic disease (eg, diabetes mellitus), current medication use, prescribed diets, selected dietary habits, and reproductive history for women. Pregnant women were excluded from the study. Questionnaires were used to assess alcohol intake (glasses/d), smoking status (none, ever, or current smoking of cigarettes), educational level (low, medium, or high) based on highest educational level achieved, and occupational status (paid work, housekeeping, unemployed, or retired or other).

Anthropometric and biological variables

Body height was measured to the nearest 0.5 cm without shoes. Body weight was measured without shoes and heavy clothing to the nearest 0.1 kg.

At all visits, nonfasting blood samples were obtained by using a standardized protocol. Plasma total and HDL cholesterol were measured at the Clinical Chemistry Laboratory of the University Hospital “Dijkzigt” in Rotterdam, which is the Lipid Reference Laboratory for standardized cholesterol determinations in the Netherlands. Total cholesterol was measured enzymatically by using a Boehringer test kit (12). HDL-cholesterol concentrations were measured after precipitation of apolipoprotein B–containing lipoproteins with magnesium phosphotungstate (13).

Outcome measurements and definitions

In PPHV, blood pressure was measured by trained technicians using a random zero sphygmomanometer while the subject was in a sitting position. The cuff size (12 × 23 cm) was applied to the left upper arm. A larger cuff (15 × 33 cm) was used in 1.1% and a smaller cuff (9 × 18 cm) in 0.4% of all examined subjects. Systolic blood pressure was recorded at the appearance of sounds (first-phase Korotkoff) and diastolic blood pressure at the disappearance of sounds (fifth-phase Korotkoff). After the first measurement, the heart rate was measured for 30 s followed by a second blood pressure measurement. In MORGEN-EPIC and at the third visit, the blood pressure measurement procedure was identical to that performed in PPHV. No restrictions were made with regard to coffee drinking before the measurements were taken.

Hypertension was defined by using cutoffs according to the recommendations in the 7th report of the Joint National Committee (JNC) of the National Heart, Lung, and Blood Institute (14), which classifies stage 1 hypertension as a systolic blood pressure of 140–159 mm Hg or a diastolic blood pressure of 90–99 mm Hg and stage 2 hypertension as having systolic blood pressure of ≥160 mm Hg or diastolic blood pressure ≥100 mm Hg, use of antihypertensive medication, or both. To have sufficient numbers of hypertensives in each category of coffee intake, these categories of hypertension were pooled to at least JNC stage 1 hypertension. Persistent hypertension was defined as having a mean systolic blood pressure ≥140 mm Hg or a mean diastolic blood pressure ≥90 mm Hg calculated over both follow-up measurements at a 5-y interval, the use of antihypertensive medication at any of the follow-up measurements, or both. The association between baseline coffee intake and incident hypertension as defined above was assessed among those who did not have hypertension at baseline. No hypertension at baseline was defined as having a systolic blood pressure <140 mm Hg and a diastolic blood pressure <90 mm Hg and no use antihypertensive medication.

Statistical analysis

The association between baseline coffee intake and incident hypertension as defined above was assessed among those who did not have hypertension at baseline as defined above. Logistic regression was used with presence of persistent hypertension (yes or no) as the dependent variable and baseline coffee intake and confounders as independent variables. Furthermore, effects of changes in coffee intake as a predictor of change of blood pressure were examined. A repeated-measures analysis with time-varying covariates was used with changes between repeated blood pressure measurements as dependent variables and time-varying changes in coffee intake and confounders as independent variables. In all analyses, we adjusted for the following possible confounders: age, sex, body height and weight, smoking, alcohol intake, tea intake, educational level, occupational status, and total energy intake.

All analyses were expressed as measures of association with corresponding 95% CIs, regarding intervals not including the respective null values as statistically significant. Analyses were performed by using SPSS version 11.0 or SAS Proc Mixed for repeated-measures analysis (SPSS Inc, Chicago, IL).
TABLE 1
Baseline characteristics of the study cohort (n = 6368)

<table>
<thead>
<tr>
<th></th>
<th>Men (n = 2985)</th>
<th>Women (n = 3383)</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>40.7 ± 10.0**</td>
<td>40.1 ± 10.3</td>
<td>&lt;0.0009</td>
</tr>
<tr>
<td>Body height (cm)</td>
<td>178.9 ± 6.8</td>
<td>165.9 ± 6.3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>81.1 ± 10.6</td>
<td>67.8 ± 10.8</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Systolic blood pressure (mm Hg)</td>
<td>125.6 ± 13.6</td>
<td>117.5 ± 14.8</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Diastolic blood pressure (mm Hg)</td>
<td>79.4 ± 10.3</td>
<td>75.5 ± 10.3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Total cholesterol (mmol/L)</td>
<td>5.6 ± 1.1</td>
<td>5.4 ± 1.0</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>HDL cholesterol (mmol/L)</td>
<td>1.1 ± 0.3</td>
<td>1.4 ± 0.3</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Normotensive (%)</td>
<td>77.0</td>
<td>85.5</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Previous myocardial infarction (%)</td>
<td>0.9</td>
<td>0.1</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Diabetes mellitus (%)</td>
<td>0.7</td>
<td>0.7</td>
<td>0.96</td>
</tr>
<tr>
<td>Current cigarette smoker (%)</td>
<td>34.9</td>
<td>33.8</td>
<td>0.35</td>
</tr>
<tr>
<td>Education level (%)</td>
<td></td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Low</td>
<td>55.3</td>
<td>68.7</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>24.5</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>20.2</td>
<td>12.6</td>
<td></td>
</tr>
<tr>
<td>Occupational status (%)</td>
<td></td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Paid work</td>
<td>86</td>
<td>43.1</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td>0.7</td>
<td>48.8</td>
<td></td>
</tr>
<tr>
<td>Unemployed or retired</td>
<td>8.6</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4.7</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>Coffee intake</td>
<td></td>
<td></td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>0 cups/d*</td>
<td>2.9</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>≤3 cups/d</td>
<td>15.7</td>
<td>27.0</td>
<td></td>
</tr>
<tr>
<td>3−6 cups/d</td>
<td>53.1</td>
<td>53.9</td>
<td></td>
</tr>
<tr>
<td>&gt;6 cups/d</td>
<td>28.3</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>Coffee intake (g/d)</td>
<td>625 (125−3000)</td>
<td>500 (62.5−2500)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Decaffeinated coffee user (no.)</td>
<td>327</td>
<td>509</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Decaffeinated coffee intake (g/d)</td>
<td>375 (125−3125)</td>
<td>375 (62.5−1875)</td>
<td>0.03</td>
</tr>
<tr>
<td>Tea intake (g/d)</td>
<td>300 (150−3000)</td>
<td>300 (150−2250)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Alchohol intake (g/d)</td>
<td>1.1 (0−14)</td>
<td>0 (0−7)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Total energy intake (kJ)</td>
<td>8119.9 (1984.6)</td>
<td>6331.4 (1941.1)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Follow-up (y)</td>
<td>11.0 ± 0.18</td>
<td>11.0 ± 0.17</td>
<td></td>
</tr>
</tbody>
</table>

* Differences in continuous data were tested by using Student’s t test; difference in median no. of glasses alcohol/d was tested by using Mann-Whitney U test; and differences in proportional data were tested by using chi-square tests.

** ± SD (all such values).

† Systolic blood pressure <140 mm Hg and diastolic blood pressure <90 mm Hg and no antihypertensive treatment (14).

‡ 1 cup = 125g.

§ Median; min-max in parentheses (all such values).

RESULTS

The baseline characteristics at the first round (1987 to 1991) of the Doetinchem cohort are shown in Table 1. The prevalence of hypertension, as defined in Methods, at baseline was 23% in the men and 14.5% in the women.

The associations between baseline coffee intake and the subsequent development of persistent hypertension among normotensives at baseline are shown in Table 2. The interaction between sex and coffee intake in relation to hypertension was borderline statistically significant (P = 0.08), and therefore we decided to do both sex-specific analyses and analysis of the total group. The unadjusted odds ratios indicated a lower risk among noncoffee drinkers than in those who drank >0–3 cups/d. After adjustment, this association was slightly attenuated but was still detectable in the total group. Furthermore, women who drank >6 cups/d had a lower risk of hypertension than did women who drank >0–3 cups/d. Among coffee drinking women, there was a statistically significant trend over coffee intake categories (P = 0.023). Because age played a central role in confounding adjustments, we further explored to what extent the association between baseline coffee intake and later blood pressure differed with age. In linear regression models with the mean systolic or diastolic blood pressure from the last 2 visits as the dependent variable and coffee intake (cups), age, and a coffee intake x age interaction term as independent variables, there was a statistically significant interaction for systolic blood pressure (P < 0.0001) as well as for diastolic blood pressure (P < 0.0001). The association between baseline coffee intake and systolic and diastolic blood pressure by median age at baseline and after full adjustment in the subjects who were not treated for hypertension at baseline is shown in Figure 1. Below the median age, there was no significant relation between coffee and blood pressure. In the group above the median, there was an inverse relation for systolic blood pressure (linear regression coefficient: −0.35 mm Hg · cup−1 · d−1; 95% CI: −0.59, −0.11 mm Hg · cup−1 · d−1) and diastolic blood pressure (−0.11 mm Hg · cup−1 · d−1).
TABLE 2
Relative risk for persistent hypertension occurrence in 11 y follow-up by baseline categories of coffee intake in 5189 normotensive subjects in the study cohort

<table>
<thead>
<tr>
<th>Coffee intake</th>
<th>Total cohort</th>
<th>No hypertension</th>
<th>Hypertension</th>
<th>OR (95% CI)</th>
<th>OR adjusted (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 cups/d</td>
<td>65</td>
<td>59</td>
<td>6</td>
<td>0.40 (0.17, 0.96)</td>
<td>0.60 (0.24, 1.49)</td>
</tr>
<tr>
<td>&gt;0–3 cups/d</td>
<td>379</td>
<td>302</td>
<td>77</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>&gt;3–6 cups/d</td>
<td>1195</td>
<td>928</td>
<td>267</td>
<td>1.13 (0.85, 1.50)</td>
<td>1.08 (0.79, 1.47)</td>
</tr>
<tr>
<td>&gt;6 cups/d</td>
<td>658</td>
<td>515</td>
<td>143</td>
<td>1.09 (0.80, 1.49)</td>
<td>1.03 (0.72, 1.46)</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 cups/d</td>
<td>166</td>
<td>155</td>
<td>11</td>
<td>0.38 (0.20, 0.71)</td>
<td>0.51 (0.26, 1.01)</td>
</tr>
<tr>
<td>&gt;0–3 cups/d</td>
<td>794</td>
<td>668</td>
<td>126</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>&gt;3–6 cups/d</td>
<td>1542</td>
<td>1275</td>
<td>267</td>
<td>1.11 (0.88, 1.40)</td>
<td>0.83 (0.64, 1.07)</td>
</tr>
<tr>
<td>&gt;6 cups/d</td>
<td>390</td>
<td>331</td>
<td>59</td>
<td>0.95 (0.68, 1.32)</td>
<td>0.67 (0.46, 0.98)</td>
</tr>
<tr>
<td>Total</td>
<td>231</td>
<td>214</td>
<td>17</td>
<td>0.38 (0.23, 0.64)</td>
<td>0.59 (0.31, 0.92)</td>
</tr>
</tbody>
</table>

1 Hypertension was defined as having at least stage 1 hypertension (mean systolic blood pressure over both follow-up measurements ≥140 mm Hg, mean diastolic blood pressure over both follow-up measurements ≥90 mm Hg, or the use of antihypertensive medication at any of both follow-up measurements) (14). Normotensive subjects at baseline were defined as having a systolic blood pressure <140 mm Hg and a diastolic blood pressure <90 mmHg and use of no antihypertensive medication. Odds ratios (ORs) were obtained from logistic regression with persistent hypertension (yes or no) as the dependent variable and dummy categories of coffee intake and adjustment factors as independent variables. The category of >0–3 cups coffee/d was the reference group. The interaction between sex and coffee intake in relation to hypertension was borderline statistically significant (P = 0.08). Among coffee drinking women, there was a statistically significant trend over coffee intake categories (P = 0.023).

2 Adjusted for baseline age, height and weight, smoking, alcohol intake, tea intake, education level, occupational status, and total energy intake. For the analysis of the total cohort, sex was added to the adjustment model.

3 The OR was statistically significant.

Hg · cup⁻¹·d⁻¹; 95% CI: −0.26, 0.03 mm Hg · cup⁻¹·d⁻¹), although the latter was not statistically significant.

No statistically significant associations between change of coffee intake and blood pressure change were observed among the cohort members not receiving antihypertensive drug treatment at any visit. No clear association was evident between intake of every extra cup of coffee and either systolic blood pressure (−0.08 mm Hg/cup change in coffee intake; 95% CI: −0.23, 0.07 mm Hg/cup change in coffee intake; P = 0.31) or diastolic blood pressure (−0.05 mm Hg/cup change in coffee intake; 95% CI: −0.16, 0.06 mm Hg/cup change in coffee intake; P = 0.37) over the total follow-up time. Adjustment for the change in confounders, such as age, body height and weight, total cholesterol, energy intake, tea intake, alcohol intake, smoking, education level, and sex, did not significantly change these findings (systolic blood pressure: 0.06 mm Hg/cup change in coffee intake; 95% CI: −0.11, 0.22 mm Hg/cup change in coffee intake; P = 0.48; diastolic blood pressure: −0.06 mm Hg/cup change in coffee intake; 95% CI: −0.18, 0.06 mm Hg/cup change in coffee intake; P = 0.34). Exclusion of non-coffee drinkers from the analysis did not significantly influence these findings.

Finally, we found in our cohort a lower risk of persistent hypertension in the 231 total abstainers from coffee than in the 411 users of strictly decaffeinated coffee. Using stage 1 or stage 2 hypertension as outcome, the unadjusted odds ratio was 0.35 (95% CI: 0.20, 0.60). Adjustment for confounding attenuated this odds ratio to a nonsignificant 0.72 (95% CI: 0.34, 1.49).

DISCUSSION
Our study indicates that both abstainers from coffee and, in women only, heavy consumers (>6 cups/d) have lower risks of hypertension than do low coffee consumers (>0–3 cups/d). An association between higher coffee consumption and lower blood pressure seems to be present only after middle age.

Nonresponses may have been related to coffee intake or blood pressure, but not likely to specific associations between coffee and blood pressure. We cannot rule out that professional advice to lower coffee consumption to persons with higher baseline intakes has led to a spurious association between higher intake and lower blood pressure. However, we analyzed persons who were normotensive at baseline to whom such advice was unlikely given. Although there may be residual or unmeasured confounding, we accounted for most confounders that are known to be risk factors for high blood pressure. We had no baseline information about intake of caffeine-containing sodas, which was recently shown to be associated with incidence of hypertension (7). We can only speculate about the effects of adjustment for that intake, but consumption of such sodas in the Netherlands in middle-aged persons in that period was probably low. A strong feature of our study is that it pertains to a large sample from the general population with >10 y of follow-up. Moreover, our outcome classification—the incidence of hypertension persisting over a 5-y period—better reflects true hypertension incidence than does measurement at a single occasion. This outcome was based on actual blood pressure measurements or hypertension treatment.
Among normotensives at baseline, we showed a lower hypertension risk (7). Our findings in women may be compatible with recent findings of our study is the elucidation of the role of coffee intake through consumption habits, with higher blood pressure levels observed in nonhabitual than in habitual coffee consumers (16, 17). Thus, a higher hypertension risk in consumers of >0–3 cups/d than in nondrinkers and consumers of >6 cups/d may be based on a lower adaptation to the effects of coffee when used in moderate to low amounts. Alternatively, coffee may have more general protective effects, because our finding of higher coffee intake leading to lower blood pressure does not seem to be specific. A lower risk for type 2 diabetes mellitus in heavy coffee users compared with non- or moderate users was first shown by one of us (18) and recently confirmed by others (19-23) and is somewhat stronger in women than in men (21). In agreement with our findings for hypertension, it was shown that women with low coffee use (<1 cup/d) had a higher risk of type 2 diabetes mellitus than did non-coffee users (20). However, it remains unclear whether and to what extent an association between coffee intake and blood pressure can explain the association with diabetes mellitus. Some studies could only adjust for known hypertension (18, 23), which may be misclassified and leave residual confounding by blood pressure as an explanation. One study adjusted for systolic blood pressure levels, whereas diastolic blood pressure levels were most strongly associated with diabetes mellitus risk (21). In other studies, there was no explicit adjustment for blood pressure or hypertension (19, 20, 22). Finally, there may be a blood pressure-lowering compound in coffee that explains lower hypertension risk with higher intake. It was recently shown in a cross-sectional study that higher habitual tea intake was associated with lower risk of hypertension (24). This effect of tea combined with our observations on coffee may indicate a central role of serum potassium concentrations. A higher intake of potassium is clearly associated with lower blood pressure (25), and tea and particularly coffee are rich sources of potassium in Western diets (26). This, however, would not explain the observed lower hypertension risk in coffee abstainers.

Overall, higher baseline coffee intake in our study was associated with lower later blood pressure only from middle age onwards, whereas there was no such relation in younger persons. We can only speculate about the mechanisms for such age-dependent effects. It may agree with the results from short-term randomized trials, in which blood pressure-raising effects of coffee were reported to be stronger in younger than in older subjects (1) and which may point at more habituation to coffee in younger persons (15, 16). Alternatively, if there is a protective salt constituent in coffee, such as potassium, it may be through increasing salt-sensitivity and higher blood pressure levels observed with increasing age (27, 28) that the protective effects of higher coffee intake become apparent. Finally, there is recent evidence to suggest that genetically determined slow caffeine metabolism in relation to cardiovascular disease risk is present only in relatively younger persons (29).

From a public health point of view, a direct implication of our study may be to reduce the incidence of hypertension by measures aimed at refraining from moderate coffee intake, but that would be unpractical if at all effective. The most important merit of our study is the elucidation of the role of coffee intake through its relation with hypertension in increasing the risk of cardiovascular disease. Although there are reports claiming coffee to be hazardous (30, 31), the larger cohorts show no association between coffee intake and cardiovascular morbidity or mortality (32) or with the prognosis of myocardial infarction (33). We consider it likely that the extent to which coffee intake explains
COFFEE AND HYPERTENSION

723

hypertension risk is too small to be detected in relation to cardio-

vascular disease. A practical implication from our findings

would therefore be to abstain from professional advice concern-

ing coffee intake in normotensive individuals, which indeed

agrees with the latest clinical guidelines on hypertension (14).

We cannot preclude that associations between coffee intake and

cardiovascular outcomes are different among hypertensive indi-

viduals (34). In conclusion, coffee abstinence was associated

with a lower hypertension risk than was low coffee consump-

tion. No other authors had any conflicts of interest.

We thank the epidemiologists and fieldworkers of the Municipal Health

Service in Doetinchem for their contribution to the data collection for this

study. We thank A Blokstra, PE Steinberger, and AWD van Kessel for data

management, J Steenbrink-van Woerden and P Vissink for logistic support,

and E van der Wolf for secretarial assistance.

WMMV was the project leader. WMMV, HBBdM, and MO were

involved in the design and conduct of the cohort. CSPMU, HCB, and DEG

analyzed the data. All authors played a role in data-interpretation and writing

of the manuscript. CSPMU was provided an unrestricted grant by the organi-

zation on Physiological Effects of Coffee (PEC) in Paris. No other authors

had any conflicts of interest.

REFERENCES

1. Noordzij M, Uiterwaal CSPM, Arends L, Kok FJ, Grobbee DE, Gelei-

jne JM. Blood pressure response to chronic intake of coffee and cafe-


2. Lang T, Degoulet P, Aime F, et al. Relation between coffee drinking and

blood pressure: analysis of 6,321 subjects in the Paris region. Am J

Cardiol 1983;52:1238–42.


4. Stensvold I, Tverdal A, Foss OP. The effect of coffee on blood lipids and

blood pressure. Results from a Norwegian cross-sectional study, men


5. Jenner DA, Puddey IB, Beilin LJ, Vandongen R. Lifestyle and occupa-

tional relation changed in blood pressure over a six-year period in a cohort


7. Winkelmayer WC, Stamper MJ, Willett WC, Curhan GC. Habitual

caffeine intake and the risk of hypertension in women. JAMA 2005;294:

2330–5.

8. Blokstra A, Smit HA, Verschuren WMM. Changes in lifestyle and

chronic disease risk factors with ageing: The Doetinchem Cohort Study


rapporten/260401003 (accessed 21 December 2006).


WMM. Monitoring of risk factors and health in The Netherlands (MORGEN-project), 1993–1997. Life-style and risk factors: preva-

lence and trends. Bilthoven, National Institute of Public Health and the


rapporten/263200008.html (accessed 21 December 2006).

11. Ocké MC. Bueno de Mesquita HB, Jansen AM, Pols MA, Kromhout D,

van Staveren WA. The semi-quantitative food frequency questionnaire
developed for the EPIC-study in the Netherlands. I. Description of ques-


12. Katterman R, Jaworek D, Möller G. Multicenter study of a new enzy-


13. Lopez-Virella MF, Stone P, Ellis S, Colwell JA. Cholesterol determi-
nation in high-density lipoproteins separated by three different methods.


14. The Seventh Report of the Joint National Committee on Detection,

Evaluation, and Treatment of High Blood Pressure (JNC VII). JAMA


15. James JE. Is habitual caffeine use a preventable cardiovascular risk


16. Sharp DS, Benowitz NL. Pharmacoepidemiology of the effect of cafe-


nerve activity and blood pressure independently of caffeine content: role


18. Van Dam RM, Feskens EJM. Coffee consumption and risk of type 2


and incidence of diabetes in Swedish women: a prospective 18-year


tion and risk of type 2 diabetes mellitus among middle-aged Finnish men


diabetes and impaired glucose tolerance in Swedish men and women.


23. Pereira MA, Parker ED, Folsom AR. Coffee consumption and risk of

type 2 diabetes mellitus: an 11-year prospective study of 28 812 post-


24. Yang YC, Lu FH, Wu JS, Wu CH, Chang CJ. The protective effect of

habitual tea consumption on hypertension. Arch Intern Med 2004;164:

1534–40.

25. Dyer AR, Elliott P, Shipley M. Urinary electrolyte excretion in 24 hours

and blood pressure in the INTERSALT Study. II. Estimates of electrolyte-blood pressure associations corrected for regression dilution
bias. The INTERSALT Cooperative Research Group. Am J Epidemiol


26. Gillies ME, Birkbeck JA. Tea and coffee as sources of some minerals in


27. Overlack A, Ruppert M, Kolloch R, Kraft K, Stumppe KO. Age is a major
determinant of the divergent blood pressure responses to varying salt


associations of blood pressure with 24-hour urinary sodium excretion

among pre- and post-menopausal women. WHO Cardiovascular Dis-

eases and Alimentary Comparison (WHO-CARDIAC) Study. J Hypr-


29. Cornelis MC, El-Sohemy A, Kabagambe EK, Campos H, Coffee, CYP1A2 genotype, and risk of myocardial infarction. JAMA 2006;295:

1135–41.

30. Happonen P, Voutilainen S, Salonen JT. Coffee drinking is dose-

dependently related to the risk of acute coronary events in middle-aged


Chronic coffee consumption has a detrimental effect on aortic stiffness


32. Grobbee DE, Rimm EB, Giovannucci E, Colditz G, Stampfer M, Willett


1990;323:1026–32.

33. Yang YC, Lu FH, Wu JS, Wu CH; Chang CJ. The protective effect of

habitual tea consumption on hypertension. Arch Intern Med 2004;164:

1534–40.

34. Hakim AA, Ross GW, Curb JD, et al. Coffee consumption in hyperten-

sive men in older middle-age and the risk of stroke: the Honolulu Heart