

Intended for  
**Swedish Match**

Prepared by  
**Ramboll**

Date  
**May 13, 2019**

# **SYSTEMATIC REVIEW AND UPDATE OF THE LITERATURE ON THE HEALTH EFFECTS OF SWEDISH SNUS**

Ramboll  
4350 North Fairfax Drive  
Suite 300  
Arlington, VA 22203  
USA  
T +1 703 516 2300  
F +1 703 516 2345  
[www.ramboll.com](http://www.ramboll.com)

# CONTENTS

	<b>Page</b>
<b>CONTENTS</b>	<b>i</b>
<b>EXECUTIVE SUMMARY</b>	<b>7</b>
Section 2 – Systematic Review of The Human Health Effects of Snus	7
Section 3 – Meta-analyses and statistical comparisons of health risks of snus with cigarettes	10
Section 4 – Health Risks of Dual Users and Switchers Compared to Smokers	12
Section 5 – Non-clinical Toxicological Studies with Snus	14
 <b>1. INTRODUCTION AND PROTOCOL</b>	 <b>15</b>
1.1 Introduction	15
1.2 Methods & Search Results	16
1.2.1 Overview	16
1.2.2 Literature Identification and Screening	16
1.2.3 Preliminary Literature Screening Results	19
1.2.4 Full-Text Literature Review and Abstraction Results	20
1.3 Guidelines for Rating Evidence and Forming Health-Related Conclusions through Weight of Evidence Evaluation	21
1.3.1 Critical Evaluation of Individual Analyses	21
1.3.2 Weight of Evidence Evaluation of the Total Evidence for a Specific Relationship	23
 <b>2. SYSTEMATIC REVIEW OF THE HUMAN HEALTH EFFECTS OF SNUS</b>	 <b>26</b>
2.1 Introduction	26
2.2 Non-Neoplastic Oral Effects	26
2.2.1 Dental Effects and Periodontal Disease	26
2.2.2 Oral Mucosal Effects	31
2.3 Cancer	33
2.3.1 Head and Neck Cancer	33
2.3.2 Pancreatic Cancer	37
2.3.3 Stomach Cancer	38
2.3.4 Colorectal and Anal Cancer	40
2.3.5 Kidney and Bladder Cancer	40
2.3.6 Lung Cancer	41
2.3.7 Skin Cancer & Melanoma	42
2.3.8 Hematopoietic Cancer	43
2.3.9 Smoke-Related Cancer	44
2.3.10 All Cancers	45

2.4	Cardiovascular Effects (Risk Factors and Disease)	46
2.4.1	Risk Factors for CVD	46
2.4.2	Chronic Cardiovascular Disease	56
2.5	Metabolic Effects	63
2.5.1	Insulin Resistance and Type 2 Diabetes	63
2.5.2	Metabolic Syndrome	69
2.5.3	Body Weight	71
2.6	Gastro Intestinal Effects	75
2.6.1	Heart burn and Gastroesophageal Reflux Symptoms (GERS), and Peptic Ulcer	75
2.6.2	Crohn's Disease and Ulcerative Colitis	76
2.6.3	Irritable Bowel Syndrome	77
2.6.4	Celiac Disease	77
2.6.5	Other Gastrointestinal Symptoms and Effects	78
2.7	Pregnancy Outcomes and Reproductive Effects	78
2.7.1	Effects on Infants	78
2.7.2	Maternal Effects	83
2.7.3	Effects on Male Fertility	83
2.8	Other Health Effects	84
2.8.1	Acoustic Neuroma	84
2.8.2	Acute Adverse Symptoms	85
2.8.3	All-Cause Mortality	85
2.8.4	Amyotrophic Lateral Sclerosis (ALS)	86
2.8.5	Chronic Pain Intensity	87
2.8.6	Complications after Hernia Surgery	87
2.8.7	Delayed Bone Healing	88
2.8.8	Gallstone Disease	88
2.8.9	General Health	90
2.8.10	Groin Hernias	91
2.8.11	Multiple Sclerosis	91
2.8.12	Musculoskeletal Disorders	93
2.8.13	Pain and Post-operative Nausea and Vomiting Following Surgery	94
2.8.14	Parkinson's disease	95
2.8.15	Psychiatric Disorders	95
2.8.16	Respiratory Symptoms and Death	97
2.8.17	Rheumatoid Arthritis	99
2.8.18	Sarcoidosis	101
2.8.19	Skin Conditions	101
2.8.20	Sleeping Problems	102
2.8.21	Survival Following a Cancer or MI Diagnosis	103
2.8.22	Tongue Abnormalities	106
2.8.23	Vitamin D Levels	106

<b>3. META-ANALYSES AND STATISTICAL COMPARISONS OF HEALTH RISKS OF SNUS WITH CIGARETTES</b>	<b>108</b>
3.1 Purpose	108
3.2 Introduction	108
3.2.1 Selection of Endpoints	110
3.2.2 Differences from Previous Report	111
3.3 Methods	112
3.3.1 Literature Identification and Review	112
3.3.2 Procedure to Determine Suitability for Meta-Analysis	112
3.3.3 Statistical Methods	114
3.4 Cancer	115
3.4.1 Head and Neck Cancer	115
3.4.2 Pancreatic Cancer	143
3.4.3 Stomach Cancer	149
3.4.4 Lung Cancer	162
3.5 Chronic Cardiovascular Disease	168
3.5.1 Overview of Evidence for cardiovascular disease	168
3.5.2 Outcome Comparability	168
3.5.3 Cardiovascular disease mortality	169
3.5.4 Incidence of MI and IHD (ICD8,9: 410-414, ICD10:I20-I25)	174
3.5.5 Mortality due to IHD and MI (ICD8,9: 410-414, ICD10:I20-I25)	179
3.5.6 Incidence of Stroke	183
3.5.7 Stroke Mortality	192
3.6 Metabolic Effects	196
3.6.1 Diabetes	196
3.6.2 Metabolic Syndrome	206
3.7 All-Cause Mortality	211
3.7.1 Outcome Comparability	211
3.7.2 Comparability of studies for all-cause mortality meta-analysis	211
3.7.3 Control for Confounders Table	212
3.7.4 All-Cause Mortality Meta-Analyses	212
3.7.5 Sensitivity Analysis Summary Table	213
3.7.6 Conclusion criteria for all-cause mortality	213
3.7.7 Discussion of all-cause mortality	214
3.8 Discussion and Graphical Summary of Results per Endpoint	217
<b>4. HEALTH RISKS OF DUAL USERS AND SWITCHERS COMPARED TO SMOKERS</b>	<b>219</b>



4.1	Introduction	219
4.2	Methods	219
4.3	Oral and Pharyngeal Cancer	220
4.3.1	Overview of evidence compared to previous report	220
4.3.2	Outcome comparability	220
4.3.3	Results for oral and pharyngeal cancer incidence in dual users	220
4.3.4	Discussion/Conclusion of oral and pharyngeal cancer incidence	220
4.4	Oral cancer	221
4.4.1	Results for oral cancer incidence	221
4.4.2	Discussion	221
4.5	Esophageal Cancer	222
4.5.1	Overview of evidence compared to previous report	222
4.5.2	Outcome considerations	222
4.5.3	Results for Esophageal cancer	223
4.5.4	Discussion of esophageal cancer	223
4.6	Pancreatic Cancer	224
4.6.1	Overview of evidence compared to previous report	224
4.6.2	Study considerations	224
4.6.3	Results for Pancreatic cancer	224
4.6.4	Discussion of pancreatic cancer incidence	225
4.7	Stomach Cancer	225
4.7.1	Overview of evidence compared to previous report	225
4.7.2	Outcome considerations	226
4.7.3	Results for Stomach cancer and its subtypes	226
4.7.4	Discussion of stomach cancer	227
4.8	Lung Cancer	228
4.8.1	Overview of evidence compared to previous report	228
4.8.2	Study considerations	228
4.8.3	Results for Lung cancer	228
4.8.4	Discussion of Lung cancer	228
4.9	Chronic cardiovascular disease	229
4.9.1	Overview of evidence compared to previous report	229
4.9.2	Outcome considerations	229
4.9.3	Results for cardiovascular disease related outcomes	230
4.9.4	Discussion	239
4.10	Incident stroke and mortality	243
4.10.1	Overview of evidence compared to previous report	243
4.10.2	Outcome considerations	243
4.10.3	Results for Stroke	243

4.10.4 Discussion of Stroke	245
4.11 Metabolic Effects: Diabetes and Metabolic syndrome	245
4.11.1 Overview of evidence compared to previous report	245
4.11.2 Metabolic Syndrome	246
4.11.3 Diabetes	247
4.12 Acute Myeloid Leukemia	249
4.12.1 Overview of evidence	249
4.12.2 Study considerations	249
4.12.3 Results for AML	249
4.12.4 Discussion	250
4.13 All-cause mortality	250
4.13.1 Overview of evidence compared to previous report	250
4.13.2 Results for Endpoints	250
4.13.3 Discussion of total mortality, cancer-related mortality, incidence of any cancer, and smoking-related cancer incidence.	251
4.14 Summary of Results	251
4.14.1 Dual users compared to never tobacco or never snus/smoke	252
4.14.2 Dual users compared to smokers	252
4.14.3 Effects in switchers and comparison to smokers	252
4.15 Discussion	253
<b>5. NON-CLINICAL TOXICOLOGICAL STUDIES WITH SNUS</b>	<b>256</b>
5.1 <i>In Vitro</i> Studies of Swedish Snus	256
5.1.1 Cardiovascular	256
5.1.2 Genotoxicity, Mutagenicity, and Cytotoxicity	256
5.2 Studies of Swedish snus in Experimental Animals ( <i>In Vivo</i> )	257
5.2.1 Cardiovascular & Developmental	257
5.2.2 Non-Cancer Soft Tissue Changes	258
5.3 Summary and Conclusions	258
<b>6. REFERENCES</b>	<b>260</b>
<b>Appendix A: The PRISMA Checklist</b>	<b>277</b>
<b>Appendix B: Search Results Tracking Table</b>	<b>280</b>
<b>Appendix C: Adapted PRISMA Literature Inclusion/Exclusion Diagram for the Updated Search</b>	<b>283</b>

<b>Appendix D: Adapted PRISMA Literature Inclusion/Exclusion Diagram for Retrospective Health Effects Literature Search Prior to December 1, 2012</b>	<b>284</b>
<b>Appendix E: Literature Abstraction Templates</b>	<b>285</b>
<b>Appendix F: Literature Abstraction Table: Health-Related Literature (Update to Section 5 of the 2013 ENVIRON Report)</b>	<b>286</b>
<b>Appendix G: Literature Abstraction Tables per Endpoint for Risk Comparison (Section 3)</b>	<b>357</b>
Oral-Pharyngeal Cancer	358
Esophageal Cancer	363
Pancreatic Cancer	367
Stomach Cancer	371
Lung Cancer	376
Cardiovascular Disease	379
Stroke	392
Diabetes	399
Metabolic Syndrome	404
All-cause mortality	406
<b>Appendix H: Sensitivity Analyses</b>	<b>408</b>
Head and Neck Cancer	408
Pancreatic Cancer	422
Stomach Cancer and Cardia Stomach Cancer	424
Lung Cancer	431
Cardiovascular Effects	433
Metabolic Effects	453
All-cause mortality	459

## EXECUTIVE SUMMARY

Ramboll (formerly ENVIRON) was asked by Swedish Match to conduct a systematic review of the literature relating to the health effects of Swedish snus, both absolute and relative to cigarette smoking as part of an update to the 2013 ENVIRON report. The 2013 report included literature published through at least December 31, 2012, and this update includes articles published through July 28, 2017 (i.e., an additional four and a half years). In the first section of the report, Ramboll defines the study protocol, the individual assessment of study quality, and the weight of the evidence approach for synthesis. In the following four content sections of this report, Ramboll evaluated: the human health effects of snus (section 2), snus risks compared to risks in smokers through meta-analyses (section 3), health risks in dual users and switchers compared to smokers (section 4), and non-clinical toxicological studies of snus (section 5). A summary of the results for each section are presented below.

### Section 2 – Systematic Review of The Human Health Effects of Snus

Over 100 distinct endpoints have been investigated in the scientific literature, including new endpoints identified from 47 newly identified studies, and those identified from literature reviewed in the 2013 ENVIRON report. The results for each endpoint were synthesized and one of six conclusions were reached based on the table below:

**Table E-1: Total Evidence Integration Guidelines**

Adapted from the IOM *Gulf War and Health, Volume II* review.

Conclusion	Guidelines
Sufficient Evidence of an Association	<ul style="list-style-type: none"><li>• Evidence from available studies is sufficient to conclude that there is a positive association (i.e., exposure leads to outcome)</li><li>• Consistent positive association from human studies in which chance and bias, including confounding, could be ruled out with reasonable confidence</li><li>• For example, several well-conducted studies report consistent positive associations. This may include 2 studies providing “strong” evidence of an association, or a mix of a single study providing “strong” evidence, and 2 or more studies providing “moderate” evidence of an association</li><li>• Epidemiological data suggests a dose-response relationship between exposure and health endpoint</li></ul>
Limited/Suggestive Evidence of an Association	<ul style="list-style-type: none"><li>• Evidence from available human studies suggests an association, but the body of evidence is limited by the inability to rule out chance and bias, including confounding, with confidence</li><li>• This may include at least one study providing “strong” evidence, and/or at least two studies providing “moderate” evidence of an association between the exposure and the outcome</li><li>• Alternatively, several studies providing weak evidence (e.g., cross-sectional), but a consistent positive association, and results are probably not due to bias, including confounding (studies may be methodologically flawed in different ways)</li></ul>
Limited/Suggestive Evidence of No	<ul style="list-style-type: none"><li>• Evidence from well-conducted studies is consistent in not showing a positive association after exposure of any magnitude</li></ul>

Association	<ul style="list-style-type: none"> <li>• Conclusion is limited to the conditions, magnitudes of exposure, and length of observation in available studies</li> <li>• This may include at least one study providing “strong” evidence of a null association, or at least two studies providing “moderate” evidence of a null association that is reliably measured within reason (i.e., reasonably narrow confidence intervals)</li> <li>• Alternatively, several studies providing weak evidence (e.g., cross-sectional), but a consistent null association, and results are probably not due to bias, including confounding</li> <li>• Possibility of a very small increase in risk from exposure studied cannot be excluded</li> </ul>
Balanced/Mixed	<ul style="list-style-type: none"> <li>• Approximately equal amounts of evidence suggesting an association and providing null results that are reliably measured within reason (i.e., reasonably narrow confidence intervals)</li> <li>• Not necessarily based on quantity of studies suggesting particular association(s)</li> <li>• At least some “moderate” or “strong” evidence from available studies</li> </ul>
Inadequate/Insufficient Evidence to Determine Whether an Association Exists	<ul style="list-style-type: none"> <li>• Evidence from available studies is of insufficient quantity, quality, or consistency to permit a conclusion regarding the existence of an association</li> </ul>

The following table presents the conclusions for each endpoint in this report.

Table E-2: Conclusions Regarding the Absolute Risk among Users of Swedish Snus		
Sufficient Evidence of an Association		
Oral Mucosal Effects		
Snuff Dipper’s Lesion		
Limited/Suggestive Evidence of an Association		
Risk factors for CVD	Pregnancy outcomes and reproductive effects	Other Health Effects
Acute increases in heart rate	Stillbirth	All-cause mortality
Acute increases in blood pressure	Preterm birth	
	Lower birthweight	
	Neonatal apnea	
	Small for gestational age	
Limited/Suggestive Evidence of an Inverse Association		
Skin Cancer & Melanoma	Other Health Effects	
CSCC, all melanoma, and CMM	Parkinson’s disease	
Limited/Suggestive Evidence of No Association		
Dental Effects and Periodontal Disease	Head and Neck Cancers	Metabolic Effects
	Oral Cancer	Insulin resistance or impaired glucose

Dental Caries and Caries-associated Factors Tooth Loss Gingivitis Periodontal Disease <b>Risk Factors for CVD</b> Lipid Levels Biochemical or Physical Measures of clotting Measures of Fitness including oxygen uptake, work capacity, and cardiac output <b>Heart Disease</b> Incident ischemic heart disease, myocardial infarction, and heart failure Incident overall cardiovascular disease Atrial Fibrillation <b>Stroke</b> Incident stroke	Oral and Pharyngeal Cancer Esophageal Adenocarcinoma <b>Pancreatic Cancer</b> <b>Stomach Cancer</b> Overall stomach cancer Cardia stomach cancer <b>Colorectal and Anal Cancer</b> Colon and rectal cancer <b>Lung Cancer</b> <b>Skin Cancer &amp; Melanoma</b> Melanoma in situ <b>Hematopoietic Cancer</b> Multiple myeloma Leukemia (ALL, AML, CLL) Non-Hodgkin's Lymphoma <b>All Cancers</b>	tolerance Metabolic syndrome BMI <b>Gastro Intestinal Effects</b> Crohn's disease and ulcerative colitis Celiac disease <b>Pregnancy outcomes and reproductive effects</b> Early neonatal mortality Maternal antenatal bleeding Maternal preeclampsia Maternal gestational hypertension <b>Other Health Effects</b> Complications after hernia surgery Multiple sclerosis Respiratory performance during exercise Rheumatoid arthritis Sarcoidosis Skin conditions
<b>Balanced/Mixed</b>		
<b>Risk Factors for CVD</b> Non-acute effects on heart rate and blood pressure High blood pressure or hypertension	<b>Heart Disease</b> Fatal ischemic heart disease, myocardial infarction, and/or sudden cardiac death Fatal overall cardiovascular disease <b>Stroke</b> Fatal stroke	<b>Head and Neck Cancers</b> Esophageal Cancer Esophageal Squamous Cell Carcinoma <b>Metabolic Effects</b> Diabetes Overweight/Obese Waist circumference or waist-to-hip ratio

<b>Inadequate/Insufficient Evidence</b>		
<b>Dental Effects and Periodontal Disease</b> Tooth Wear Gingival Recession <b>Oral Mucosal Effects</b> Dysplasia Leukoplakia Oral melanin pigmentation p-53 expression <b>Risk Factors for CVD</b> Acute ventricular heart function and heart-rate variability White blood cell count Cardiovascular/circulatory symptoms Allostatic load <b>Gastro Intestinal Effects</b> Heart burn or gastroesophageal reflux symptoms, and peptic ulcer Irritable bowel syndrome Other gastrointestinal symptoms and effects including dyspepsia, epigastric pain, abdominal pain, H. pylori infection, and esophagitis	<b>Head and Neck Cancers</b> Cancer at other sites in the head and neck <b>Stomach Cancer</b> Non-cardia stomach cancer <b>Colorectal and Anal Cancer</b> Anal cancer <b>Kidney and Bladder Cancer</b> <b>Skin Cancer &amp; Melanoma</b> Intraocular malignant melanoma <b>Hematopoietic Cancer</b> Hodgkin's Lymphoma <b>Smoke-related Cancer</b> <b>Pregnancy outcomes and reproductive effects</b> Infant heartrate variability Infant oral clefts Male fertility <b>Metabolic Effects</b> Becoming underweight Incident weight gain	<b>Other Health Effects</b> Acoustic neuroma Acute adverse symptoms Amyotrophic lateral sclerosis Chronic pain intensity Delayed bone healing Gallstone disease General health Groin hernias Musculoskeletal disorders Pain and post-operative nausea Non-affective psychosis and schizophrenia Nervous problems and psychosocial distress Major depression and depressive symptoms Asthma and other respiratory issues Respiratory death Sleeping problems Survival following a cancer diagnosis Survival following an MI diagnosis Tongue abnormalities Vitamin D levels

### **Section 3 – Meta-analyses and statistical comparisons of health risks of snus with cigarettes**

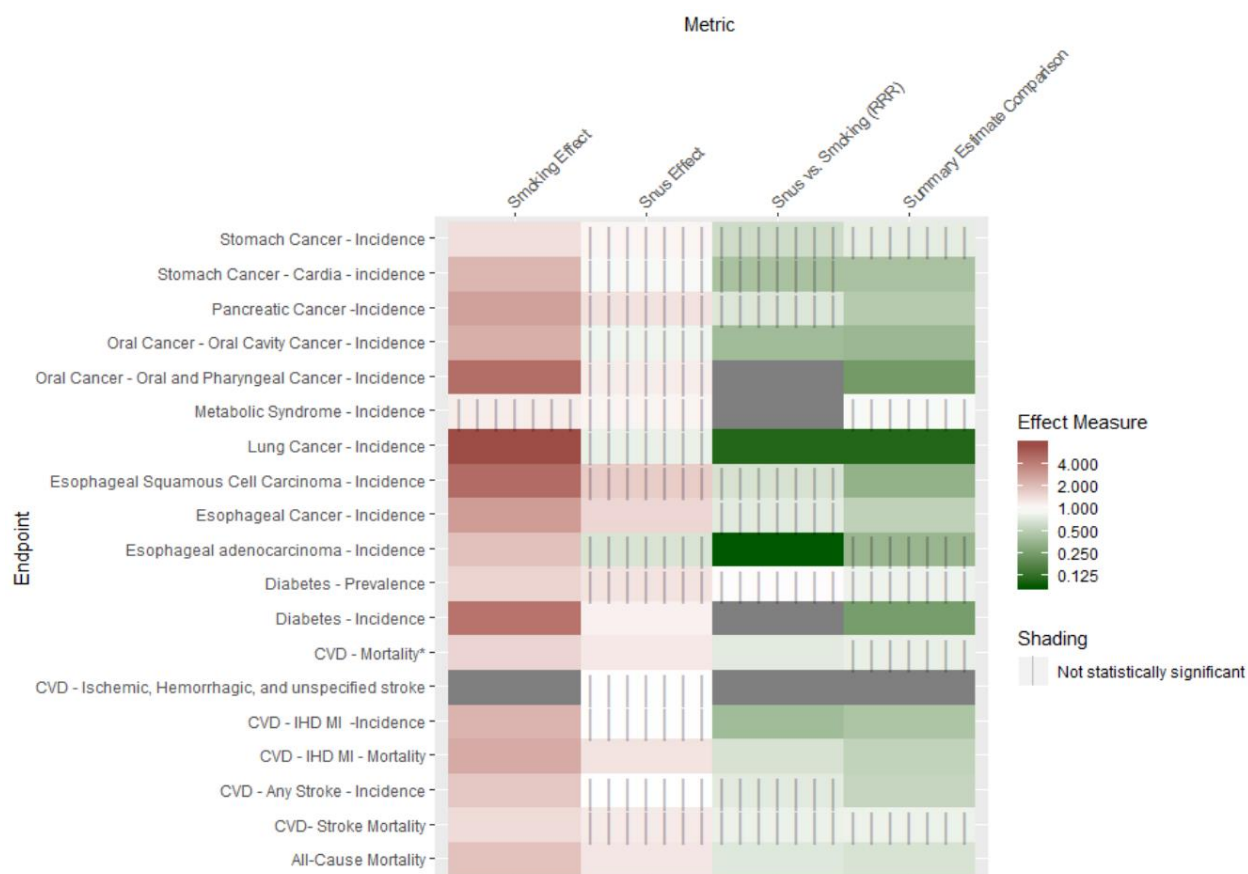
The previous ENVIRON (2013) report focused on cause-specific mortality outcomes attributed to smoking with a qualitative synthesis of evidence paired with pictorial depictions of individual snus- and smoking-related study relative risk estimates, summary estimates from contemporary snus meta-analyses, and smoking relative risk estimates from large US cohorts. See Appendix VI of the ENVIRON (2013) report for complete details. The previous pictorial depictions of studies included relevant reported relative risk estimates, however did not include meta-analysis summary estimates or statistical tests of heterogeneity. The prior report also excluded studies with no smoking comparison group within the same study. In response to comments from the FDA, this report used standard meta-analysis techniques to calculate summary estimates for snus users and smokers for the snus-related

epidemiological studies, which allowed us to include all relevant studies for the endpoints evaluated, as well as to compare potential differences in risk among snus users and smokers quantitatively.

After systematic identification and review of all relevant human health effects literature (described in Section 1 and 2), standard meta-analysis methods were used to quantitatively assess absolute and relative morbidity and mortality risks in snus users and smokers related to the ten smoking-related outcomes listed in Appendix VI of the 2013 ENVIRON report. These outcomes included lung, pancreatic, oral, esophageal, and stomach cancer, as well as metabolic syndrome, diabetes, cardiovascular diseases, and all-cause mortality. The summary health risks for each of these outcomes were calculated for snus users and smokers in the same study population. A within study comparative risk (RRR - Relative Risk Ratio) between snus users and smokers was calculated when mutually exclusive estimates were available. An additional wald-type test was done between snus and smoker summary estimates for all outcomes (Summary Estimate Comparison).

The results for each endpoint are presented in the Figure E-1. The summary estimates for smokers and snus users are presented in the first two columns. The third column presents a summary estimate of the comparison of relative risks in snus users to the relative risk in smokers within relevant studies. The final column presents the results of a wald-type test that compared snus summary estimates to smoker summary estimates. The color indicates the magnitude of the effect measure. Darker reds indicated increasingly larger effect measures above one, while darker greens indicate effect measures below one and closer to zero. A gray cell indicates there were not enough studies to calculate the metric. Lastly, shading identifies statistically non-significant results.

**Figure E-1:**





Of the nineteen different endpoints, only one (metabolic syndrome incidence) reported statistically non-significant results for smokers. In contrast, most endpoints had evidence of statistically non-significant risk for snus users. Five endpoints (esophageal cancer, diabetes incidence, cardiovascular disease mortality, IHD/MI mortality, and all-cause mortality) provided evidence of statistically significant risk in snus users compared to never tobacco users. Notably, the magnitude of the risk in these five endpoints were closer to one than the corresponding magnitude of risk in smokers. The statistical significance of this observation was tested by comparing the relative risks in snus users who have never smoked to the relative risks in smokers who have never used snus within the same study. The resulting snus vs smoker estimates found a statistically significant lower risk of five endpoints (oral cancer incidence, lung cancer incidence, esophageal adenocarcinoma, IHD/MI incidence, IHD/MI mortality, and all-cause mortality) in snus users. These results from within study comparisons were supported by comparisons of the summary estimates. Comparison of snus and smoker summary estimates found a statistically significant lower risk of twelve endpoints in snus users (cardia stomach cancer incidence, pancreatic cancer incidence, oral cancer incidence, oral and pharyngeal cancer, lung cancer, esophageal squamous cell carcinoma, esophageal cancer, diabetes incidence, IHD/MI incidence, IHD/MI mortality, incidence of any stroke, and all-cause mortality). The difference in statistical significance between the two types of comparisons likely result from the requirement of effect measures stratified by tobacco use for within study comparisons. Stratified effect measures typically have wider confidence intervals due to using a subset of the study population. In contrast, the comparison of summary estimates included effect measures adjusted for other tobacco use. This typically provides more statistical power, although can be subject to residual confounding. Regardless of these differences, the overall results suggest evidence of no statistically significant difference in risk for snus users compared to never snus/tobacco, and evidence of a statistically significant lower risk in snus users compared to smokers for most of the endpoints. No analyses suggested that snus might be more harmful than cigarettes.

#### **Section 4 – Health Risks of Dual Users and Switchers Compared to Smokers**

This section reviewed the subset of studies identified in sections 1 and 2 that reported health effect estimates for snus users who concurrently smoke referred to as “dual users” or current snus users who have quit smoking referred to as “switchers”. Comparison of results focused on presentation of results from prior studies that compared effect estimates in dual users and switchers to effect measures in former and/or current smokers. This section assessed the following outcomes: oral and pharyngeal cancer, oral cancer, esophageal cancer and subtypes, pancreatic cancer, stomach cancer and subtypes, lung cancer, overall cardiovascular disease, incident and fatal ischemic heart disease and MI, nonfatal MI, incident and fatal stroke, sudden cardiac death, metabolic syndrome, diabetes prevalence and incidence, acute myeloid leukemia, and all-cause mortality.

##### **Dual users compared to never tobacco or never snus/smoke**

The majority of endpoints had statistically non-significant results for the comparison of dual users to never tobacco or never snus/smoke, however eight endpoints varied in evidence. Results did not exist for oral and pharyngeal cancer. Lung cancer had evidence of a lower risk in dual users, while four endpoints (non-fatal MI, fatal stroke, total mortality-related outcomes, and pancreatic cancer) had evidence of an increased risk. Two endpoints (IHD/MI incidence and mortality) had mixed evidence of increased risk and statistically non-significant results. The remaining ten outcomes have statistically non-significant results only. Notably endpoints with statistically significant increased, decreased, or

mixed evidence of risk in dual users did not have evidence for significant risk compared to smokers and/or no evidence of statistical interaction.

### **Dual users compared to smokers**

Except for three endpoints (oral and pharyngeal cancer, lung cancer, and pancreatic cancer), all studies present some evidence of statistical non-significance either through statistical comparison, tests of interaction, or effect measures that overlap confidence intervals. Dual users compared to smokers was not assessed in two endpoints (lung cancer, pancreatic cancer) due to a lack of smoking effect estimates. Oral and pharyngeal cancer was the only study to report increased risk in dual users, although with evidence of statistically non-significant interaction. Two endpoints (fatal stroke and fatal IHD/MI) did not have a statistical comparison reported but had evidence of a statistically non-significant interaction between smoking and snus use. Two endpoints (diabetes incidence and total mortality related outcomes) had mixed evidence of lower risk and statistical non-significance. Five endpoints (non-fatal MI, SCD, MetSy, Diabetes prevalence, AML) had neither a statistical comparison between dual users and smokers or an assessment of interaction, however all of these had dual user effect measures that overlapped the confidence interval for the smoker effect measure suggesting no statistically significant difference in relative risks. The remaining six endpoints (IHD/MI incidence, oral, esophageal, stomach, overall cardiovascular disease, and incident stroke) had statistically non-significant results assessed through a statistical test.

### **Effects in switchers and comparison to smokers**

Only ten endpoints had evidence for switchers in this report: non-fatal MI, incident and fatal IHD/MI, diabetes incidence and prevalence, oral cancer, overall cardiovascular disease, stroke incidence, sudden cardiac death, and metabolic syndrome.

### **Switchers compared to never tobacco or never smoke/snus**

Only evidence for non-fatal MI suggests an increased risk for switchers. Evidence for IHD/MI incidence is mixed with studies suggesting increased risk and statistical non-significance. Notably, these two endpoints (IHD/MI incidence and non-fatal MI) have evidence suggesting a significant lower risk in dual users compared to smokers. The remaining eight endpoints have evidence of statistical non-significance through a statistical test.

### **Switchers compared to current smokers**

In the comparison of switchers to current smokers, evidence for all endpoints suggested either lower risk, mixed evidence of lower or non-significant risk, or statistical non-significance. Four endpoints (non-fatal MI, IHD/MI incidence, overall cardiovascular disease, and incident stroke) had lower risk, while one endpoint (Fatal IHD/MI) had mixed evidence of lower or non-significant risk. The remaining five endpoints had evidence that suggested statistical non-significance due to effect measures overlapping confidence intervals or a statistical test.

### **Switchers compared to former smokers**

All studies had evidence suggesting statistical non-significance either due to a statistical test or effect measures overlapping confidence intervals.

## Section 5 – Non-clinical Toxicological Studies with Snus

Nine potentially relevant non-clinical toxicological and *in vitro* studies were identified in the July 28, 2017 literature search. Of the nine, five were identified as relevant, with four excluded for reasons including nonuse of Swedish Match snus product(s), or previous inclusion in the 2013 ENVIRON report.

Similar to the 2013 report, some of the new studies included genotoxicity, mutagenicity, and cytotoxicity endpoints investigated *in vitro*, as well as an *in vivo* study of rats. New endpoints included *in vitro* effects on platelet function (adhesion) and aneuploidy (abnormal number of chromosomes), and an *in vivo* study of potential cardiovascular and developmental effects of Swedish snus on zebrafish embryos.

Consistent with previous findings, one study of the combined effect of three Swedish snus products (one of which was not Swedish Match brand) indicated that Swedish snus may be mutagenic (increased mutation revertants), genotoxic (increased micronuclei), and cytotoxic (lower cell viability) *in vitro*. Another *in vitro* study of the potential genotoxicity of Swedish snus did not report a statistically significant increase in aneuploid HPV-positive keratinocytes. A third *in vitro* study reported a reduction in platelet adhesion to fibrinogen and collagen for 10% Ettan snuff extract. The potential clinical significance of these results is unclear, and it remains unknown to what extent any of the *in vitro* effects from these studies may be relevant to humans *in vivo*.

In an *in vivo* study of rats that consumed a tobacco slurry of Swedish snus, consistent with previous findings in animals as well as oral changes in humans, non-cancerous soft tissue changes in the forestomach were observed including cell proliferation, and a thickening of the basal region of squamous epithelium. In a new study of the potential cardiovascular and developmental effects of Swedish snus on zebrafish embryos, a variety of toxic effects including early embryonic mortality, developmental delay, defects in lymphatics development and ventricular function, and aneurysm development were observed following injection with Swedish snus extracts. Aside from the potential differences between human and zebrafish embryos, the conditions for which the embryos were exposed in this study (injection) is not necessarily representative of potential real-world exposure of human embryos as a result of the mother using snus.

# 1. INTRODUCTION AND PROTOCOL

## 1.1 Introduction

Ramboll (formerly ENVIRON) was asked and funded by Swedish Match to conduct a systematic review of the literature relating to the health effects of Swedish snus, both absolute and relative to cigarette smoking as part of an update to the 2013 ENVIRON report. The funders had no role in study design, data collection, and analysis of this review.

The previous review included studies published through December 31, 2012, as well as some relevant articles published in early 2013. The objective of this review was to identify and evaluate all original primary scientific studies published since December 1, 2012 through July 28, 2017, and not included in the previous review, to comprehensively update previous conclusions contained within the following specific sub-sections of the 2013 ENVIRON report (Review of the Scientific Literature on Snus (Swedish Moist Snuff)):

- Section 4: Non-Clinical Toxicological Studies with Snus
- Section 5: Human Health Effects of Snus (including all previous and new endpoints)
- Appendix VI (to Section 5): Relative Risks among Snus Users and Smokers Compared to Nontobacco Users
- Appendix VII (to Section 5): Comparison of Risks from Dual Use, Switching, and Quitting

This updated report includes a summary of the conclusions from the document listed above (which is comprehensive through December 2012), a presentation of new information (if available) for each endpoint, and an updated evaluation of the total available evidence and conclusion. Newly identified human health endpoints were presented with their own new summary, evaluation, and conclusion. This review and update of the 2013 ENVIRON report is intended to be systematic, with the methods clearly and transparently presented so the literature searches and evaluations could be replicated. This systematic review is intended to comply with all relevant guidelines of the Preferred Reporting Items for systematic Reviews and Meta-Analyses (PRISMA) statement, a well-established and highly-regarded standard for the reporting of systematic reviews and meta-analyses.<sup>1</sup> The 27-item checklist of this protocol is provided in Appendix A, with relevant page numbers cited for each item on the checklist.

The systematic review update to Section 5 of the 2013 ENVIRON report included the following steps:

- Development of a protocol, and a relevant and comprehensive search strategy;
- Systematic literature searches;
- Screening of potentially relevant literature identified in the comprehensive searches, including the application of inclusion and exclusion criteria;
- Detailed evaluation of literature deemed potentially relevant from the initial screening;

---

<sup>1</sup> For more information, visit <http://www.prisma-statement.org/>.

- Data abstraction from relevant new studies, and quality assessment of individual analyses;
- Quality assessment of all previously identified studies from the 2013 ENVIRON report;
- Qualitative synthesis of the total available evidence (Section 2);
- Quantitative synthesis and comparisons with cigarette smoking, switching, and dual use (Sections 3 and 4);
- Preparation of written reports.

Any relevant human studies identified in the update to Section 5 of the 2013 ENVIRON report (Section 2) were included in the updates to Appendices VI and VII (Section 3 & 4). The methods/protocol involved in the update to these appendices are described in detail in those sections.

## **1.2 Methods & Search Results**

### **1.2.1 Overview**

The purpose of this update is to identify and evaluate all new literature on the human health effects of Swedish snus, as well as *in vitro* and *in vivo* toxicology studies of Swedish snus. This section describes in detail the steps taken to identify all relevant literature, abstract relevant data, and evaluate and report upon the reviewed literature.

### **1.2.2 Literature Identification and Screening**

#### **1.2.2.1 Relevant Literature Definitions**

Relevant literature for this update included publications pertaining to the topics described in section 1.2.1, that have been published and/or made publicly available after December 1st, 2012, and were not included in the 2013 ENVIRON report.

Attention was paid to the snus product evaluated within publications, as publications considered relevant will have evaluated the exposures, use, and/or perceptions of Swedish snus in particular. Studies of other or unknown brands of snus were not included or evaluated in this review, with the exception of Swedish or Norwegian studies that do not disclose the brand of snus or type of smokeless tobacco evaluated. Due to Swedish Match's dominant market share in these countries, Ramboll reasonably assumed that the vast majority of snus and/or smokeless tobacco used in these countries was likely Swedish snus.

In addition to an update to the human health effects literature published after December 1, 2012, a retrospective literature search on the human health effects of Swedish snus was also conducted without a start date through December 1, 2012. This was done because of a lack of a reproducible systematic approach regarding the literature search strategy described in the 2013 ENVIRON report. Any potentially relevant studies identified through this search that were not included in the 2013 ENVIRON report were evaluated and included in this update if deemed relevant.

The publication types considered for this update included:

- Peer-reviewed primary studies;
- Secondary sources, including reviews, meta-analyses, government and non-government organization reports, and survey reports (human studies only);

- Publicly available primary data sources, including scientific abstracts, clinical trial data, and academic theses providing relevant results.

The peer-reviewed literature considered for this report includes epidemiological studies, human clinical studies, and toxicology studies. Secondary sources, such as reviews, meta-analyses, and government reports, were used as supporting evidence of that presented in the primary literature when forming conclusions for the human health effects of snus. Due to the extensive use of Swedish snus in countries such as Sweden and Norway, relevant studies also included those published in languages other than English. Potentially relevant non-English studies were considered for inclusion in the final evaluation if the studies could be translated into English.

### **1.2.2.2 Literature Databases and Search Terms**

Structured searches in PubMed/Medline (<http://www.pubmed.com>), Scopus (<http://www.scopus.com/>), and ClinicalTrials.gov (<http://clinicaltrials.gov/>) were used to identify the relevant literature spanning across the disciplines and publication types of interest. Additionally, searches of select, pre-determined government and non-government organization websites were also conducted to identify reports of primary data not traditionally captured in literature databases. The searches were completed on July 28, 2017.

Our objective was to capture all Swedish snus-related literature in one step to allow us to be as systematic and comprehensive as possible in updating the literature. Thus, following exploratory searches of the National Library of Medicine's PubMed database, we developed search terms for these topics that were general and broad, and designed to capture all relevant literature on Swedish snus. Each batch of search results were saved and imported into Mendeley<sup>2</sup> reference manager software for additional review, screening, and tagging (categorizing). Details of these literature searches are provided in Appendix B. The numbers of articles saved from each search and database were documented. Mendeley includes an automated feature by which duplicates are eliminated; the tables in Appendices B, C, and D also include the total number of unique articles that required screening.

The bibliographies of potentially relevant reviews, meta-analyses, and reports were also reviewed in order to identify publications not otherwise captured by the initial search queries. No additional articles were identified in this way.

### **1.2.2.3 Inclusion and Exclusion Criteria**

Articles imported into Mendeley were initially screened according to their title, abstract, and key words. Following the initial review of this information, the article was labeled with pre-determined "inclusion" or "exclusion" tags to reflect the reviewers' initial judgment regarding potential relevance. Full-text copies of articles marked for inclusion were ordered, reviewed, and abstracted in detail, while articles marked for exclusion were not reviewed further, unless re-reviewed during QAQC (see Section 1.2.3.1). If a reviewer was unsure of an article's overall relevance, the article was initially included as

---

<sup>2</sup> For more information, visit <http://www.mendeley.com>.

“check” so that it could be reviewed further. The intention of this approach was to help minimize the number of missed relevant articles prior to the full-text review.

Table 1-1 describes the inclusion and exclusion criteria used in this review, and lists the “tags” used in Mendeley to label publications determined to be potentially relevant. Only one tag was applied per article.

<b>Table 1-1: Inclusion and Exclusion Criteria for Updated Search</b>	
<b>Topic / Mendeley Tag</b>	<b>Criteria</b>
<b>Included Studies (Potentially Relevant)</b>	
Health	Publications evaluating the human health effects of Swedish snus <ul style="list-style-type: none"> <li>• Primary epidemiology studies of any health effect</li> <li>• Involves use of Swedish snus, or smokeless tobacco use in a Scandinavian country</li> </ul>
Tox	Toxicology or <i>in vitro</i> studies involving Swedish snus
Meta/Review	Relevant commentaries, reviews, and/or meta-analyses that will be reviewed for additional publications not originally captured by the source, and/or provide supporting evidence to the primary health effects data
Check	Publications requiring additional discussion or consideration by the reviewing team; these articles were converted into another inclusion or exclusion tag following discussion
<b>Excluded / Non-Relevant Studies</b>	
Not a study	Publications that are not primary studies and do not provide evidence related to the human health effects or toxicology of Swedish snus. <ul style="list-style-type: none"> <li>• May include commentaries, editorials, policy-related articles, etc. that otherwise do not provide reliable primary scientific evidence.</li> </ul>
Not snus	Health and/or tobacco use-related publications that do not consider exposure to Swedish snus. <ul style="list-style-type: none"> <li>• May include studies of non-Swedish snus (e.g., snus from brands other than Swedish Match), smokeless tobacco as a group, cigarettes, or other unrelated or grouped exposures</li> </ul>
Use	Publications involving primary data that evaluate the use patterns related to Swedish snus in human populations
Risk Perception	Publications evaluating the risk perceptions of Swedish snus
Other KAB	Studies on knowledge, attitudes, or beliefs related to Swedish snus that do not include an evaluation of health risk perceptions of Swedish snus
Animal/cell	Toxicology or <i>in vitro</i> studies involving tobacco/tobacco component exposures other than Swedish snus
Chemistry	Studies of the chemical composition of Swedish snus

Misc	Any other non-relevant publications
------	-------------------------------------

Table 1-2 describes the inclusion and exclusion criteria used in the retrospective literature search on the health effects of Swedish snus through December 1, 2012, and lists the “tags” used in Mendeley to label publications determined potentially relevant. Only one tag was applied per article.

<b>Table 1-2: Inclusion and Exclusion Criteria for Retrospective Health Effects Literature Search through December 1, 2012</b>	
<b>Topic / Mendeley Tag</b>	<b>Criteria</b>
<b>Included Studies (Potentially Relevant)</b>	
Health	Publications evaluating the human health effects of Swedish snus <ul style="list-style-type: none"> <li>• Primary epidemiology studies of any health effect</li> <li>• Involves use of Swedish snus, or smokeless tobacco use in a Scandinavian country</li> </ul>
Meta/Review	Relevant reviews, and/or meta-analyses that will be reviewed for additional publications not originally captured by the source, and/or provide supporting evidence to the primary health effects data
Check	Publications requiring additional discussion or consideration by the reviewing team; these articles were converted into another inclusion or exclusion tag following discussion
<b>Excluded / Non-Relevant Studies</b>	
Commentary	Publications that are not primary studies or formal reviews/meta-analyses on the health effects of Swedish snus. <ul style="list-style-type: none"> <li>• May include commentaries, editorials, policy-related articles, etc. that otherwise do not provide reliable primary scientific evidence.</li> </ul>
Not snus	Health and/or tobacco use-related publications that do not consider exposure to Swedish snus. <ul style="list-style-type: none"> <li>• May include studies of non-Swedish snus (e.g., snus from brands other than Swedish Match), smokeless tobacco as a group, cigarettes, or other unrelated or grouped exposures</li> </ul>
Duplicate	Duplicate studies that have already been tagged/categorized.
Exclude	Any other non-relevant publications

### 1.2.3 Preliminary Literature Screening Results

Detailed screening results of the updated literature searches and for the retrospective human health effects literature search through December 1, 2012 are provided in PRISMA diagrams in Appendices C and D, respectively. After conducting the literature search update (described in Appendix B), and after removing duplicates, we identified 1,428 articles that potentially related to the human health effects



or toxicology of Swedish snus. Following the preliminary screening of these articles, 1,309 were excluded, with 119 identified as potentially relevant requiring further review.

After conducting the retrospective literature search of the health effects literature through December 1, 2012, we identified 4,037 articles for further screening after most duplicates were automatically removed. Following the preliminary screening of these articles, 3,713 were excluded, with 324 identified as potentially relevant requiring further review.

#### **1.2.3.1 Quality Assurance/Quality Control (QA/QC) of Screened Literature**

An independent reviewer conducted an initial QA/QC review following the review of the first 100 publications by each reviewer. The reviewer blindly selected 10 (10%) of the screened publications, and documented their own determination regarding inclusion or exclusion. Following this initial QA/QC check, an error rate of 0% was identified for both the updated search and the retrospective search of the health effects literature. Since no error patterns were identified, the preliminary screening progressed.

Following the screening of all publications in the databases, an independent reviewer randomly screened 10% of excluded references and 20% of the included. Following the QA/QC review of the updated search results, none of the excluded articles were determined to be potentially relevant except for two that were changed to "Meta/Review," and no serious patterns of disagreement were observed.

Following the QA/QC review of the retrospective health effects search results, seven studies previously included in the 2013 ENVIRON report were re-categorized to excluded. This suggested that the screeners were conservative in their inclusion of potentially relevant studies, and did not indicate any serious screening issues. However, two of the 380 excluded studies reviewed during QA/QC were identified as potentially relevant (a 0.52% error rate). To determine whether a pattern of missed relevant studies might exist, the relevant studies from the 2013 ENVIRON report were compared to those that were excluded in the retrospective search and no further missed relevant studies were identified. This suggested that no serious patterns of disagreement existed.

#### **1.2.4 Full-Text Literature Review and Abstraction Results**

Detailed screening results of articles identified as potentially relevant following the preliminary screening of articles related to the updated, and retrospective health effects literature search through December 1, 2012 are provided in PRISMA diagrams in Appendices C and D, respectively.

Following the retrieval and/or purchase of publications initially identified as potentially relevant, each full-text publication was reviewed in detail. 53 studies were ultimately included in the qualitative synthesis. These included 47 "Health" studies (two of which were identified in the retrospective search that had not been previously included in the 2013 ENVIRON report), five "Tox" studies, and one "Meta/Review" study.

The detailed review of articles relevant to the update of Section 5 of the 2013 ENVIRON report (articles tagged as "Health") included abstraction of information according to a pre-determined template and an overall determination of evidence quality from the article. Information was abstracted from each publication using the template in Appendix E, and the abstraction table is provided in

Appendix F. The process by which evidence quality is rated from new articles and integrated into the conclusions from the previously published reports (where applicable) is discussed in Section 1.3.

92 “Health” studies were reviewed in detail, and 47 were excluded for various reasons including the following:

- Included in the 2013 ENVIRON report
- No health outcomes evaluated
- Did not include an evaluation of Swedish snus (e.g., cigarettes, combined tobacco, non-relevant brands or tobacco types, etc.)
- Non-relevant study (e.g., case report, use-behavior, non-relevant commentary, animal study)
- Commentaries

47 relevant primary studies on the human health effects of Swedish snus were identified and included in the qualitative syntheses (including two additional studies identified from the retrospective literature search through December 1, 2012).

#### **1.2.4.1 Quality Assurance/Quality Control (QA/QC) of Abstracted Data**

Following abstraction, a QA/QC review of the “Health” data was conducted by a team member of 20% of the studies abstracted. This review involved documentation of any potential omission or other errors. Although all relevant results were included for nearly every abstracted study that was reviewed, some minor omissions involving various study data were identified for eight of the nine abstracted studies. For this reason, all remaining abstracted data was reviewed for accuracy and completeness, and any omissions or errors were corrected. All excluded studies were also re-reviewed to confirm that they were not improperly excluded.

### **1.3 Guidelines for Rating Evidence and Forming Health-Related Conclusions through Weight of Evidence Evaluation**

This section describes the manner in which Ramboll 1) critically evaluated the quality of individual analyses presented within human health-related studies and 2) evaluated the total evidence across studies examining the same relationships (e.g., all studies, both old and new, related to the same outcome). These two steps assisted with the update and summary of the total body of human evidence (described in Section 1.1).

#### **1.3.1 Critical Evaluation of Individual Analyses**

As part of the data abstraction process, a “quality rating” was applied to each analysis<sup>3</sup> that examined a tobacco use behavior and health endpoint (Table 1-3). We developed these quality rating guidelines/criteria specifically for evaluation of epidemiology studies (primarily observational) involving

---

<sup>3</sup> The word “analysis” used here to reflect the idea that a single study may include multiple, possibly unrelated analyses of different outcomes, and/or different measures of exposure.

tobacco-related exposures. These criteria were partially adapted from the Institute of Medicine's (IOM) (2003) Gulf War and Health, Volume II report, and were based on standard differences in characteristics and potential limitations of epidemiology studies. Although FDA does not endorse specific methods or tools for assessing quality or synthesizing evidence, these criteria are consistent with FDA's informal recommendations on interpreting relevant studies presented at the October 17, 2016 public seminar on the PMTA for ENDS (FDA 2016). The quality rating helped to anchor an individual analysis' relative importance within the overall causal determination involving all similar studies, old and new. The individual analysis rating considered the study's overall quality (e.g., objectives, study methods, outcome and exposure measurement), as well as the robustness of the analysis in question (e.g., statistical power, control of confounding and potential biases, exposure definition).

This approach helped to account for the variation of strength that a similar study may present for individual analyses; though an individual study may be of high quality overall, the strength of each individual analyses may differ within that study. For example, a study reporting results for multiple outcomes may have sufficient power to detect changes in risk for a common outcome, but may not have sufficient power with respect to a less common outcome. In this scenario, the study's risk estimate for the more common outcome may provide stronger evidence of an association compared to the risk estimate for the less common outcome. Different ways of analyzing data may also affect the strength of evidence provided from a study. For example, while an analysis of Swedish snus use controlled for cigarette smoking may have more statistical power, a risk estimate from an analysis of exclusive Swedish snus users might be more relevant, but also more imprecise. Thus, the strength of evidence of a specific analysis within a given study will be assessed using a fixed rating scale and guidelines; the use of such tools is consistent with the approach outlined by PRISMA.

<b>Table 1-3: Quality Ratings for Individual Analyses</b>	
<b>Evidence</b>	<b>Definition/Guidelines</b>
Strong	<ul style="list-style-type: none"> <li>• Evidence originates from a well-designed study (e.g., study methods adequately described, reasonable sample size, well-designed large randomized controlled trial, cohort, or case-control study);</li> <li>• Effect estimate is precise and calculated using sufficient statistical power;</li> <li>• Exposure is relevant to study question (e.g., analysis of exclusive Swedish snus users with sufficient statistical power, and may account for changes over time);</li> <li>• Bias and confounding (appropriate for the specific exposure and endpoint) can be reasonably ruled out.</li> </ul>
Moderate	<ul style="list-style-type: none"> <li>• Evidence originates from a study with some quality-related limitations (e.g. limited sample size, some methodological flaws);</li> <li>• Effect estimate is imprecise or calculated using limited statistical power, possibly due to origin from a smaller cohort or case-control study;</li> <li>• Exposure is relevant, but may not be ideal (e.g., an estimate with high precision may involve an analysis of Swedish snus users adjusted for smoking, and may not account for changes in use behavior over time);</li> <li>• Evidence may not be entirely free of bias, including confounding. However, adjustment for other confounder(s) may indirectly mitigate potential confounding.</li> </ul>
Weak	<ul style="list-style-type: none"> <li>• Evidence may originate from a cross-sectional analysis, a very small cohort or case-control study, or an otherwise methodologically flawed study;</li> <li>• Evidence may be imprecise, perhaps due to the estimate's low statistical power,</li> </ul>

	<ul style="list-style-type: none"> <li>• Exposure is not well defined, or may likely include mixed tobacco use;</li> <li>• Evidence subject to a high likelihood of bias and/or confounding.</li> </ul>
--	---

### 1.3.2 Weight of Evidence Evaluation of the Total Evidence for a Specific Relationship

Following the quality determination of newly identified analyses, Ramboll integrated the new findings (where applicable) with previously established evidence and conclusions. The synthesis of the total body of human evidence to form conclusions was based on the following guidelines adapted from the Institute of Medicine's (IOM) (2003) Gulf War and Health, Volume II review (Table 1-4).

Determinations for new relationships previously unexamined were also developed by following these guidelines. The IOM (2003) guidelines were chosen specifically because of their focus on epidemiology studies (primarily observational), and conclusion language that is relevant to describing potential relationships between an exposure and disease.

The objective of this review was to form conclusions based on an evaluation of the available human evidence. The studies discussed here assessed differences in prevalence, incidence or mortality related to different levels of snus use (ranging from none to frequent or heavy use). Although no individual study can determine a causal relation, all of these studies contribute to our knowledge of the potential effects of snus use when considered in the broader context of other research (epidemiological as well as chemical and toxicological). Epidemiological studies of the highest quality contribute the most to a causality determination. The design and careful planning and conduct of the study are important in considering a study's contribution to the weight of evidence for the determination of a causal association between exposure and outcome in humans. Epidemiological study designs include intervention studies and several types of observational studies. The study participants' exposure status is under the control of the investigator in intervention studies such as clinical trials. There are no intervention studies of the long-term health effects of snus use in humans, but this methodology was used to assess several short-term, so-called acute, health effects. Evidence of the potential long-term health effects of snus comes from a variety of types of observational studies including: cohort, case-control, and cross-sectional.

Because of the relative lack of experimental evidence involving Swedish snus for most of the studied endpoints, and our consideration of mostly observational human evidence in forming these conclusions, our goal was to evaluate potential associations, rather than causal relationships. An association is present when evidence suggests that two variables are related (or correlated), while a causal relationship exists when the evidence is sufficient to indicate that a direct relationship exists between one variable and another (e.g., the exposure causes a particular disease). As stated by IOM (2003), sufficient evidence of a causal relationship includes the following:

"Evidence from available studies is sufficient to conclude that a causal relationship exists between exposure to a specific agent and a specific health outcome in humans, and the evidence is supported by experimental data. The evidence fulfills the guidelines for sufficient evidence of an association [see table 1-4 below] and satisfies several of the guidelines used to assess causality: strength of association, dose-response relationship, consistency of association, biologic plausibility, and a temporal relationship."

The highest category of evidence for a positive association included in our guidelines was “Sufficient Evidence of an Association,” whereas the highest category of evidence for no association is “Limited/Suggestive Evidence of No Association.” A category such as “Sufficient Evidence of No Association” is not included, in part due to philosophical reasons. It is not possible to prove a negative, and an absence of evidence is not necessarily evidence of an absence of a potential effect. For these reasons, IOM (2003) states that “the possibility of a very small increase in risk after exposure studies cannot be excluded,” even when several well-conducted studies do not show an association. This may result in a body of evidence that varies in quality and amount for endpoints in this category.

**Table 1-4: Total Evidence Integration Guidelines**

Adapted from the IOM *Gulf War and Health, Volume II* review.

<b>Conclusion</b>	<b>Guidelines</b>
Sufficient Evidence of an Association	<ul style="list-style-type: none"> <li>• Evidence from available studies is sufficient to conclude that there is a positive association</li> <li>• A causal relationship is at least suspected</li> <li>• Consistent positive association from human studies in which chance and bias, including confounding, could be ruled out with reasonable confidence</li> <li>• For example, several well-conducted studies report consistent positive associations. This may include 2 studies providing “strong” evidence of an association, or a mix of a single study providing “strong” evidence, and 2 or more studies providing “moderate” evidence of an association</li> <li>• Epidemiological data suggests a dose-response relationship between exposure and health endpoint</li> </ul>
Limited/Suggestive Evidence of an Association	<ul style="list-style-type: none"> <li>• Evidence from available human studies suggests an association, but the body of evidence is limited by the inability to rule out chance and bias, including confounding, with confidence</li> <li>• This may include at least one study providing “strong” evidence, and/or at least two studies providing “moderate” evidence of an association between the exposure and the outcome</li> <li>• Alternatively, several studies providing weak evidence (e.g., cross-sectional), but a consistent positive association, and results are probably not due to bias, including confounding (studies may be methodologically flawed in different ways)</li> </ul>
Limited/Suggestive Evidence of No Association	<ul style="list-style-type: none"> <li>• Evidence from well-conducted studies is consistent in not showing a positive association after exposure of any magnitude</li> <li>• Conclusion is limited to the conditions, magnitudes of exposure, and length of observation in available studies</li> <li>• This may include at least one study providing “strong” evidence of a null association, or at least two studies providing “moderate” evidence of a null association that is reliably measured within reason (i.e., reasonably narrow confidence intervals)</li> <li>• Alternatively, several studies providing weak evidence (e.g., cross-sectional), but a consistent null association, and results are probably not due to bias, including confounding</li> <li>• Possibility of a very small increase in risk from exposure studied cannot be excluded</li> </ul>
Balanced/Mixed	<ul style="list-style-type: none"> <li>• Approximately equal amounts of evidence suggesting an association and providing null results that are reliably measured within reason</li> </ul>

	<p>(i.e., reasonably narrow confidence intervals)</p> <ul style="list-style-type: none"> <li>• Not necessarily based on quantity of studies suggesting particular association(s)</li> <li>• At least some “moderate” or “strong” evidence from available studies</li> </ul>
Inadequate/Insufficient Evidence to Determine Whether an Association Exists	<ul style="list-style-type: none"> <li>• Evidence from available studies is of insufficient quantity, quality, or consistency to permit a conclusion regarding the existence of an association</li> </ul>

## 2. SYSTEMATIC REVIEW OF THE HUMAN HEALTH EFFECTS OF SNUS

### 2.1 Introduction

This section serves as an update to Section 5 of the 2013 ENVIRON report, which involves the absolute risks of Swedish snus. Further details of previously reviewed studies can be found in that report. As noted in Section 1.2.4, 47 new studies (those not previously included in the 2013 ENVIRON report) on the human health effects of Swedish snus were identified and included in the qualitative synthesis conducted in this section. The health endpoints evaluated in these studies are numerous, exceeding 100 distinct endpoints, under a variety of endpoint categories including body weight, cancer, cardiovascular effects and disease, dental and non-cancer oral effects, diabetes and metabolic syndrome, gastrointestinal effects, and reproductive effects, among many other studies not included in these categories. As noted previously, this section presents a brief summary from the 2013 ENVIRON report, followed by a detailed evaluation of any new studies, information regarding the quality rating that we applied to the individual studies (old and new), and an overall discussion and conclusion based on the quality rating and conclusion guidelines outlined in Section 1.3.

### 2.2 Non-Neoplastic Oral Effects

#### 2.2.1 Dental Effects and Periodontal Disease

##### 2.2.1.1 Dental Conditions

###### Summary from 2013 ENVIRON Report

Of the eight cross-sectional studies of dental effects, two reported a statistically significant association with the use of snus and dental caries and tooth loss (Hirsch et al. 1991) and tooth wear (Ekfeldt et al. 1990). Neither study accounted for the potential confounding effects of socioeconomic status, or dietary or oral hygiene habits. Several studies that did account for these potential confounding factors did not find a relationship between the use of snus and dental caries (Hugoson et al. 2012; Rolandsson et al. 2005) or for tooth loss (Hugoson and Rolandsson 2011; Montén et al. 2006; Rolandsson et al. 2005). None of the five studies that investigated the relationship between snus use and dental plaque reported a statistically significant relationship between the two (Bergström et al. 2006; Hugoson and Rolandsson 2011; Montén et al. 2006; Rolandsson et al. 2005; Wickholm et al. 2004). Three out of those five studies accounted for socioeconomic status, or dietary or oral hygiene habits (Hugoson and Rolandsson 2011; Montén et al. 2006; Rolandsson et al. 2005).

###### Newly Identified Studies

Two studies on the dental effects of Swedish snus have been published since the 2013 ENVIRON report (Hellqvist et al. 2012; Hellqvist et al. 2015). Hellqvist et al. (2012) evaluated the potential effect of Swedish snus on plaque pH in a clinical cross-over study of 10 Swedish adults. Intraoral pH increased following use of four nicotine-containing snus products, including the Swedish Match product, General Original Portion. Plaque pH decreased among three of six nicotine-free snus products (including the old recipe of the Swedish Match product, Onico snus, but not the newer Onico product), and all 10 products differed significantly from a sucrose control ( $p < 0.001$ , area under the curve) (the plaque pH dropped much further in the sucrose control compared to the snus products). The authors noted that a lowering of plaque pH can cause demineralization of the dental hard tissue (enamel and

dentine), and that in the present study, there “appears to be a relationship between the content of fermentable carbohydrates in the snus and the pH fall in dental plaque.” However, the biological relevance of short-term changes in pH as observed in this study is unknown, and in all products, plaque pH was statistically significantly higher compared to a sucrose control. The quality of evidence presented in this study was rated as weak based on the relevance to the risk of long-term dental effects such as caries, as well as the small number of participants included in the study.

Hellqvist et al. (2015) evaluated the effects of Swedish snus on plaque pH, plaque index, caries, number of decayed and filled tooth surfaces, and other factors related to the development of caries in a cross-sectional study of 101 exclusive snus users of 10 or more years and 100 non-users of tobacco for 10 or more years living in or near Karlstad, Sweden. Among a sample of 10 snus users and 10 non-users, non-users experienced a more pronounced drop in plaque pH compared to snus users, though this difference was not statistically significant. When snus users placed snus under the lip and then rinsed with sucrose, the pH fall was statistically significantly smaller than when no snus was present in the mouth. Among the larger study population, there were no significant differences between snus users and non-users with respect to plaque index (as well as when considering upper front teeth only), enamel caries, manifest caries, number of decayed and filled tooth surfaces (as well as when considering upper front teeth only), cariogram value, buffer capacity, *Mutans streptococci* in saliva, and *Lactobacilli* in saliva. Snus users, however, did have a higher ( $p=0.005$ ) salivary secretion rate compared to non-users. The authors concluded that there were no statistically significant differences in prevalence of dental caries between snus users and non-users, with “only minor differences regarding caries-associated factors.” Although the authors did not account for potential confounding variables in the models, they noted that there was no statistically-significant difference between snus users and non-users regarding tooth-brushing habits and approximal cleaning with toothpicks and interdental brush. There was also no significant difference in the intake of candy, sweets, and soft drinks between the two groups, although use of dental floss was more frequent among non-users, and visits to dental clinics were less frequent among tobacco users. In the current study, the authors reported that “poor oral hygiene was the main risk factor for caries development and that the main risk factor for poor oral hygiene was intellectual disability.” Due to the small number of participants, unadjusted results, and cross-sectional design, the evidence quality from this study was rated as weak.

#### Quality Rating of all Studies

Study	Endpoint(s)	Evidence Quality Rating
Bergstrom et al. 2006	Dental plaque	Weak
Eckfeldt et al. 1990	Tooth wear	Weak
Hellqvist et al. 2012	Intraoral pH	Weak
Hellqvist et al. 2015	Plaque pH, plaque index, caries, number of decayed and filled tooth surfaces, and other factors related to the development of caries	Weak
Hirsch et al. 1991	Dental caries, tooth loss	Weak
Hugoson and Rolandsson 2011	Tooth loss, dental plaque	Weak
Hugoson et al. 2012	Dental caries	Weak
Monten et al. 2006	Tooth loss, dental plaque	Weak



Rolandsson et al. 2005	Dental caries, dental plaque	Weak
Wickholm et al. 2004	Dental plaque	Weak

### Discussion and Conclusions

Although study findings were summarized in the 2013 ENVIRON report, standardized conclusions were not provided. A discussion of the new studies as well as standardized conclusions that consider the old and new evidence are provided below.

#### *Dental Caries and Caries-associated Factors*

The findings reported by Hellqvist et al. (2015) provide additional evidence of no association between the use of snus and dental caries. Furthermore, Hellqvist et al. (2015) reported no differences in the number of caries or plaque index between snus users and non-users when considering only the upper teeth, where snus is typically placed against. The authors also reported no differences in caries-associated factors such as cariogram value, buffer capacity, *Mutans streptococci* in saliva, and *Lactobacilli* in saliva. Intraoral or plaque pH either increased (Hellqvist et al. 2012), or showed a less pronounced drop (Hellqvist et al. 2015) following use of snus. Given that a drop in pH is associated caries development, this evidence suggests that snus does not increase the risk through this mechanism.

Though Hirsh et al. (1991) reported a significant association between snus use and dental caries, the authors did not account for potentially important confounders, and acknowledged that a definitive conclusion could not be made based on this. Several of the available studies controlled for, or assessed important potential confounding factors such as socioeconomic status or oral hygiene habits (Hellqvist et al. 2015; Hugoson et al. 2012; Rolandsson et al. 2005; Hugoson and Rolandsson 2011; Montan et al. 2006). These studies did not report any differences in risk of dental caries or caries-associated factors between snus users and non-users. Though no prospective cohort or case-control studies are available, several descriptive studies, although rated as weak, have consistently shown no association between snus use and dental caries and caries-associated factors.

The studies on snus use and dental caries and caries-associated factors provide *limited/suggestive evidence of no association* between snus use and dental caries.

#### *Tooth Wear*

No new studies were identified since publication of the 2013 ENVIRON report.

There is *inadequate/insufficient evidence to determine whether an association exists* between snus use and tooth wear given that only a single, weak study exists.

#### *Tooth Loss*

No new studies were identified since publication of the 2013 ENVIRON report.

Three cross-sectional studies (Hugoson and Rolandsson 2011; Montan et al. 2006; Rolandsson et al. 2005) that accounted for important confounders reported no association between the use of Swedish snus and tooth loss (the average number of teeth in Swedish snus users was statistically significantly higher compared to non-users in the Hugoson and Rolandsson 2011 study, and similar to non-users in the other two studies). The one study that did not account for these important confounders reported an association between Swedish snus use and tooth loss (Hirsch et al. 1991), but the authors

acknowledge that a definitive conclusion could not be made because of this. Given that the studies that controlled for important confounders consistently reported no association between Swedish snus use and tooth loss, there is *limited/suggestive evidence of no association*.

### 2.2.1.2 Gingivitis

#### Summary from 2013 ENVIRON Report

Of six cross-sectional studies of gingivitis, gingival index, or gingival bleeding, one reported a significant association between a higher gingival index and the use of snus (Modeer et al. 1980). The authors of this study did not report whether oral hygiene habits or sociodemographic variables differed between snus users and non-users of tobacco. The mean gingival index of snus users was 1.10 compared to 0.89 among non-users (a gingival index of 2 or 3 is considered gingivitis). Among the five studies that reported no association with gingivitis or other endpoints associated with gingivitis (Bergstrom et al. 2006; Hugoson and Rolandsson 2011; Montén et al. 2006; Rolandsson et al. 2005; Wickholm et al. 2004), three of the five accounted for either oral hygiene habits and/or socioeconomic variables (Hugoson and Rolandsson 2011; Montén et al. 2006; Rolandsson et al. 2005).

#### Newly Identified Studies

A single study on the potential relationship between use of Swedish snus and gingival index was published since the 2013 ENVIRON report (Hellqvist et al. 2015). Hellqvist and colleagues (2015), described previously, reported that snus users had significantly higher gingival index values compared to non-users for the whole dentin (20.4% of snus users had a GI index of 2 or 3 vs. 14.4% among non-users,  $p=0.009$ ) and for the upper front teeth (14.9% of snus users had a GI index of 2 or 3 vs. 7.7% among non-users,  $p=0.003$ ).

#### Quality Rating of all Studies

Study	Evidence Quality Rating
Bergstrom et al. 2006	Weak
Hellqvist et al. 2015	Weak
Hugoson and Rolandsson 2011	Weak
Modeer et al. 1980	Weak
Montén et al. 2006	Weak
Rolandsson et al. 2005	Weak
Wickholm et al. 2004	Weak

#### Discussion and Conclusions

Most of the available studies, including those that accounted for important confounders reported no association between the use of snus and gingivitis. Two studies, including a new study published by Hellqvist et al. (2015) reported significant associations between snus use and a higher gingival index. Hellqvist et al. (2015) noted that use of dental floss and visits to dental clinics was less frequent among snus users compared to non-users, which could explain this finding. Given that all of the studies that did account for socioeconomic status and/or oral hygiene habits reported no association, the evidence suggests that there is *limited/suggestive evidence of no association* between snus use and gingivitis.

### 2.2.1.3 Gingival Recession

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of All Studies

Study	Evidence Quality Rating
Andersson and Axéll 1989	Weak
Hugoson and Rolandsson 2011	Weak
Monten et al. 2006	Weak
Wickholm et al. 2004	Weak

#### Discussion and Conclusions

Of three cross-sectional studies that compared gingival recession among snus users and non-users of tobacco, one reported that snus use was associated with gingival recession (Monten et al. 2006). Of the two other studies, one reported that the prevalence of gingival recession among snus users and non-users was not significantly different (Wickholm et al. 2004), while the other reported a significantly lower percentage of sites with gingival recession  $\geq 1$  mm among snus users compared to non-users (adjusted for sociodemographic variables) (Hugoson and Rolandsson 2011). A fourth study found that loose snuff was significantly associated with gingival recession compared to the use of portion-bag snuff, while the authors provided no comparison of the effects of loose or portion-bag snuff use with non-use of tobacco (Andersson and Axell 1989). Given the inconsistent results and the cross-sectional nature of the existing studies, there *is inadequate/insufficient evidence to determine whether an association exists* between snus use and gingival recession.

### 2.2.1.4 Periodontal Disease

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of All Studies

Study	Evidence Quality Rating
Bergstrom et al. 2006	Weak
Hugoson and Rolandsson 2011	Weak
Julihn et al. 2008	Weak
Kallestal and Uhlin 1992	Weak
Monten et al. 2006	Weak
Rolandsson et al. 2005	Weak
Wickholm et al. 2004	Weak

#### Discussion and Conclusions

In all six cross-sectional studies and the one case-control study (Kallestal and Uhlin 1992), snus use was not associated periodontal disease or individual indicators of periodontal disease. Most studies, with only two exceptions (Bergstrom et al. 2006; Kallestal and Uhlin 1992), adjusted, or accounted for, socioeconomic status or oral hygiene habits. The five remaining studies accounted for either socioeconomic factors (Hugoson and Rolandsson 2011; Julihn et al. 2008; Wickholm et al. 2004) or oral hygiene habits (Monten et al. 2006; Rolandsson et al. 2005). Therefore, although the quality of the studies was rated as weak, the consistent results, including among those that adjusted for

important confounders, suggests that there is *limited/suggestive evidence of no association* between snus use and periodontal disease.

## 2.2.2 Oral Mucosal Effects

### 2.2.2.1 Snuff Dipper's Lesion

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of All Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Andersson et al. 1989	Weak
Andersson et al. 1990	Weak
Andersson et al. 1991	Weak
Andersson et al. 1994	Weak
Andersson et al. 1995	Weak
Andersson and Axéll 1989	Weak
Andersson and Warfvinge 2003	Weak
Axéll 1976	Weak
Axéll et al. 1976	Weak
Axéll 1987	Weak
Axéll and Hedin 1982	Weak
Axéll and Henricsson 1985	Weak
Axéll 1993	Weak
Frithiof et al. 1983	Weak
Hirsch et al. 1982	Weak
Larsson et al. 1991	Weak
Martensson 1978	Weak
Mornstad et al. 1989	Weak
Rolandsson et al. 2005	Weak
Roosaar et al. 2006	Weak
Rosenquist et al. 2005	Weak
Salonen et al. 1990	Weak
Wallstrom et al. 2011	Weak

#### Discussion and Conclusions

Although much of the studies employ a cross-sectional or case-series design, there is a general consensus from the available literature that Swedish snus causes a characteristic type of oral mucosal lesion; and in this causal relationship, there is *sufficient evidence of an association*. However, the literature also demonstrate that the oral mucosal lesion caused by snus use typically regress following cessation of snus use, or among long-time users who do not change their snus habits, with no evidence that they progress to cancer, even with long-term use.

### 2.2.2.2 Leukoplakia

No new studies were identified since publication of the 2013 ENVIRON report.

### Discussion and Conclusions

Confusion exists surrounding the use of the term leukoplakia, especially as related to the use of oral snuff. This is reflected in the various terms used to describe the condition in snuff users such as snuff dipper's lesion, oral leukoplakia, smokeless tobacco lesions, smokeless tobacco keratosis (Bouquot 1994; Greer 2006) and tobacco pouch keratosis (Neville and Day 2002). These differences in terminology, their varying definitions, and the multiple number of classification systems used to grade the severity of these lesions, combine to make assessment of the literature difficult. Due to these current difficulties, the available literature is currently the evidence provided in the current literature is *inadequate/insufficient to determine whether an association exists*.

#### **2.2.2.3 Dysplasia**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of All Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Frithiof et al. 1983	Weak
Hirsch et al. 1982	Weak

### Discussion and Conclusions

Two studies that comprise only snus users reported dysplasia in the population; 5 cases in 21 users in one study (Frithiof et al. 1983) and 9 in 50 users (Hirsch et al. 1982) in the other. Due to the lack of valid comparison groups (i.e. snus non-users), there is *inadequate/insufficient evidence to determine whether an association exists* with respect to snus use and dysplasia.

#### **2.2.2.4 Miscellaneous Oral Changes**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of All Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Axéll and Hedin 1982	Weak

### Discussion and Conclusions

Axéll and Hedin (1982) examined whether snus use was associated with increased oral melanin pigmentation. Among 1,541 individuals examined, 42 were snus users and the prevalence of pigmentation in snus users (4.7%) was not significantly higher than that among non-users of tobacco (3.0%). Axell and Hedin (1982) concluded that the use of snus did not significantly elevate the prevalence of oral melanin pigmentation. Given that the only study to date is of weak quality and reported no association, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and oral melanin pigmentation.

#### **2.2.2.5 Biological Markers Associated with Oral Cancer in Oral Lesions from Swedish Snus Users**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Ibrahim et al. 1996	P53 protein expression	Weak
Merne et al. 2002	p53 protein expression p21 protein expression PCNA protein expression Ki-67 protein expression	Weak
Schildt et al. 2003	p53 protein expression PCNA protein expression Ki-67 protein expression bcl-2 protein expression	Weak
Wedenberg et al. 1996	p53 protein expression	Weak
Wood et al. 1994	p53 protein expression	Weak

## Discussion and Conclusions

### *p-53 expression*

Five studies investigated p-53 protein expression in tissue samples of oral lesions from snus users as compared to tissues samples from snus non-users (Ibrahim et al. 1996; Merne et al. 2002; Schildt et al. 2003; Wedenberg et al. 1996; Wood et al. 1994). All of these studies were constrained by weak methodology, including small sample sizes and inability to control for potential confounding factors such as alcohol consumption. In addition, all but one of the studies (Schildt et al. 2003) used methods that could not distinguish between wildtype and mutant p53 proteins. Two studies detected significantly increased p53 expression in snuff-induced lesions, compared to healthy tissue (Wedenberg et al. 1996; Wood et al. 1994), while one did not (Merne et al. 2002). Two studies showed a low (13-14%) frequency of p53 expression in snuffers' lesions (Ibrahim et al. 1996; Merne et al. 2002). The remaining study (Schildt et al. 2003), which analyzed oral squamous cell carcinoma tumor samples in a case-control study, found no positive association between snus use and p-53 positive tumors. Given the mixed results, and limitations present in the studies, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and p-53 protein expression levels.

## **2.3 Cancer**

### **2.3.1 Head and Neck Cancer**

#### **2.3.1.1 Oral and Pharyngeal Cancer**

##### Summary from 2013 ENVIRON Report

The available evidence suggests that use of Swedish snus is not associated with an increased risk of oral cancer. Results of high-quality epidemiological studies specifically examined the possibility that use of snus causes oral cancer, and found no relationship; only one study yielded a statistically significant association with oral cancer (Roosar et al. 2008). Several meta-analyses restricted to Swedish snus did not report a significantly increased risk of oral cancer, and other public health committees have agreed that snus does not increase the risk of oral cancer (Rodu and Jansson 2004; Stratton et al. 2001; Boffetta et al. 2008; Lee 2011; Lee and Hamling 2009b).

##### Newly Identified Studies

One study relating Swedish snus use to oral cancer has been published since the 2013 ENVIRON report. Hirsch et al. (2012) conducted a case series study of 16 male Swedish snuff users diagnosed with oral squamous cell carcinoma. All patients used snus for a mean duration of 42.9 years (range: 8-71 years) prior to diagnosis, and were diagnosed at a mean age of 72.9 years. Six of the patients had a history of smoking conventional cigarettes. The authors noted that all patients developed cancer at the "exact anatomical location where the snuff quid was placed daily" (Hirsch et al. 2012). The generalizability and validity of these results, however, are limited by the study's design and participant selection. The participants were selected for study participation due to their referral and treatment at seven specialty clinics in Sweden, and do not reflect a representative sample of Swedish snus users. Given the limitations related to possible selection bias, the quality of evidence presented in this study was rated as weak.

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
<b>Oral Cancer</b>		
Ahlbom 1937	Oral squamous cell carcinoma	Weak
Axell et al. 1978	Oral cancer	Weak
Hirsch et al. 2012	Oral squamous cell carcinoma	Weak
Lewin et al. 1998	Oral cavity	Moderate
Luo et al. 2007	Oral cancer, corresponding to ICD-7 codes 140 (lip); 141 (tongue); 143 (floor of mouth); and 144 (oral cavity, not otherwise specified). Analyses did not include cancers of the salivary glands, pharynx, or larynx.	Moderate
Rosenquist et al. 2005*	Oropharyngeal squamous cell carcinoma (OOSCC), corresponding to ICD-7 codes 141 (tongue), 143 (floor of mouth), 144 (oral cavity, not otherwise specified) and 145 (oropharynx)	Moderate
Schildt et al. 1998b*	Squamous cell oral cancer, corresponding to ICD-7 codes 140 (lip), 141 (tongue), 143 (floor of mouth), 144 (oral cavity, not otherwise specified), 145 (oropharynx)	Moderate
*Grouped with oral cancer because the outcome definitions only included part of the pharynx.		
<b>Oral and Pharyngeal Cancer</b>		
Boffetta et al. 2005	Oral/pharyngeal cancer: cancers of the oral cavity and pharynx (ICD-7 codes 141-148)	Moderate
Lewin et al. 1998	Oral cavity; Pharynx	Moderate
Roosaar et al. 2008	Oral and pharyngeal cancer, corresponding to ICD-7 codes 140-148	Moderate

#### Discussion and Conclusions

Because the definitions of oral cancer differ from study to study, we conducted separate evaluations for oral cancer and oral and pharyngeal cancer.

#### *Oral Cancer*

The new study published by Hirsch et al. (2012) contributes little to the greater understanding of a potential relationship between snus use and oral cancer, as the study provides weak evidence. Similar to two older studies (Ahlbom 1937; Axell et al. 1978) reviewed in the 2013 ENVIRON report, risk of oral cancer cannot be estimated from these studies. The cohort study conducted by Luo et al. (2007) provided no evidence of an association between exclusive ever, current, or former snus use and oral cancer, as well as no evidence of an increasing risk of oral cancer with increased consumption of snus. A statistically significant protective effect against oral cancer was observed among all snus users in the cohort, adjusted for age, BMI, and smoking. This study, however, was rated as moderate due to the lack of control for important potential confounding factors such as alcohol. Three case-control studies similarly did not observe a statistically significant increased risk of oral cancer (Rosenquist et al. 2005; Schildt et al. 1998b), all of which adjusted for alcohol consumption, an important potential confounder. Furthermore, Rosenquist et al. (2005) and Schildt et al. (1998), did not observe any statistically significant evidence of an exposure response relationship between snus use and oral cancer. The evidence provided by these four moderate quality studies is *limited/suggestive of no association* between snus use and oral cancer.

#### *Oral and Pharyngeal Cancer*

The three studies on oral and pharyngeal cancer included the appropriate study design and representative study populations, though most were limited by a small number of cases and low statistical power. Nonetheless, risks of oral and pharyngeal cancers were not significantly increased within a study of exclusive snus users providing moderate evidence (Roosaar et al. 2008), or among studies that presented smoking-adjusted risks among snus users (Boffetta et al. 2005; Lewin et al. 1998). Boffetta et al. (2005) was the only study that did not control for alcohol consumption, an important potential confounder. The only statistically significant increased risk of oral and pharyngeal cancer was reported by Roosaar et al. (2008), but only among all cohort members, adjusted for smoking, and not among exclusive snus users, as noted previously. For both analyses, however, the number of available cases were small, and confidence intervals were imprecise. Overall, given that several well-conducted studies providing moderate quality evidence consistently showed no association between snus use and oral and pharyngeal cancer after exposure of any magnitude, particularly among exclusive snus users, we concluded that the evidence is *limited/suggestive of no association*. Results from several meta-analyses also support this conclusion (Boffetta et al. 2008; Lee 2011; Lee and Hamling 2009b).

### **2.3.1.2 Esophageal Cancer**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Four epidemiology studies have examined the relationship between snus use and esophageal cancer (Boffetta et al. 2005; Lagergren et al. 2000; Lewin et al. 1998; Zendejdel et al. 2008); one study, of the Swedish Construction Worker cohort (Zendejdel et al. 2008), reported evidence of a significant association with one type of esophageal cancer (squamous cell, the subtype most strongly associated with smoking), but not another type (esophageal adenocarcinoma). The meta-analysis that used this



squamous cell finding result reported an increased summary risk estimate (Boffetta et al. 2008), whereas the meta-analyses that used the combined cell type risk estimates from the individual studies did not report an increased summary risk estimate for esophageal cancer (Lee 2011; Lee and Hamling 2009b). Overall, the epidemiology studies suggest no association between snus use and esophageal cancer, but limitations in the available studies, and inconsistent results of the meta-analyses indicate a need for additional study of this outcome.

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Boffetta et al. 2005	Esophageal cancer	Moderate
Lagergren et al. 2000	Esophageal adenocarcinoma; esophageal squamous-cell carcinoma	Moderate
Lewin et al. 1998	Esophagus	Moderate
Zendejdel et al. 2008	Esophageal cancer, corresponding to ICD-7 code 150. The cancer subtype was further separated into esophageal adenocarcinoma and esophageal squamous-cell carcinoma.	Moderate

#### Discussion and Conclusions

Four studies providing moderate evidence examined the association between snus use and esophageal cancer (Boffetta et al. 2005; Lagergren et al. 2000; Lewin et al. 1998; Zendejdel et al. 2008). Of these, three studies of Swedish or Norwegian populations did not identify a statistically significant and increased risk of esophageal cancer among snus users in any exposure group (Boffetta et al. 2005; Lagergren et al. 2000; Lewin et al. 1998). However, a 2008 study of the Swedish Construction Worker's cohort identified an increased risk of esophageal squamous cell carcinoma among never smokers who exclusively used snus (10 cases, RR=3.5; 95% CI: 1.6-7.6), ever-smokers, and current smokers (Zendejdel et al. 2008), while a case-control study did not report an alcohol-adjusted statistically significant increased risk for adenocarcinoma or squamous cell carcinoma (Lagergren et al. 2000). Although the Zendejdel et al. (2008) study is strengthened by the investigators' analysis of a large cohort (including approximately 336,000 construction workers) and complete, lengthy follow-up (mean 22.2 years), this study is limited by its one-time evaluation of each participants' tobacco use behaviors, low number of exposed cases, and the lack of information related to participants' alcohol consumption behaviors.

A meta-analysis conducted by Boffetta and colleagues (2008) reports a statistically significant and elevated relative risk of esophageal cancer among snuff users when considering the results of five studies. One of the five studies considered US smokeless tobacco users, while the other four studies considered Scandinavian populations (snus users), including that of Zendejdel and colleagues (2008). More recent meta-analyses considering only Scandinavian populations (Lee 2011; Lee and Hamling 2009b), do not report statistically significant summary relative risks for this relationship, primarily due to the selection of different relative risks from the Zendejdel (2008) study. The relative risk from the Zendejdel (2008) study that should be used in a meta-analysis for esophageal cancer is the subject of debate (Lee and Hamling 2009a).

Overall, the available studies provide *balanced/mixed evidence of an association* between snus use and esophageal cancer overall and esophageal squamous cell carcinoma, and *limited/suggestive evidence of no association* between snus use and esophageal adenocarcinoma.

### **2.3.1.3 Cancer at Other Sites in the Head and Neck**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Discussion and Conclusions

One case-control study of Swedish men conducted by Lewin and colleagues examined the association between snus use and cancers at other sites in the head and neck (Lewin et al. 1998). Specifically, the study concluded that compared to never users of snus, ever users of snus do not have significantly increased risks for general “cancer of the head and neck,” (RR=1.1; 95% CI 0.7-1.5), nor do ever users of snus experience increased risks of laryngeal cancer (RR=0.9; 95% CI 0.5-1.5) (Lewin et al. 1998). Although this study provided moderate quality evidence of a lack of an association to support a relationship between snus use and cancers at other sites in the head and neck, the available data is *inadequate/insufficient to determine whether an association exists* based on this single study.

### **2.3.2 Pancreatic Cancer**

#### Summary from 2013 ENVIRON Report

Two cohort studies suggest that use of Scandinavian smokeless tobacco could be associated with increased risk of pancreatic cancer among some subgroups of the population (Boffetta et al. 2005; Luo et al. 2007). However, there are inconsistencies between the two studies with respect to the specific subgroups at risk (only individuals who were also current smokers in one study (Boffetta et al. 2005) vs. only never-smokers of tobacco in the second study (Luo et al. 2007)). As with esophageal cancer, the authors of one of the available meta-analyses (Boffetta et al. 2008) chose different risk estimates from (smoking adjusted and never-smoking snus user estimates), whereas other researchers who combined like risk estimates did not observe an increased risk of pancreatic cancer among snus users, nor among smokeless tobacco users in the US and other Western populations (Lee et al. 2011; Lee and Hamling 2009b). Combined with evidence from a recent pooled analysis of the risk of pancreatic cancer among smokeless tobacco users in other Western populations (Bertuccio et al. 2011), the available evidence suggests that snus and other smokeless tobacco forms are not associated with pancreatic cancer.

#### Newly Identified Studies

Update searches identified one new study that investigated the potential relationship between use of Swedish snus and pancreatic cancer (Araghi et al. 2017). Araghi et al. (2017) conducted a pooled cohort study of 424,152 male participants from nine cohort studies. Data were pooled from the Swedish Collaboration on Health Effects of Snus Use, and participants were followed up through linkage to health registries. The cohorts included in the analysis included the Swedish Construction Worker Cohort; Malmo Diet and Cancer Study; Multinational Monitoring of Trends and Determinants in Cardiovascular disease (MONICA) study; National March Cohort, Scania Public Health Cohort; Stockholm Public Health Cohort; Vasterbotten Intervention Programme (VIP); and the Work, Lipids, and Fibrinogen Study. Participant recruitment began as early as 1978, and participants were followed through 2013. Thirty percent of the 418,448 total participants reported ever having used snus at study entry and 321 of these ever users were diagnosed with pancreatic cancer. Compared to never-

users of snus (n=1,1203, 1) current snus use, 2) ever snus use, and 3) former snus use were not individually associated with a significantly increased risk of pancreatic cancer, nor was an association observed at any intensity (<4, 4-6, and 7+ cans/week) or duration (<5, 5-<10, 10-<15, 15-<20, and 20+ years) of snus use. The authors reported hazard ratios generally equal to or lesser than 1. Adjustment for smoking behaviors yielded similar results; analyses of exclusive, never-smoking snus users did not suggest increased pancreatic cancer risks compared to never users of snus. All analyses were adjusted for attained age, smoking (for non-exclusive snus user analyses), and BMI. Additional analyses among ever, former, and current users that were further adjusted for alcohol consumption, physical activity, and the interaction between alcohol consumption and smoking showed similar results. The authors of this study concluded that their "findings, from the largest sample to date, do not support a role of snus use in the development of pancreatic cancer in men... [the findings] point to tobacco smoke constituents other than nicotine or its metabolites, i.e. carcinogens associated with combustion, as the causal agent explaining the increased risk of pancreatic cancer in smokers." This study had several strengths, including its prospective design, relatively large sample size, examination of potential dose-response relationships, and control for important confounders. A limitation of this study was that tobacco use was assessed only at baseline, which could have contributed to potential misclassification of exposure and consequent bias towards the null.

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Araghi et al. 2017	Pancreatic cancer, corresponding to ICD-7 code 157 and ICD-10 code C25.	Strong
Boffetta et al. 2005	Pancreatic cancer	Moderate
Heuch et al. 1983 (updated by Boffetta et al. 2005)	Pancreatic cancer, including histologically verified cases	Weak
Luo et al. 2007	Pancreatic cancer, corresponding to ICD-7 code 157.	Moderate

#### Discussion and Conclusions

The new study published by Araghi et al. (2017) provides strong evidence of a lack of an association between snus use and pancreatic cancer. In contrast to Luo et al. (2007) and Boffetta et al. (2005), this study controlled for alcohol consumption, an important potential risk factor for pancreatic cancer, and included a larger study population and exposed cases. The evidence provided by the three other studies on snus and pancreatic cancer are limited, and contradictory (Boffetta et al. 2005; Heuch et al. 1983; Luo et al. 2007). The Araghi et al. (2017) study provides strong support of our previous conclusion that the available evidence is *limited/suggestive of no association* between use of snus and pancreatic cancer.

### **2.3.3 Stomach Cancer**

No new studies were identified since publication of the 2013 ENVIRON report.

### Summary from 2013 ENVIRON Report

No studies found that use of snus was associated with any significant increase in risk of overall or cardia stomach cancer (cardia is the upper portion of the stomach) (Boffetta et al. 2005; Hansson et al. 1994; Lagergren et al. 2000; Ye et al. 1999; Zendehdel et al. 2008), but one study found an elevated risk for the noncardia subtype of stomach cancer (Zendehdel et al. 2008). These data suggest no association between snus use and stomach cancer overall, but additional research will help confirm whether the finding for the noncardia subtype is real.

### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Boffetta et al. 2005	Stomach cancer	Moderate
Hansson et al. 1994	Gastric cancer	Moderate
Lagergren et al. 2000	Adenocarcinoma of the gastric cardia	Moderate
Ye et al. 1999	Newly and histologically confirmed gastric cardia cancer, distal stomach cancer (of the intestinal and diffuse type), and total gastric and cardia cancer	Moderate
Zendehdel et al. 2008	Cardia and non-cardia stomach cancer, corresponding with ICD-7 code 151	Moderate

### Discussion and Conclusions

#### *Overall Stomach Cancer*

A statistically significant elevated risk of overall stomach cancer among snus users was not reported in two case-control studies (Hansson et al. 1994; Ye et al. 1999) and a cohort study (Boffetta et al. 2005) of moderate quality. Only Ye et al. (1999) examined the risk of overall stomach cancer among exclusive snus users, while the other two studies controlled for smoking. Ye et al. (1999) additionally controlled for alcohol consumption, an important potential confounder. Overall, the available studies provide *limited/suggestive evidence of no association* between use of snus and overall stomach cancer.

#### *Cardia Stomach Cancer*

Among the two case-control studies (Lagergren et al. 2000; Ye et al. 1999) and cohort study (Zendehdel et al. 2008) of moderate quality that examined the potential relationship between snus use and cardia stomach cancer, none reported any statistically significant increase in risk. The authors of the two case-control studies controlled for alcohol consumption, an important potential confounder, and reported no significant trend in risk of cardia cancer with increasing intensity or duration of snus use. Zendehdel et al. (2008), however, was the only study that included an analysis among never-smokers, while the two case-control studies controlled for other tobacco use among snus users. Overall, these three studies provide support of our previous conclusion that the available studies provide *limited/suggestive evidence of no association* between use of snus and cardia stomach cancer.

#### *Non-Cardia Stomach Cancer*

The potential relationship between non-cardia stomach cancer and snus use was examined in a case-control (Ye et al. 1999) and cohort study (Zendehdel et al. 2008), both of moderate quality. Ye et al. (1999) did not report elevated risks of non-cardia stomach cancers including distal gastric cancer of

the intestinal type, and distal gastric cancer of the diffuse type. Zendehdel et al. (2008) reported a statistically significant increased risk of non-cardia stomach cancer among never-smoking snus users overall, and in participants aged 70 or older (but not among participants under age 70). These results were based on few cases (n=8 cases among snus users overall, and n=5 in the older age group). The authors did not observe an elevated risk of non-cardia stomach cancer among total participants or among ever-smokers, adjusted for smoking. Neither study included adjustments for alcohol consumption, an important potential confounder. Overall, the available studies provided *inadequate/insufficient evidence to determine whether an association exists* between snus use and non-cardia stomach cancer.

#### 2.3.4 Colorectal and Anal Cancer

No new studies were identified since publication of the 2013 ENVIRON report.

##### Summary from 2013 ENVIRON Report

Nordenvall and colleagues (2010) examined the impact of smoking and snus use on anal and colorectal cancer incidence among 336,381 males in the Swedish construction worker cohort. There was no excess risk of colon (RR=1.08; 95% CI: 0.91-1.29), rectal (RR=1.05; 95% CI: 0.85-1.31), or anal (RR=0.61; 95% CI: 0.07-5.07) cancer among exclusive users of snus. No dose-response relationships were observed based on duration of snus use at inclusion, however a significantly elevated risk was observed for the left-sided colon sub-site among snus users with 35-44 years of total estimated snus use at inclusion and during follow-up. A significant excess was not observed among the group with at least 45 years of total estimated snus use. The authors commented that the results among the 35-44 year group were imprecise, that multiple significance testing may have generated borderline significant results by chance, and that larger studies were warranted.

##### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Nordenvall et al. 2010	Colon cancer; right-sided colon cancer; left-sided colon cancer; cancer of the rectum; cancer of the anus	Strong (Colon and Rectal Cancer) Moderate (Anal Cancer)

##### Discussion and Conclusions

The evidence for colon and rectal cancer presented by Nordenvall et al. (2010) was rated as strong, due to the prospective design large number of participants investigated/high statistical power, long follow up, restriction to pure snus users, and evaluation of a potential duration-response relationship. Based on this, and the results presented above, the Nordenvall et al. (2010) study provides *limited/suggestive evidence of no association* between use of snus and colon and rectal cancer.

The evidence for anal cancer was rated as moderate, due to the observation of only a single anal cancer case observed among pure snus users, which resulted in hazard ratios with wide confidence intervals. For this reason, the Nordenvall et al. (2010) study provides *inadequate/insufficient evidence to determine whether an association exists* between snus use and anal cancer.

#### 2.3.5 Kidney and Bladder Cancer

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

The cohort study conducted by Boffetta and colleagues (2005) also presents data on the relationship between snus use and development of kidney and bladder cancers. The authors concluded that the use of snus (either current or former) was not associated with any increase in the risk of kidney or bladder cancer. In fact, current snus users had a significantly lower risk of kidney cancer than did never-users (RR=0.47; 95% CI: 0.23-0.94).

#### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Boffetta et al. 2005	Kidney and urinary bladder cancer	Moderate

#### Discussion and Conclusions

Elevated risks of kidney or bladder cancer were not observed in the cohort study conducted by Boffetta et al. (2005). Relative risks were below 1.0 for ever and current users of snus for both kidney and bladder cancer, including a statistically significant decreased risk of kidney cancer among current snus users. This prospective study included over 10,000 Norwegian men, though the available evidence was rated as moderate quality due to the lack of analyses among exclusive snus users, and adjustment for potential confounders (relative risks were adjusted only for age and other tobacco use). The available evidence suggests a decreased risk of these cancers among snus users, with potential confounding from smoking unlikely to have biased the results towards a lower risk. However, given that only one moderate quality study was available, the available study provides *inadequate/insufficient evidence to determine whether an association exists* between snus use and kidney or bladder cancer.

### **2.3.6 Lung Cancer**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Three large cohort studies have collected data on the relationship between use of snus and lung cancer (Boffetta et al. 2005; Bolinder et al. 1994; Luo et al. 2007). These studies found no evidence that use of snus increases the risk of lung cancer.

#### Quality Rating of All Studies

Study	Evidence Quality Rating
Boffetta et al. 2005	Moderate
Bolinder et al. 1994	Moderate
Luo et al. 2007	Moderate

#### Discussion and Conclusions

Three large cohort studies, two involving participants of the Swedish Construction Worker cohort (Bolinder et al. 1994; Luo et al. 2007), and the third involving 10,000 Norwegian men (Boffetta et al. 2005), reported that use of snus was not associated with a statistically significant increase in the relative risk of lung cancer. Furthermore, no trend was observed when the risk of lung cancer was evaluated by amount of snus consumed per day (Luo et al. 2007). Overall, the available studies provide *limited/suggestive evidence of no association* between use of snus and lung cancer.

### 2.3.7 Skin Cancer & Melanoma

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Odenbro and colleagues (2005; 2007) examined the relationship between use of snus and several forms of skin cancer in two analyses of the construction worker cohort. An initial analysis (Odenbro et al. 2005) examined the effect of tobacco use on the risk of cutaneous squamous cell carcinoma (CSCC) among 337,311 male construction workers who were followed for 30 years. The authors found that snuff use was not associated with any increased risk; in fact, it was associated with a significantly decreased risk of CSCC (RR=0.64; 95% CI: 0.44-0.95).

In their second analysis, Odenbro and colleagues (2007) examined data from 339,802 male construction workers to determine whether tobacco use was associated with any of four types of melanoma, including all melanoma, cutaneous malignant melanoma (CMM), melanoma in situ (MIS), and intraocular malignant melanoma (IMM). Snuff-only users had a significantly reduced risk of CMM (RR=0.63; 95% CI: 0.48-0.81) and all melanoma (RR=0.65; 95% CI: 0.52-0.82), a non-statistically significant reduced risk of MIS (RR=0.64; 95% CI: 0.36-1.14), and there was no effect on IMM (RR=1.14; 95% CI: 0.43-3.07). Risk of CMM decreased with increasing duration of snuff use. The authors note that the biological mechanisms behind these findings are unclear, and that this cohort is relatively young, with some workers not reaching the mean age for melanoma diagnosis.

#### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Odenbro et al. 2007	All melanoma; cutaneous malignant melanoma (CMM); melanoma in situ (MIS); intraocular malignant melanoma (IMM)	Strong (all melanoma, CMM, MIS) Moderate (IMM)
Odenbro et al. 2005	Cutaneous squamous cell carcinoma (CSCC)	Strong

#### Discussion and Conclusions

The evidence for CSCC, all melanoma, CMM, and MIS presented by Odenbro et al. (2005; 2007) was rated as strong, due to the prospective design, large number of participants investigated/high statistical power, long follow up, restriction to pure snus users, and evaluation of a potential duration-response relationship. Relative risks of CSCC, all melanoma, and CMM decreased significantly with increasing duration of snus use. Although Odenbro et al. (2005) did not control for sunlight exposure, occupational sunlight exposure had been previously evaluated in this cohort, and no association was found. Odenbro et al. (2007), however, did control for this potential confounder. Based on these reasons, and the results presented above, these studies provide *limited/suggestive evidence of an inverse association* between use of snus and CSCC, all melanoma, and CMM, and *limited/suggestive evidence of no association* for MIS.

The evidence for IMM was rated as moderate, due to the observation of few reported cases, which resulted in relative risk ratios with wide confidence intervals. For this reason, the Odenbro et al.

(2007) study provides *inadequate/insufficient evidence to determine whether an association exists* between snus use and IMM.

### 2.3.8 Hematopoietic Cancer

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Two analyses by Fernberg and colleagues (2006; 2007) investigated the role of tobacco use and BMI in the development of various hematopoietic malignancies. An initial study (Fernberg et al. 2006) evaluated the effect of these factors on the incidence of malignant lymphomas, specifically non-Hodgkin's lymphoma (NHL) or Hodgkin's disease (HD), among 335,612 male and female Swedish construction workers. There was no link between snuff use and risk of NHL, even among men who had used snuff for more than 30 years (incidence rate ratio (IRR)=0.69; 95% CI: 0.41-1.15). With respect to HD, the overall analysis did not show snuff use to be associated with significant increased risk. However, men who had used snuff for more than 30 years had a significantly increased risk of HD (IRR=3.78; 95% CI: 1.23-11.15). This is a novel finding that must be verified by additional studies, and it was based on only four cases, which limits the statistical power of the finding. Women who had ever used snuff were not at significantly increased risk of either NHL or HD, however, only one woman used snus out of 17,691 women surveyed in the cohort.

In their second study, Fernberg and colleagues (2007) investigated the role of tobacco smoking, oral moist snuff use, and BMI on the incidence of leukemia and multiple myeloma (MM) among 336,381 Swedish male construction workers. The authors reported that exclusive use of snuff was not associated with an increased risk of either acute lymphocytic leukemia (IRR=1.24; 95% CI: 0.39-4.01), acute myelogenous leukemia (IRR=0.81; 95% CI: 0.41-1.60), chronic myelogenous leukemia (IRR=1.17; 95% CI: 0.60-2.28), or multiple myeloma (IRR=0.92; 95% CI: 0.61-1.40), after adjustment for age and BMI.

#### Newly Identified Studies

A single case-control study that investigated the potential relationship between snus use and NHL, published prior to the 2013 ENVIRON report was identified during the retrospective literature search of the health effects of snus through December 1, 2012 (Hardell et al. 1994). The study consisted of men aged 25 to 85 years who were admitted to the Department of Oncology in Umea, Sweden between 1974 and 1978 with histopathologically verified NHL, including 105 cases in total, of which 35 were snuff users. The authors did not find a statistically significant increased odds of NHL among snus users (unadjusted odds ratio:1.5; 95% CI: 0.9-2.5). Because of the low number of exposed cases, and the lack of adjustment for potential confounders, the quality of this evidence was rated as weak.

#### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Fernberg et al. 2007	Acute lymphocytic leukemia (ALL); acute myelogenous leukemia (AML); chronic myelogenous leukemia (CML); multiple myeloma (MM)	Moderate (ALL, AML, CML) Strong (MM)
Fernberg et al. 2006	non-Hodgkin's lymphoma (NHL);	Strong (NHL)



	Hodgkin's disease (HD)	Moderate (HD)
Hardell et al. 1994	non-Hodgkin's lymphoma (NHL)	Weak

### Discussion and Conclusions

#### *Multiple Myeloma*

The evidence for MM presented by Fernberg et al. (2007) was rated as strong, due to the prospective design, large number of participants investigated/high statistical power, long follow up, and restriction to pure snus users. Based on these reasons, and the results presented above, this study provides *limited/suggestive evidence of no association* between snus use and MM.

#### *Leukemia (ALL, AML, CLL)*

Fernberg et al. (2007) also reported that snus use was not associated with increased risk of leukemia (ALL, AML, CML). The overall cohort was large, though there were few cases of each of the leukemias and thus lowering statistical power. Based on this single study providing moderate quality evidence for these endpoints, there is *limited/suggestive evidence of no association* between snus use and ALL, AML, and CML.

#### *Lymphomas (NHL and HD)*

The observational analyses of NHL conducted by Fernberg et al. (2006) was rated as strong due to the prospective design, large cohort, long follow-up, restriction to pure snus users, and evaluation of a potential duration-response relationship. The evidence for HD was rated as moderate due to the low number of exposed cases in the duration-response analyses. No increased risks of NHL or HD were reported to be associated with snus use. The analyses were adjusted for age, and BMI. When the authors stratified by years of snus use, they reported a significant association between snus use for more than 30 years and HD. However, the statistical power was limited in that there were only four cases for this specific finding. The case-control study conducted by Hardell et al. (1994) also found no increased odds of NHL with snus use. However, due to the lack of control for any potential confounding variables, and limited statistical power (only 35 cases reported snus use), the study was rated as weak. Based on these two studies presenting analyses of varying quality, there is *limited/suggestive evidence of no association* between snus use and NHL, and *inadequate/insufficient evidence to determine whether an association exists* between snus use and HD.

### **2.3.9 Smoke-Related Cancer**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

The cohort study by Roosaar and colleagues (2008) presents data on the risk of smoke-related cancers among approximately 10,000 Swedish men. With respect to smoke-related cancers, a significantly elevated risk was observed among never-smoking ever-daily snus users (HR=1.6; 95% CI: 1.1-2.5). Contrary to what would be expected, a significantly elevated risk was not observed among snus users that included smokers, as smoking alone was significantly associated with both the development of any cancer and smoke-related cancers in the analysis. Residual confounding from smoking or misclassification of tobacco use are important concerns, nonetheless, the authors concluded that relative risks of the outcomes studied were consistently lower among snus users than those associated with smoking.

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Roosaar et al. 2008	"Smoke-related cancer," corresponding to ICD-7 codes 140-148	Moderate

#### Discussion and Conclusions

The study conducted by Roosaar and colleagues (2008) followed a large cohort of Swedish men for 29 years. Among snus users who never smoked, there was a statistically significant elevated risk of smoke-related cancer. However, among snus users who also smoked daily or occasionally, the risk for smoke-related cancer was not elevated. This study did not assess tobacco habits after study entry, and misclassification may have occurred due to changing of tobacco habits over the almost three-decade long study. Based on this single study, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and smoke-related cancer.

### **2.3.10 All Cancers**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

The cohort study by Bolinder and colleagues (1994) presented data on death due to any type of cancer among 84,781 male construction workers. There was no excess risk of cancer mortality among the 6,297 "smokeless tobacco (snuff)" users in this cohort. The study did not examine specific types of cancer, except for lung cancer, possibly due to relatively small numbers of cancers (there were only 96 malignancies among 6,297 snus users).

Roosaar and colleagues (2008) presented data on the risk of any type of cancer in addition to smoking-related cancers among approximately 10,000 Swedish men followed for 29 years. For any cancer type, no excess risk was observed among never-smoking, ever-daily snus users and snus users that included some smokers. Residual confounding from smoking or misclassification of tobacco use are important concerns, nonetheless, the authors concluded that relative risks of the endpoints studied were consistently lower among snus users than those associated with smoking.

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Bolinder et al. 1994	All cancers	Moderate
Roosaar et al. 2008	"Any cancer," corresponding to ICD-7 codes 140-209	Moderate

#### Discussion and Conclusions

The evidence presented by Bolinder et al. (1994) and Roosaar et al. (2008) regarding the association between snus use and any cancer was rated as moderate. The study conducted by Bolinder and colleagues used a large cohort of construction workers and reported a relatively small occurrence of cancer deaths. The risk estimates were adjusted for age and region of origin, and the authors found no effect on risk even after adjustment for area of residence, BMI, blood pressure, diabetes, and heart symptoms. The study conducted by Roosaar et al. (2008) did not report increased risks of all cancer in both a smoking-adjusted analysis and an analysis restricted to never-smokers. The risk models were

adjusted for calendar period, alcohol consumption, and area of residence. These two studies of moderate quality provide *limited/suggestive evidence of no association* between snus use and cancer.

## **2.4 Cardiovascular Effects (Risk Factors and Disease)**

### **2.4.1 Risk Factors for CVD**

#### **2.4.1.1 Blood Pressure and Heart Rate**

##### Summary from 2013 ENVIRON Report

Though there appears to be acute increases in heart rate and blood pressure, it is not clear if blood pressure is elevated among regular snus users. A single cross-sectional study reported higher mean blood pressure and heart rates among snus users (Bolinder and de Faire 1998), but several additional studies did not identify group differences when compared to nontobacco users (Eliasson et al. 1991; Bolinder et al. 1997a; Bolinder et al. 1997b; Angman and Eliasson et al. 2008; Wennmalm et al. 1991).

Although the available studies on hypertension were described in the 2013 ENVIRON report, standardized conclusions were not provided. A discussion of the new studies as well as standardized conclusions accounting for the old and new evidence are provided below.

##### Newly Identified Studies

###### *Acute Effects*

Three new studies were identified that examined the potential acute effects of Swedish snus on blood pressure, heart rate, and other effects on the heart (e.g., heart rate variability) (Morente-Sanchez et al. 2015; Ozga et al. 2016; Zandonai et al. 2016). Morente-Sanchez et al. (2015) conducted a double-blind randomized crossover study in which 18 nonsmoking, non-snus-using male amateur football players in Spain consumed either a 1.0 g portion (8 mg of nicotine) of Swedish Match brand Catch White Eucalyptus snus or placebo 40 minutes prior to a fitness test. The authors examined the effect of snus use on heart rate variability, among other performance-related endpoints. At 35-minutes following snus administration, the authors observed a statistically significant decrease in heart rate variability, with no significant changes observed during the placebo session. In particular, values were reduced for the following measures: R-R interval (RRi) ( $P < 0.001$ ), root mean square of successive differences (rMSSD) ( $P = 0.05$ ), and instantaneous beat-to-beat variability of the data (SD1) ( $P = 0.04$ ). The authors noted that these results “confirm that nicotine leads to a reduced vagal tone,” in line with previous results among smokers.

Ozga et al. (2016) conducted a clinical study in which six men and five women (age 19-26) who reported fewer than 100 lifetime uses of tobacco and no tobacco in the past three months were given ascending doses of nicotine in the form of Swedish Match brand General White Large snus. The session lasted for five hours, with 20-25 minutes separating the end of a pouch and the start of the next pouch. Nicotine doses ascended from 0.0, 1.6, 3.2, 4.8, 6.4, to 8.0 mg. Statistically significant main effects of dose were observed across dose groups during the experimental session including a decrease in heart rate, and increases in systolic and diastolic blood pressure. Significant dose-time interactions were also observed for heart rate and systolic blood pressure. Heart rate generally decreased from pre- to post-dose for the initial snus doses, but increased toward the end of the session. Systolic blood pressure increased from pre- to post-dose at nearly every active dose, though

these increases were significant only for the final, 8.0 mg nicotine dose. Little to no change was observed in diastolic blood pressure during the session, except following the final dose, where diastolic blood pressure was significantly higher than after all other doses.

Zandonai et al. 2016 conducted a double-blind, randomized crossover study of 12 healthy, non-smoking and non-snus-using men (age 18-45). Participants received either Swedish Match brand Catch White Eucalyptus snus (8.0 mg nicotine), or a snus placebo. The authors examined a variety of factors, including potential heart rate and blood pressure changes during an endurance exercise activity following use of Swedish snus or snus placebo. Heart rate and systolic blood pressure did not differ significantly between the Swedish snus and snus placebo groups during the exercise, while diastolic blood pressure at time to exhaustion during the activity was significantly lower in the Swedish snus group ( $73.10 \pm 8.53$  mmHg) compared to the snus placebo group ( $80.70 \pm 8.56$  mmHg). The authors concluded that "nicotine induced diastolic hypotension at exhaustion."

#### *Non-acute Effects*

Two new studies were identified that examined the potential non-acute effects of snus use on blood pressure and heart rate (Bjorkman et al. 2017; Overland et al. 2013). Bjorkman et al. (2017) conducted a clinical study in which the potential effects of snus cessation after several years of use were examined in 24 participants with a history of snus use exceeding two years. The authors compared various endpoint measures between a snus cessation group (5 females, 19 males) and a group that continued to use snus as usual (2 females, 9 males). Although heart rate and blood pressure improved (decreased) following cessation of snus, there were no statistically significant differences in these measures between the cessation group and the control group that continued to use snus.

Overland et al. (2013) examined the potential relationship between snus use and cardiovascular risk factors in a cross-sectional study involving a general population sample of 25,163 participants from the 3<sup>rd</sup> wave of the Nord-Trondelag Health Surveys (HUNT3) in the county of Nord-Trondelag, Norway. Following adjustment for age, smoking, gender, education, physical exercise, and frequency of alcohol use, the authors reported a statistically significant higher systolic blood pressure among "extensive" snus users ( $b=1.98$ ; 95% CI: 0.87, 3.1) compared to never-users of snus. No differences in systolic blood pressure were observed among former users, those who use snus "sometimes," or daily users compared to never-users of snus. No significant differences in diastolic blood pressure were observed between any of the previously mentioned snus use categories compared to never-users of snus. The authors noted that the associations observed in this study were "generally quite weak, and not particularly consistent."

#### *Hypertension*

A single new study examined the potential relationship between snus use and high blood pressure (Byhamre et al. 2017). Byhamre et al. (2017) examined the risk of metabolic syndrome and its components, including high blood pressure, among 880 Swedish compulsory school students who had attained the 9<sup>th</sup> grade (age 16) in 1981. This sample consisted of students from the municipality of Lulea, as part of the 27-year prospective Northern Swedish cohort. The participants completed self-administered questionnaires at baseline and follow-ups at ages 16, 21, 30, and 43. At age 43, participants underwent a health exam, the results of which were used to define the presence of metabolic syndrome in each participant. Tobacco use information was self-reported at baseline and at

each follow-up. The authors noted that health exams at age 16 were “insufficient to determine exact presence of the metabolic syndrome,” and “could not exclude prevalent cases at baseline.” They further noted, however, that only five of the 880 participants had a BMI of 30 or greater at age 16, and suggested that “the number was considered too low to alter the results significantly.” Strictly speaking, this study did not meet the criteria for a prospective cohort study, unless one assumes that the effect of some prevalent cases of metabolic syndrome at baseline is negligible, and that only participants that used snus throughout all four periods are considered to ensure that initiation of snus use likely preceded development of metabolic syndrome. Regardless, analyses of metabolic syndrome components, including high blood pressure, appear to be cross-sectional. The risk of high blood pressure ( $\geq 130$  mm Hg systolic and/or  $\geq 85$  mm Hg diastolic) for current snus users who have never smoked was statistically significantly elevated (odds ratios were around 2.0) only for crude analyses at ages 21, 30, and 43, and the risk was attenuated and no longer statistically significant (for all age groups) when the analyses were adjusted for sex, cumulative smoking, BMI at 16 years, socioeconomic status at 16 years, family history of diabetes, alcohol consumption at 43 years, and physical activity at 43 years compared to never-users of tobacco. The authors also reported that high blood pressure was associated with cumulative snus use over the four periods, though the association did not remain significant in the fully adjusted model. Given the lack of an association when analyses were adjusted for potential confounding variables, the authors noted that “this indicated that differences between non-tobacco users and snus users regarding the potential confounders, rather than snus itself, may explain the associations.”

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
<b>Acute Effects</b>		
Bolinder et al. 1997b	Heart rate and blood pressure	Moderate
Bolinder and de Faire 1998	Heart rate and blood pressure	Moderate
Hirsch et al. 1992	Heart rate and blood pressure	Moderate
Lunell and Curvall 2011	Heart rate	Moderate
Morente-Sanchez et al. 2015	Heart rate variability	Moderate
Ozga et al. 2016	Heart rate and blood pressure	Moderate
Rohani and Agewall 2004	Heart rate and blood pressure	Moderate
Sundstrom et al. 2012	Heart rate, blood pressure, and ventricular heart function.	Moderate
Zandonai et al. 2016	Heart rate and blood pressure	Moderate
<b>Non-Acute effects</b>		
Angman and Eliasson 2008	Blood pressure	Weak
Bjorkman et al. 2017	Heart rate and blood pressure	Moderate
Bolinder et al. 1997a	Heart rate and blood pressure	Weak
Bolinder et al. 1997b	Heart rate and blood pressure	Moderate
Eliasson et al. 1991	Heart rate and blood pressure	Weak
Janzon and Hedblad 2009	Blood pressure	Weak
Norberg et al. 2006	Blood pressure	Weak

Overland et al. 2013	Blood pressure	Weak
Sundstrom et al. 2012	Blood pressure	Weak
Wennmalm et al. 1991	Blood pressure	Weak
<b>High Blood Pressure / Hypertension</b>		
Bolinder et al. 1992	Hypertension	Weak
Byhamre et al. 2017	High blood pressure	Moderate
Hergens et al. 2005	Hypertension	Weak
Hergens et al. 2008a	High blood pressure and hypertension	Moderate
Janzon and Hedblad 2009	Hypertension	Weak
Norberg et al. 2006	Hypertension	Weak

## Discussion and Conclusions

### *Acute Effects on the Heart and Blood Pressure*

The findings reported in the three new studies on the acute cardiovascular effects of Swedish snus were mixed, and differed in some ways from most of the studies reviewed in the 2013 ENVIRON report. The newly published studies were limited due to a small number of participants, though they were strengthened by their experimental design. Additionally, all three were unique in that they are the first available experimental studies that examined the acute effects of snus on the heart and blood pressure of tobacco-naïve users. Evidence from all the available studies investigating acute effects, including those newly published, was rated moderate in quality.

With respect to heart rate, most of the available studies, indicate acute, transient increases in heart rate at least after 20 minutes or so following snus use. The results from the new study conducted by Ozga et al. (2016) are consistent with these findings in that heart rate increases were observed towards the end of the experimental session (though there was a decrease initially). The new study by Zandonai et al. (2016), however, reported no differences in heart rate during exercise between those who used Swedish snus and those who used a snus placebo. Overall, the available studies provide *limited/suggestive evidence of an association* between snus use and acute increases in heart rate.

Similarly, blood pressure tended to increase, particularly systolic, following consumption of Swedish snus in most of the available studies. Results from the new study by Ozga et al. (2016) are consistent with this, though the results from the new study by Zandonai et al. (2016) did not indicate an increase in blood pressure during exercise following snus use (a decrease in diastolic blood pressure was actually observed at time during exhaustion during the experiment). However, overall, the available studies provide *limited/suggestive evidence of an association* between snus use and acute increases in blood pressure.

Two other studies have examined the potential relationship between snus use and acute effects on ventricular heart function (Sundstrom et al. 2012), and heart rate variability (Morente-Sanchez et al. 2015). Smoking habits were not described in the Sundstrom et al. (2012) study. These studies provide *inadequate/insufficient evidence to determine whether an association exists* between snus use and either endpoint.

### *Non-Acute Effects on Heart Rate and Blood Pressure*

Two new studies provided additional evidence of a positive relationship between snus use and increased heart rate and blood pressure. Though most of the available studies do not suggest a

relationship exists, two moderate quality studies are suggestive of an association, while most of the studies that do not suggest an association are of weak quality (with the exception of a single moderate quality study). Overall, the evidence of an association between snus use and a non-acute increase in blood pressure and heart rate is *balanced/mixed*.

#### *High Blood Pressure / Hypertension*

A single new, cross-sectional study reported an increased risk of high blood pressure in snus users compared to never-users of tobacco in crude analyses, but not in analyses adjusted for various potential confounders (Byhamre et al. 2017). Two other previously reviewed cross-sectional studies reported an increased risk of hypertension (Bolinder et al. 1992; Hergens et al. 2005). In another cross-sectional analysis, Hergens et al. (2008b) reported an increased risk of high blood pressure at baseline), but when those free of hypertension at baseline were examined prospectively, the risk of developing hypertension at follow-up among snus users was not elevated in the overall cohort. The authors of two additional studies that did not account for the potential confounding effects of smoking did not report a relationship between snus use and hypertension (Janzon and Hedblad 2009; Norberg et al. 2006). Overall, the evidence of an association between snus use and high blood pressure or hypertension is *balanced/mixed*.

### **2.4.1.2 Lipid Levels**

#### Summary from 2013 ENVIRON Report

Several cross-sectional studies examined lipid measurements (high-density lipoprotein (HDL) or low-density lipoprotein (LDL)), triglycerides, or apolipoproteins (Bolinder et al. 1997a; Eliasson et al. 1991; Eliasson et al. 1995). One case-control study examined whether controls who were snus users had increased risk of hyperlipidemia compared to controls who never used snus, controlling for smoking in multivariate analysis (Hergens et al. 2005). None of these studies reported increased prevalence of these lipid measurements among snus users compared to the nontobacco users. Norberg et al. (2006) and Wallenfeldt et al. (2001) examined the potential relationship between snus use and triglyceride and cholesterol levels, but were excluded from this evaluation because the analyses were not adjusted for current smoking (29% of the population of snuff users studied were current smokers).

#### Newly Identified Studies

Three new studies were identified that examined the potential effects of snus use on blood lipid levels (Bjorkman et al. 2017; Byhamre et al. 2017; Overland et al. 2013). Bjorkman et al. (2017), described previously, conducted a clinical study in which the potential effects of snus cessation after several years of use were examined in 24 participants with a history of snus use exceeding two years. Although cholesterol levels (total, LDL) increased following cessation of snus, there were no statistically significant differences in these measures between the cessation group and the control group that continued to use snus. HDL levels remained relatively unchanged. The authors concluded that the “effects of snuff on CVD risk factors are unsettled.”

Byhamre et al. (2017), described previously, conducted cross-sectional analyses of the potential relationship between exclusive snus use and raised/high triglycerides and low HDL cholesterol. In crude analyses, the authors reported statistically significant increased risks of raised triglycerides among snus users at age 16, 21, and 30, but not at age 43 (statistically significant odds ratios ranged from 1.83 to 2.21) compared to never-users of tobacco. After adjusting for sex, BMI at 16 years,

socioeconomic status at 16, family history of diabetes, alcohol consumption at age 43, and physical activity at age 43, none of these results remained significant. Compared with never-users of tobacco, no significant increased risk was observed for low HDL cholesterol among exclusive snus users in crude or adjusted analyses.

Overland et al. 2013, described previously, conducted a cross-sectional study and reported statistically significant higher levels of HDL cholesterol among snus users who use snus “sometimes,” daily users, and extensive users compared to never-users of snus following adjustment for age, smoking, gender, education, physical exercise, and frequency of alcohol use. The authors referred to these results among snus users as “beneficial,” and noted that “snus use was associated with more favourable HDL-cholesterol levels.” No statistically significant difference was reported for former snus users. Compared to current exclusive snus users, never-users of tobacco had significantly lower HDL. Statistically significant higher levels of triglycerides were reported among former and “sometimes” snus users, but not among daily, or extensive snus users. Compared to current exclusive snus users, never-users of tobacco did not have significantly different levels of triglycerides. Though the authors noted that Norwegians who use snus extensively faced an increased risk of higher HDL cholesterol, they concluded that “the significant associations between snus use and the cardiovascular risk factors we found were generally quite weak, and not particularly consistent.”

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Bjorkman et al. 2017	Cholesterol levels after cessation of snus	Strong
Bolinder et al. 1997a	Cholesterol, apolipoprotein, and triglyceride levels	Weak
Byhamre et al. 2017	Low HDL, raised triglycerides	Moderate
Eliasson et al. 1991	Cholesterol, and triglyceride levels	Weak
Eliasson et al. 1995	Cholesterol, and triglyceride levels	Weak
Hergens et al. 2005	Hyperlipidemia	Weak
Norberg et al. 2006	Triglycerides $\geq 1.7$ mmol/L	Excluded
Overland et al. 2013	HDL, and triglyceride levels	Weak
Wallenfeldt et al. 2001	Cholesterol, and triglyceride levels	Excluded

#### Discussion and Conclusions

Most of the previously evaluated studies involved cross-sectional analyses of potential differences in lipid levels between tobacco user (and non-user) groups, including Swedish snus users (Bolinder et al. 1997a; Eliasson et al. 1991; Eliasson et al. 1995). No statistically significant differences were reported in any of these studies. Hergens et al. (2005) conducted a cross-sectional analysis of the potential risk of hyperlipidemia among snus users compared to never users of snus. No increased risk was observed among snus users. Due largely to the cross-sectional design of these studies, they were rated as weak.



Some results from one of three newly identified studies contradict findings from the earlier studies. Byhamre et al. (2017) reported an increased risk of raised triglycerides among snus users at age 16, 21, and 30, but not at age 43. This study was rated as moderate, though it would have otherwise been rated as weak since each individual analysis was cross-sectional, although there was an element of prospective follow-up given that the population was evaluated at different ages over the course of the participants' lives. The authors reported that snus users faced no increased risk of low HDL (i.e., good cholesterol) compared to never users of tobacco. Overland et al (2013) and Bjorkman et al. (2017) reported generally favorable results among snus users. For example, Bjorkman et al. (2017) conducted a clinical study (rated as strong) in which total and LDL cholesterol levels increased in regular snus users that stopped using it (though plasma levels were not significantly different from participants that continued using snus). Overland conducted a cross-sectional study (rated as weak) and reported higher levels of HDL (good cholesterol) in snus users compared to never-users of tobacco, with no differences in triglyceride levels observed.

Although most of the studies are cross-sectional, a single, strong clinical study supports the consistent lack of an association observed between snus use and increased levels of certain lipids (or a lack of an association with hyperlipidemia). Overall, there is *limited/suggestive evidence of no association* between snus use and unhealthy blood levels of lipids.

#### **2.4.1.3 Other Indicators of Cardiovascular Disease Risk**

##### Summary from 2013 ENVIRON Report

##### *Biochemical or Physical Measures of Clotting*

Several cross-sectional studies examined other biochemical or physical measures of clotting or of atherosclerosis among snus users compared to nontobacco users; these include indicators such as carotid artery diameters and lumen thickness, to which may indicate increased risk of CVD events (Bolinder et al. 1997a; Eliasson et al. 1991; Eliasson et al. 1995; Wennmalm et al. 1991). In these studies, none reported a significant difference between snus users and nontobacco users.

Two analyses of a population of healthy male firefighters showed no significant difference between smokeless tobacco users and non-users of tobacco with respect to measurements of carotid wall thickness, lumen diameter, or the presence of carotid plaques (Bolinder et al. 1997a) or an "atherogenic index" (Bolinder 1997). A cross-sectional study of clinically healthy men by Wallenfeldt and colleagues (2001) found no statistically significant association between use of oral moist snuff and any ultrasound-assessed measures of subclinical atherosclerosis (intima-media thickness in the carotid bulb, carotid artery, or femoral artery, or carotid or femoral plaques). However, Wallenfeldt et al. (2001) was excluded because approximately 29% the population of snuff users examined in the study were current smokers.

Additionally, an experimental study of 20 healthy, middle-aged men and women suggests that acute use of Swedish snuff may be associated with endothelial dysfunction, but the study's authors do not describe the smoking status of the participants, and therefore, the results of this study were previously excluded (Rohani and Agewall 2004). As this was a controlled, experimental study of the acute effects of snus, these results should have been considered relevant in the 2013 ENVIRON report, and are therefore being included in this update.

##### *Measures of Fitness: Oxygen Uptake, Work Capacity, Cardiac Output*

The results of four studies on the potential effects of snus use and oxygen uptake/work capacity were presented in the 2013 ENVIRON Report. No statistically significant difference in work capacity was observed between snus users and non-users of tobacco in three cross-sectional studies (Bolinder et al. 1997b; Bolinder and de Faire 1998; Wennmalm et al. 1991) and one experimental study (Hirsch et al. 1992).

#### *Cardiovascular/circulatory symptoms*

A large cross-sectional study of Swedish construction workers found a significantly higher risk of reporting cardiovascular/circulatory symptoms (i.e., breathlessness on slight effort, chest pain walking up hill, pain in the leg while walking, white finger symptoms) among “smokeless tobacco” users compared to nonusers of tobacco (Bolinder et al. 1992).

#### *Allostatic Load*

In a study of participants from the Northern Swedish Cohort, Gustafsson and colleagues (2011a) examined demographic and behavioral factors that affected allostatic load. In addition to biologic parameters such as systolic and diastolic blood pressure, fasting glucose, and blood lipid measurements in participants, salivary cortisol concentrations used as a measure of total cortisol secretion, were summed in an index used as a measure of allostatic load. Sociodemographic variables and behaviors, including snus use and smoking, were examined in a multivariate model as predictors of allostatic load. Smoking, but not snus use, was found to be a significant predictor of allostatic load (stress) in men. In women, neither tobacco type was significantly associated with allostatic load.

#### Newly Identified Studies

Two new studies were identified that examined the potential effects of snus use on other indicators of cardiovascular disease risk, including endothelial function (FMD) (Skaug et al. 2016) and cardiac output (Zandonai et al. 2016). Zandonai et al. (2016) conducted a double-blind, randomized crossover clinical trial in which 12 healthy male non-tobacco users used snus or a placebo during exercise. No significant difference between snus or snus placebo were observed for cardiac output (Zandonai et al. 2016).

Skaug et al. (2016) conducted a cross-sectional study involving 5,633 men and women from the HUNT Fitness study, a subset of participants from the third wave of the Nord-Trøndelag Health Study (HUNT3). The authors excluded participants with established cardiovascular disease, and the healthiest subset of the population self-selected into the study. The authors examined the potential relationship between exclusive snus use and endothelial function (flow mediated dilation: percent difference in vessel diameter) compared to non-users of tobacco. This relationship was also examined by physical activity level (i.e., recommended, not recommended) and aerobic capacity (i.e., low, high). Although the authors noted that “snuff-users had a clear tendency towards lower endothelial function compared to non-users,” there were no statistically significant differences in FMD between exclusive snuff users, including most subgroups (overall, recommended physical activity, high aerobic capacity, low aerobic capacity). The percent difference in vessel diameter was -0.83% (95% CI: -1.59, -0.06) lower in exclusive snuff users that did not attain the recommended physical activity level compared to non-users of tobacco (the only statistically significant result).

#### Quality Rating of all Studies

Study	Endpoint(s)	Evidence Quality Rating
-------	-------------	-------------------------

Bolinder et al. 1992	Cardiovascular/circulatory symptoms (breathlessness on slight effort, chest pain walking up hill, pain in the leg while walking, white finger symptoms)	Weak
Bolinder 1997	Atherogenic index	Weak
Bolinder et al. 1997a	Atherosclerotic indices (Wall thickness, lumen diameter, plaque %), Fibrinogen levels	Weak
Bolinder et al. 1997b	Oxygen uptake/work capacity	Moderate
Bolinder and de Faire 1998	Oxygen uptake/work capacity, low	Weak
Eliasson et al. 1991	Fibrinogen levels, white blood cell count	Weak
Eliasson et al. 1995	Fibrinogen levels	Weak
Gustafsson et al. 2011a	Allostatic load	Moderate
Hirsch et al. 1992	Maximum work load	Moderate
Rohani and Agewall 2004	Impaired endothelial function (flow-mediated dilatation)	Moderate
Skaug et al. 2016	Endothelial function: FMD	Weak
Wallenfeldt et al. 2001	Atherosclerosis, C-Reactive Protein	Excluded
Wennmalm et al. 1991	Thromboxane A2 production, Maximum work load	Weak
Zandonai et al. 2016	Cardiac output	Moderate

## Discussion and Conclusions

### *Biochemical or Physical Measures of Clotting*

The authors of four cross-sectional studies, rated as weak due largely to the study design, reported no differences between blood levels of biochemical measures of clotting (e.g., thromboxane A2 production, fibrinogen) between snus users and non-users of tobacco (Bolinder et al. 1997a; Eliasson et al. 1991; Eliasson et al. 1995; Wennmalm et al. 1991).

An experimental study, rated as moderate, suggests that acute use of Swedish snuff may be associated with endothelial dysfunction, though the study's authors do not describe the smoking status of the participants (Rohani and Agewall 2004). The results of a new cross-sectional study indicated no statistically significant differences in FMD between exclusive snuff users, including most subgroups (overall, recommended physical activity, high aerobic capacity, low aerobic capacity), except for those who do not engage in recommended physical activity levels.

Two cross-sectional analyses (also rated as weak) of a population of healthy male firefighters showed no significant difference between snus users and non-users of tobacco with respect to measurements

of carotid wall thickness, lumen diameter, or the presence of carotid plaques (Bolinder et al. 1997a) or an “atherogenic index” (Bolinder 1997).

Although most of the available studies on biochemical and physical measures of clotting were cross-sectional, the results indicate a consistent lack of a statistically significant difference in these measures between snus users and non-users of tobacco. Although some indication of a potential effect of snus use on endothelial function was reported in two studies discussed above, limitations of these studies preclude the ability to draw conclusions. However, endothelial dysfunction is believed to precede the development of atherosclerosis (Hadi et al. 2005). Given that no associations were reported between snus use and other biochemical components of atherogenesis (clotting factors), and no associations were reported between snus use and physical markers of atherosclerosis, the evidence overall is *limited/suggestive of no association* between snus use and biochemical and physical measures of clotting and atherosclerosis.

#### *Measures of Fitness: Oxygen Uptake, Work Capacity, Cardiac Output*

No statistically significant difference in work capacity or oxygen uptake was observed between snus users and non-users of tobacco in three cross-sectional studies (Bolinder et al. 1997b; Bolinder and de Faire 1998; Wennmalm et al. 1991) and one experimental study (Hirsch et al. 1992). A newly identified experimental study reported no differences in cardiac output during exercise following snus use, compared to placebo (Zandonai et al. 2016). Though the three cross-sectional studies were rated as weak, the results from these studies support those reported in the two experimental studies (rated as moderate). Based on these five studies, there is *limited/suggestive evidence of no association* between snus use and measures of fitness including oxygen uptake, work capacity, and cardiac output.

#### *White Blood Cell Count*

Eliasson et al. (1991) conducted a cross-sectional study, and compared levels of white blood cells in snus users with non-users of tobacco. An elevated white blood cell count is associated with an increased risk of cardiovascular events including coronary heart disease and ischemic stroke risk. Eliasson et al. (1991) reported white blood cell counts that were not statistically significantly different between the two groups. Because there is only a single study, which was rated as weak due largely to the cross-sectional study design, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and white blood cell count.

#### *Cardiovascular/circulatory symptoms*

The cross-sectional study conducted by Bolinder et al. (1992) was rated as weak, due to the cross-sectional design, and lack of control for any potentially confounding variables beyond age. Therefore, this study presents *inadequate/insufficient evidence to determine whether an association exists* between snus use and the cardiovascular/circulatory symptoms described by the authors including breathlessness on slight effort, chest pain walking up hill, pain in the leg while walking, and white finger symptoms.

#### *Allostatic Load*

In a prospective study of participants from the Northern Swedish Cohort, Gustafsson and colleagues (2011a) reported that snus use, which was investigated as a potential confounding variable with SES, was not associated with allostatic load. Overall, this single moderate study provides

*inadequate/insufficient evidence to determine whether an association exists between snus use and allostatic load.*

## **2.4.2 Chronic Cardiovascular Disease**

### **2.4.2.1 Heart disease**

#### Summary from 2013 ENVIRON Report

Twelve studies have evaluated the relationship between use of snus and various chronic cardiovascular diseases (CVDs). The following conclusions can be made about the use of snus and its possible effect on the risk of heart disease.

Most studies have not revealed an increased risk of myocardial infarction (MI) or an overall increased risk of CVD. A single study (Bolinder et al. 1994) found an increased risk only for fatal MI in an analysis of the Swedish Construction Worker cohort, and an analysis of heart failure among snus users controlled for smoking observed an increased risk especially in men ages 75 years and older (Arefalk et al. 2011). A large, pooled analysis, which pooled data from many of the major Scandinavian cohorts, confirmed previous findings that the use of snus is not associated with an increased risk of MI, and noted that slight increases in fatal MI may be explained by confounding (Hansson et al. 2012). Though there are known acute effects of nicotine on the cardiovascular system, no increased risk of cardiovascular disease has been detected epidemiologically, with the possible exception of a moderate increased risk of death due to a CV event. This increased risk of mortality due to a CV event among snus users has only been observed in the Construction Workers Cohort in Sweden (Bolinder et al. 1994).

#### Newly Identified Studies

Two new studies were identified that examined

Arefalk and colleagues (2014) followed a cohort of 20,911 MI patients who were admitted to a Swedish coronary care unit between 2005 and 2009 to investigate the effects of quitting snus on cardiovascular mortality and events. The population included 1,799 post-MI snus users and 675 post-MI snus quitters. The risk of cardiovascular events was reduced by over half (HR=0.38; 95% CI 0.11-1.32) and mortality due to cardiovascular events was similarly decreased (HR=0.56; 95% CI: 0.16-2.00), though these risk estimates were not statistically significant. In this model, covariates were adjusted for age, sex, past smoking, present sun exposure, occupation status, and participation in a cardiac rehabilitation program. This study presented some limitations, including a lack of analyses that included exclusive snus users due to the low number of exposed cases, as well as comparisons with never users of tobacco. In a letter to the editor, Rodu and Phillips (2015) noted that the mortality rate was higher among non-users compared to continuing snus users and snus quitters.

Hergens et al. (2014) examined the potential relationship between snus use and atrial fibrillation, using pooled data including 425 current exclusive snus users and 3,069 snus non-users from a total population of 127,907 Swedish males from seven prospective cohort studies. Study entry took place between 1978 and 2004, though follow-up information was not provided, and exposure assessment was unclear and likely done at a single timepoint for all cohorts. Compared with never-smoking non-current snus users, there was no elevated risk of atrial fibrillation in never-smoking current snus users

(HR=1.07; 95% CI: 0.97-1.19). However, this study design may have biased the results toward null due to the reference group including never-smoking former snus users.

#### Reviews and Meta-analyses of Heart Disease Due to Use of Snus

One systematic review and meta-analysis of the epidemiological literature on snus use and the potential effect on ischemic heart disease (IHD) was published since the 2013 ENVIRON report (Vidyasagaran et al. 2016), but only included studies detailed in the previous ENVIRON report. The search strategy included a wide geographic range for smokeless tobacco, but the risks of fatal and non-fatal IHD were reported separately for European studies, all of which were based in Sweden where snus is the conventional smokeless tobacco product used. Based on seven risk estimates from Sweden, the overall relative risk of IHD was 0.91 (95% CI: 0.83-1.01), and in contrast, the overall risk of IHD deaths was 1.38 (95% CI: 1.13-1.67) based on three risk estimates (Vidyasagaran et al. 2016). This elevated risk of IHD mortality was statistically significant ( $p=0.001$ ) in snus users with the referent group as non-users with adjustments for former smoking and excluding current smokers as each study required. The calculated combined risk of ischemic heart disease based on seven risk estimates from Sweden was not statistically significant ( $P=0.09$ ). This publication draws strength in its explicit review criteria excluding study designs not case-control nor cohort, as well as only including studies with effective control of confounding and thorough definitions of exposure and outcome. However, the authors were unable to adjust for alcohol consumption and other potential confounding effects including blood pressure, serum lipids, BMI, and diabetes.

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Arefalk et al. 2011	Heart failure	Moderate
Arefalk et al. 2014	Post-MI Cardiovascular events and mortality from cardiovascular events	Moderate
Bolinder et al. 1994	Cardiovascular disease and ischemic heart disease mortality	Moderate
Haglund et al. 2007	Fatal and nonfatal Ischemic heart disease	Moderate
Hansson et al. 2009	Ischemic heart disease; cardiovascular disease	Strong
Hergens et al. 2005	Nonfatal and fatal myocardial infarction	Moderate
Hergens et al. 2007	Nonfatal and fatal myocardial infarction, post-MI fatal cardiovascular disease	Strong
Hergens et al. 2014	Atrial fibrillation	Strong
Huhtasaari et al. 1992	Myocardial infarction	Moderate

Huhtasaari et al. 1999	Myocardial infarction, and fatal myocardial infarction alone	Moderate
Janzon and Hedblad 2009	First ever myocardial infarction or ischemic heart disease	Moderate
Johansson et al. 2005	Coronary heart disease	Moderate
Roosar et al. 2008	Cardiovascular death	Moderate
Wennberg et al. 2007	Myocardial infarction, fatal myocardial infarction within 28 days, sudden cardiac death with survival less than 24 hours and less than 1 hour	Moderate

### Discussion and Conclusion

Fourteen epidemiological studies were included in this examination on snus use and cardiovascular diseases and events: four case-control studies (Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Wennberg et al. 2007) and ten cohort studies (Arefalk et al. 2011; Arefalk et al. 2014; Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2009; Hergens et al. 2007; Hergens et al. 2014; Janzon and Hedblad 2009; Johansson et al. 2005; Roosar et al. 2008).

#### *Incident ischemic heart disease, myocardial infarction, and heart failure*

Of ten studies reported in eleven publications investigating incidence of ischemic heart disease, myocardial infarction (all cases or non-fatal), or heart failure, none reported evidence of an increased risk among snus users (Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Wennberg et al. 2007; Hergens et al. 2007; Janzon and Hedblad 2009; Johansson et al. 2005; Haglund et al. 2007; Hansson et al. 2009; Arefalk et al. 2011; Arefalk et al. 2014). Two studies by Huhtasaari and colleagues (1992, 1999) found no evidence of an increased risk of myocardial infarction with snus use in their population-based Northern Sweden case-control studies. Wennberg and colleagues (2007), reported a similar lack of risk of myocardial infarction compared to non-users of tobacco and Hergens et al. (2005) estimated a relative risk for first acute myocardial infarction among current snus users who had never smoked to be less than 1: 0.73 (95% CI 0.35-1.5). A cohort study followed 3,120 healthy men and examined the incidence of coronary heart disease over an average follow-up of 11.2 years (Johansson et al. 2005). Men who used snus daily but never smoked were not at a significantly increased risk of coronary heart disease after adjustment for age, physical activity, BMI, diabetes, and hypertension. A follow-up study with an expanded cohort also reported no statistically significant excess risk of ischemic heart disease (Haglund et al. 2007). Janzon and Hedblad (2009) conducted a population-based cohort study that included male and female residents, and reported no increased risk of first-ever myocardial infarction. Hansson et al. (2009) similarly reported no increased risk of incidence of ischemic heart disease among current or former snus users nor in heavy users (4 or more cans of snus per week) and longtime users (20 or more years of snus use). During follow-up of a cohort of snus-using patients admitted to a coronary care unit after a

myocardial infarction, the risk of cardiovascular events was nonsignificantly reduced by over half in those who quit snus at the start of the study (Arefalk et al. 2014). Using the Swedish Construction Worker Cohort and another community-based sample of elderly men, current snus use was not significantly associated with risk of heart failure in either cohort with full adjustment for covariates (Arefalk et al. 2011). Also using the Construction Workers Cohort, Hergens and colleagues (2007) observed no increased overall risk of myocardial infarction among snus users though they did find a and increased risk of fatal myocardial infarction (See section below: "Fatal myocardial infarction and/or sudden cardiac death").

Based on strong evidence of no association from two studies (Hansson et al. 2009; Hergens et al. 2007) and moderate evidence of no association from nine additional studies, there is *limited/suggestive evidence of no association* between snus use and incident ischemic heart disease, myocardial infarction, or heart failure.

#### *Fatal IHD, MI, and/or Sudden Cardiac Death*

Five studies investigated the association between snus use and fatal myocardial infarction and/or sudden cardiac death; two cohort studies reported evidence of a statistically significant association (Bolinder et al. 1994; Hergens et al. 2007) and four studies (two cohort and two case-control) did not (Haglund et al. 2007; Hergens et al. 2005; Huhtasaari et al. 1999; Wennberg et al. 2007). Hergens and colleagues (2007) extended the follow-up of Bolinder et al.'s (1994) Swedish construction workers cohort through 2003. Information on snus use was obtained from follow-up visits starting in 1978. The study presented strong evidence, with the relative risk for fatal myocardial infarction statistically significantly elevated among current snus users overall (RR=1.32; 95% CI: 1.08-1.61), and at the lowest and highest consumption levels investigated (of four). This increased risk at the highest consumption level was only evident in the older age group (age 55-65). Wennberg et al. (2007) reported that never-smoking snus users did not have an increased risk of either myocardial infarction or sudden cardiac death with survival less than 24 hours. A population-based case-control study in two Swedish counties reported a nonsignificantly elevated relative risk estimate (OR=1.7; 95% CI: 0.48-5.5) for fatal myocardial infarction among current snus users who had never smoked (Hergens et al. 2005).

Though most of the available studies suggest no association between snus use and fatal MI, two publications evaluating the same population reported an increased risk (Bolinder et al. 1994; Hergens et al. 2007). With one of these studies presenting strong evidence (Hergens et al. 2007), we concluded that there is *balanced/mixed evidence of an association* between snus use and fatal myocardial infarction or sudden cardiac death. However, given the clear lack of an association of snus with incident IHD or MI, it's unclear how use of Swedish snus could plausibly and directly cause an increase in the risk of fatal MI.

#### *Incident Cardiovascular Disease*

A single study conducted by Hansson et al. (2009) presented strong evidence of no association between never-smoking current snus use and incident cardiovascular disease (RR=1.00; 95% CI: 0.69-1.46). Statistically significant increased risks were also not observed in heavy users (4 or more cans of snus per week) or longtime users (20 or more years of snus use). Based on this evidence, we concluded that there is *limited/suggestive evidence of no association* between snus use and incident CVD.



### *Fatal Cardiovascular Disease*

Four studies investigated the potential relationship between snus use and fatal cardiovascular disease (CVD). Two Swedish population-based cohort studies did not report a statistically significant association with snus use (Roosaar et al. 2008; Arefalk et al. 2014), and two studies of participants from the Swedish Construction Worker cohort did report an association (Bolinder et al. 1994; Hergens et al. 2007). Bolinder et al. (1994) reported increased risks of death from all cardiovascular diseases in the overall cohort, among smokeless tobacco users aged 35-45 years, but not among older participants aged 55-65 years. Hergens et al. (2007) conducted an expanded follow-up of this cohort, and reported that snuff users that had previously experienced a non-fatal MI during follow-up had a statistically significant increased risk of death from cardiovascular disease compared with never-tobacco users (RR=1.55; 95% CI: 1.19–2.01). Misclassification of exposure and bias toward the null are concerns in cohort studies with long or unclear follow-up, as tobacco use as well as other lifestyle habits can change over the years. In contrast to Hergens et al. (2007), Arefalk et al. (2014) followed coronary center patients post-MI, and reported a nearly halved risk of mortality due to cardiovascular events in those who quit snus compared with those who continued to use snus, though this finding was not statistically significant (Arefalk et al. 2014). Roosaar et al. (2008) did not observe a statistically significant increased risk of cardiovascular death among snus users.

Based on moderate evidence of no association from two population-based studies (Roosaar et al. 2008; Arefalk et al. 2014), and two studies involving the Swedish Construction Worker cohort presenting moderate (Bolinder et al. 1994) and strong (Hergens et al. 2007) evidence of an association between snus use and fatal CVD or fatal CVD post-MI, we concluded that there *balanced/mixed evidence of an association* between snus use and fatal CVD. However, as with fatal IHD/MI, given the clear lack of an association of snus with incident CVD, it's unclear how use of Swedish snus could plausibly and directly cause an increase in the risk of fatal CVD.

### *Atrial Fibrillation*

One cohort study examined the association between snus use and atrial fibrillation and reported no evidence of an increase or decrease in risk when snus users were compared with never smoking, non-current snus users (Hergens et al. 2014). Even when snus users were stratified by never-smoker, current smoker, and former smoker, the study authors observed no association between snus use and atrial fibrillation. Age, BMI, and education were assessed as covariates, and made no difference in the final risk estimates. This study was strong in its large sample size and pooled cohort design, but limited in that exposure assessment of snus use was done at a single timepoint leading to potential non-differential misclassification of exposure and possible bias toward the null.

Based on this single publication presenting strong evidence, there is *limited/suggestive evidence of no association* between snus use and atrial fibrillation.

## **2.4.2.2 Stroke**

### Summary from 2013 ENVIRON Report

Seven analytic studies (two case-control and five cohort) were identified that examined the relationship between snus and risk of stroke. Males only were studied in all but two studies (Janzon and Hedblad 2009; Koskinen and Blomstedt 2006), though the study by Janzon and Hedblad had too few female snus users to report risk estimates. Thus, the findings from the studies are applicable

generally only to males. None of the studies found an increased risk of all stroke types combined among current or former snus users. No association between hemorrhagic stroke and snus use was observed in the two studies that examined this stroke type (Hergens et al. 2008b; Koskinen and Blomstedt 2006). In one study that examined ischemic stroke, an increased risk of ischemic stroke was observed among snus users, however, in this study, no dose-response relationship with ischemic stroke was observed, and analyses of this cohort have often produced significant findings where other studies have not (Hergens et al. 2008b). In the study by Hansson et al. (2009), the dose-response analysis was suggestive of a higher overall stroke risk for snuff users using four or more cans per week, but this finding was not statistically significant.

#### Newly Identified Studies

Hansson and colleagues (2014) examined the association between different types of snus use and stroke in a pooled cohort (the Swedish Collaboration on Health Effects of Snus Use) of 130,485 men who had never smoked in eight prospective cohort studies with follow-up ranging from 5 to 29 years. The vast majority of study participants, and stroke cases came from the Swedish Construction Worker cohort, at 99,308. The authors reported no statistically significant association between snus use and incident stroke. The hazard ratios after adjustment for age and BMI for first ever stroke in current snus users and former snus users with the referent group of never-users were 1.01 (95% CI: 0.89-1.14) and 0.88 (95% CI: 0.64-1.22), respectively. Similarly, no association was observed between current snus use unspecified stroke after adjustment for age and BMI, compared to noncurrent snus users (HR=1.1; 95% CI: 0.78-1.54). The association between 28-day case fatality for overall stroke in current snus users compared with never tobacco users, after adjusting for age, BMI, and year of diagnosis was not statistically significantly increased (1.42; 95% CI: 0.99-2.04). Hansson and colleagues (2014) also examined first ever stroke, ischemic stroke, hemorrhagic stroke, and unspecified stroke in snus users stratified by frequency of use (<4, 4-6, 7+ cans per week) and duration of use (<20 years and 20 or more years) compared with noncurrent snus users. The associations were not statistically significant, and the hazard ratios were close to 1. The authors reported a statistically significant elevated risk in mortality due to first-ever stroke and hemorrhagic stroke in current snus users compared with noncurrent snus users: HR=1.32 (95% CI: 1.08-1.61) and 1.76 (95% CI: 1.16-2.67), respectively, while a borderline-significant association was reported for ischemic stroke mortality (HR=1.29; 95% CI: 1.00-1.67). These three analyses were adjusted for age, BMI, and year of diagnosis, but the number of exposed cases were not provided. The authors further noted, however, that after exclusion of participants from the Construction Worker Cohort, the statistically significant associations between snus use and stroke mortality did not persist. The analyses of incident stroke types were rated as strong. The mortality analyses were rated as moderate, given that no information was provided on the number of exposed cases, and all reference groups included former snus users. Confidence intervals were also less precise, and the findings were largely driven by data from a single cohort (Construction Worker).

#### Reviews and Meta-analyses of Stroke Due to Use of Snus

One systematic review and meta-analysis (described previously in Section 2.4.2.1) of the epidemiological literature on snus use and the potential effect on stroke was published since the 2013 ENVIRON report (Vidyasagan et al. 2016). Based on four risk estimates from Sweden, the overall relative risk of non-fatal stroke was 1.01 (95% CI: 0.90-1.13), and the overall risk of fatal stroke was 1.28 (95% CI: 0.98-1.68) based on three risk estimates (Vidyasagan et al. 2016). This elevated risk was not statistically significant ( $P<0.07$ ) in never-smoking snus users with the referent group of

never-users of tobacco. This publication draws strength in its explicit review criteria excluding study designs not case-control nor cohort, as well as only including studies with effective control of confounding and thorough clear and relevant definitions of exposure and outcome. However, the authors were unable to adjust for alcohol consumption and other potential confounding effects including blood pressure, serum lipids, BMI, and diabetes.

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Asplund et al. 2003	First ever fatal or nonfatal stroke (combined)	Moderate
Bolinder et al. 1994	Stroke mortality	Moderate
Haglund et al. 2007	Fatal stroke; nonfatal stroke	Moderate
Hansson et al. 2009	Incident stroke	Strong
Hansson et al. 2014	First ever: All types (fatal and nonfatal); 28-day case fatality for all types; ischemic (fatal and nonfatal); Hemorrhagic stroke (fatal and nonfatal)	Strong (incident) Moderate (mortality)
Hergens et al. 2008b	All types (all, fatal, and nonfatal); ischemic (all, fatal, and nonfatal); hemorrhagic (all, fatal, and nonfatal), unspecified (all, fatal, and nonfatal)	Moderate
Janzon and Hedblad 2009	Incident stroke	Moderate
Koskinen and Blomstedt 2006	Subarachnoid hemorrhage	Weak

#### Discussion and Conclusions

Eight epidemiological studies were included in this evaluation of snus use and stroke incidence and fatalities: two case-control studies (Asplund et al. 2003; Koskinen and Blomstedt 2006) and six cohort studies (Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2008b; Janzon and Hedblad 2009). One study of a cohort of Swedish construction workers reported a statistically significant association between current snus use and fatal ischemic stroke (Hergens et al. 2008b). A large pooled cohort study of Swedish men showed a statistically significant elevated risk of fatal first-time stroke of all types, and hemorrhagic stroke, but not ischemic stroke in current snus users compared with noncurrent snus users (Hansson et al. 2014). However, other analyses conducted in this study comparing the stroke incidence in snus users and never tobacco users reported no statistically significant associations, and no dose- or duration-response effect of

snus use was observed for all stroke types combined, and subtypes (ischemic, hemorrhagic unspecified) (Hansson et al. 2014). Some limitations of this pooled cohort study include potential misclassification bias due to snus exposure measured only at baseline, and confounding from having former snus users in the referent group for some of the analyses (Hansson et al. 2014). Collectively, the other six studies identified in this review of snus use and stroke reported no evidence of an elevated risk of stroke or stroke fatality with snus use, even after adjustment for a variety of covariates. A recent review (Vidyasagaran et al. 2016) reported a no statistically significant overall risk of fatal or nonfatal stroke in snus users compared with non-users, which is consistent with findings of other meta-analyses conducted previously (Boffetta and Straif 2009; Lee 2007; Lee 2011).

Based on consistent observations of no increased risk of stroke incidence among one strong and several moderate studies, there is *limited/suggestive evidence of no association* between snus use and incident stroke, including the subtypes: ischemic and hemorrhagic.

Based on inconsistent findings related to fatal stroke, including the subtypes: hemorrhagic and ischemic, the available studies currently provide *balanced/mixed evidence for whether an association exists* between snus use and fatal stroke and its subtypes. However, as with fatal CVD and MI/IHD, given the clear lack of an association of snus with incident stroke, it's unclear how use of Swedish snus could plausibly and directly cause an increase in the risk of fatal stroke.

## **2.5 Metabolic Effects**

### **2.5.1 Insulin Resistance and Type 2 Diabetes**

#### **2.5.1.1 Insulin Resistance or Impaired Glucose Tolerance**

##### Summary from 2013 ENVIRON Report

The relationship between snus use and insulin resistance or impaired glucose tolerance was examined in five descriptive studies of risk factors for cardiovascular disease (Bolinder 1997; Eliasson et al. 1991; Eliasson et al. 1995; Persson et al. 2000; Wallenfeldt et al. 2001), one experimental study (Attvall et al. 1993), and two cohort studies (Eliasson et al. 2004; Norberg et al. 2006). Seven of the eight studies found no statistically significant associations between snus use and impaired insulin or glucose tolerance, including two studies that examined the association by the amount of snus used (Norberg et al. 2006; Persson et al. 2000).

One cross-sectional study (Eliasson et al. 1991) suggested that serum insulin levels may be somewhat higher in snus users compared to non-users of tobacco, though this study was also unclear in how the analysis was conducted. For this study (Eliasson et al. 1991) and other cross-sectional studies (Bolinder 1997, Eliasson et al. 1995, Persson et al. 2000), it is not possible to determine whether the snus use preceded or followed the observed effects on the insulin and glucose of the participants. Most the studies investigating snus use and insulin resistance or impaired glucose tolerance support the conclusion that snus use is not associated with measures of insulin resistance or glucose impairment.

##### Newly Identified Studies

Four studies of varying designs that examined the relationship between snus use and insulin resistance or glucose intolerance were published since the 2013 ENVIRON report (Bjorkman et al. 2017; Byhamre et al. 2017; Overland et al. 2013; Neumann et al. 2013). Bjorkman and colleagues

(2017) conducted a randomized controlled trial (details described previously in Section 2.4.1.1.) wherein the resting blood glucose and resting insulin measurements of 11 regular snus users who stopped using for over 6 weeks were compared with those of 10 regular snus users who served as controls. Neither the blood glucose (p-value not reported) nor the insulin measurements ( $p=0.093$ ) were statistically significantly different between the cessation group and the continued use groups (Bjorkman et al. 2017). Per interaction and time effects from a RM ANOVA, insulin values were significantly higher post-test; however post-hoc analysis attributed this result to one individual with an extremely high post-snus cessation insulin measurement (Bjorkman et al. 2017).

A cohort study of students in Sweden who were followed from 1981 to 2008 (previously described) reported no statistically significant associations between snus use and impaired fasting glucose or type 2 diabetes at any of four follow-up times (age 16, 21, 30, or 43) (Byhamre et al. 2017) when comparing never-smoking snus users with never-users of tobacco. The exposed group consisted of snus users who never smoked but was relatively small in number. At age 16, the risk estimate of having impaired fasting glucose or type 2 diabetes was 1.08 (95% CI: 0.59-1.97) and at follow-up at age 21 and 30, the risk estimates were similar: age 21 OR 1.28 (95% CI: 0.63-2.62), age 30 OR 1.01 (95% CI: 0.48-2.11). The odds ratio of having impaired fasting glucose or type 2 diabetes was lower for those followed until age 43, but not statistically significant: OR 0.38 (95% CI: 0.12-1.16) (Byhamre et al. 2017). In addition to the small number of individuals exclusively using snus used in the analyses, there is a possibility of residual confounding from changes in other variables over time that were not accounted for.

A larger cohort study of almost 30,000 adults aged 30, 40, or 50 in Sweden were examined in 1990-1999, and followed-up 10 years later as part of the Vasterbotten Intervention Program (VIP) (Neumann et al. 2013). The primary endpoint investigated was the progression of normal glucose tolerance to impaired fasting glucose, or to impaired fasting glucose and impaired glucose tolerance in snus users compared with those who were not currently using snus. After adjusting for a variety of covariates including sex, age, smoking, physical activity, BMI, blood pressure, and diet, the risk estimates were not statistically significant between groups. The odds ratio for having progressed from normal glucose tolerance to impaired fasting glucose was 0.92 (95% CI: 0.82-1.03), and the odds ratio for having progressed from normal to impaired fasting glucose and impaired glucose tolerance was 0.79 (95% CI: 0.59-1.05) (Neumann et al. 2013). Two of the limitations of this cohort study (Neumann et al. 2013) were that the snus exposure was only measured at baseline indicating possible misclassification of exposure due to potential changes in habits during follow-up, and that no comparisons were made with an exclusive snus-user group.

One cross-sectional study previously described in Section 2.4 investigating snus use and the effect on non-fasting glucose reported findings stratified by frequency of snus use and smoking habits (Overland et al. 2013). Overland and colleagues (2013) examined 849 exclusive snus users, 1214 daily snus users, 941 sometimes snus users, and 1265 previous snus users separately and concluded that, when compared with never snus users in linear regression analyses, there were no statistically significant associations with non-fasting glucose measurements: previous snus use  $b=0.7$  (95% CI: -0.44, 1.85), sometimes snus use 1.01 (95% CI: -0.3, 2.32), daily snus use -0.51 (95% CI: -1.68, 0.66), extensive snus use -1.31 (95% CI: -2.7, 0.08). The analyses were adjusted for age, smoking, gender, education, physical exercise, and frequency of alcohol use. A major limitation of this study,

aside from the inherent limits of the cross-sectional design, was selection bias: the participation rate was 53%, and even lower in younger participants.

#### Quality Rating of All Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Bolinder 1997	Weak
Eliasson et al. 1991	Weak
Eliasson et al. 1995	Weak
Wallenfeldt et al. 2001	Weak
Attvall et al. 1993	Strong
Eliasson et al. 2004	Moderate
Norberg et al. 2006	Weak
Persson et al. 2000	Weak
Bjorkman et al. 2017	Strong
Byhamre et al. 2017	Moderate
Overland et al. 2013	Weak
Neumann et al. 2013	Moderate

#### Discussion and Conclusions

Twelve publications were included in this investigation of snus use and effects on insulin resistance and glucose intolerance: two experimental studies (Attvall et al. 1993; Bjorkman et al. 2017), four cohort studies (Eliasson et al. 2004; Norberg et al. 2006; Byhamre et al. 2017; Neumann et al. 2013), and five cross-sectional studies (Bolinder 1997; Eliasson et al. 1991; Eliasson et al. 1995; Wallenfeldt et al. 2001; Persson et al. 2000; Overland et al. 2013). Of these studies, only one cross-sectional study (Eliasson et al. 1991) reported evidence suggesting that insulin levels may be higher in snus users compared to those who do not use tobacco. This study was limited in that it was not possible to determine whether snus use preceded or followed the observed increase in insulin and that the analysis did not adjust for diet and lifestyle factors that could influence insulin levels.

Each study included in this section was limited in its final conclusions regarding the effects of snus on insulin and glucose in the body as measured in a group of participants. For example, Overland and colleagues (2013) reported cross-sectional analyses using a population-based group, but the participation rate was low and suggested possible selection bias. The two experimental studies (Attvall et al. 1993, Bjorkman et al. 2017) were limited in sample size and follow-up, and Attvall and colleagues (1993) did not evaluate snus use without excluding the potential impact of smoking. Some of the limitations of the cohort studies were potential confounding from current or past concurrent smoking (Norberg et al. 2006), limited power due to small numbers of exposed individuals (Byhamre et al. 2017), and possible misclassification of exposure due to long follow-up without reassessment of habits after baseline (Neumann et al. 2013). However, based on consistent findings of no association

among most of the studies, including all three rated as moderate in quality, there is *limited/suggestive evidence of no association* between snus use and insulin resistance and glucose intolerance.

### **2.5.1.2 Diabetes**

#### Summary from 2013 ENVIRON Report

Five studies of varying designs have evaluated the relationship between Swedish snus use and type 2 diabetes (Eliasson et al. 2004, Ostenson et al. 2012, Hergens et al. 2005, Wandell et al. 2008, Persson et al. 2000). Conclusions regarding the association between snus use and diabetes were inconsistent.

Eliasson and colleagues (2004) report a population-based cross-sectional study with prospective follow-up providing odds ratios of prevalence and incidence. At study entry, the prevalence of diabetes was significantly higher among smokers compared to never-tobacco users, but the prevalence was not significantly elevated among snus users. Furthermore, no cases of diabetes developed (incidence) among consistent exclusive snus users, but odds ratios for incidence of diabetes associated with exclusive smokers or ex-smokers were significantly elevated compared to non-tobacco users regardless of adjustment for confounders. Another prospective study (Ostenson et al. 2012) found that snus use was associated with type 2 diabetes after adjustment for smoking, while a significant association was not observed among never-smoking snus users.

The population-based cross-sectional study (Wandell et al. 2008) examined the effect of snus use and smoking on risk of diabetes among 1,859 men aged 60 years. Wandell and colleagues (2008) reported that the prevalence of newly diagnosed diabetes was not significantly elevated among any category of snus use based on 78 participants diagnosed with diabetes. The only risk factors found to be associated with newly diagnosed diabetes were waist size and high alcohol consumption. The second cross-sectional study included 8,128 Swedish men, half of whom had a family history a diabetes (Persson et al. 2000). The authors found that exclusive-snus users had approximately a four-fold increased prevalence of type 2 diabetes compared to never-users of tobacco (OR 3.9; 95% CI: 1.1 – 14.3), based on four cases of diabetes among snus users (Persson et al. 2000). Hergens and colleagues (2005) conducted a cross-sectional analysis of the odds for having diabetes among the controls that participated in their population-based case-control study, which was 1.5 (95% CI: 0.76 – 2.9), based on six cases.

#### Newly Identified Studies

Three studies investigating the association between Swedish snus use and type 2 diabetes were published since the 2013 ENVIRON report (Byhamre et al. 2017, Carlson et al. 2017, Rasouli et al. 2017). One study also examined the association of snus use and incident latent autoimmune diabetes of adulthood (LADA) (Rasouli et al. 2017).

A cohort of students (described in Section 2.4.1.1) from the Swedish municipality of Lulea who attended 9<sup>th</sup> grade in 1981 were followed until 2008 (n=1,001) and assessed for risk of metabolic syndrome and its components including impaired fasting glucose and type 2 diabetes (Byhamre et al. 2017). The authors concluded that snus exposure in different life periods and cumulative snus exposure from age 16 to 43 were not associated with developing impaired fasting glucose or type 2 diabetes at or before age 43, with adjustment for covariates such as sex, cumulative smoking, BMI and SES at 16 years of age, family history of diabetes, and alcohol use and physical activity at 43

years of age (Byhamre et al. 2017). The exposed group consisted of snus users who never smoked at different ages, and the referent group included never-users of tobacco (Byhamre et al. 2017).

Carlsson and colleagues (2017) reported on a pooled set of five Swedish cohort studies lasting between 1991 and 2013. There was a total of 248 incident type 2 diabetes cases among current snus users and 118 cases among former users. Compared to never-tobacco users, current snus users had a borderline significant risk of having type 2 diabetes (HR=1.15; 95% CI: 1.00–1.32), after adjustment for age, calendar time, BMI, physical activity, level of education and alcohol consumption. Former snus users did not have a significant risk of developing the disease (HR=0.86; 95% CI: 0.71–1.05). The authors explored dose-response effect of snus use by stratifying by number of boxes consumed per week in current snus users: 1-2 boxes, 3-4 boxes, 5-6 boxes, 7 or more boxes, and 1-4 boxes or 4 or more boxes per week. There was a statistically significant elevated risk of incident type 2 diabetes in the group who used 5-6 boxes in a week (HR=1.42; 95% CI: 1.07–1.87) and the group who used 4 or more boxes per week (HR 1.43; 95% CI 1.15–1.79). When examining the relationship between duration of snus use and incident diabetes among current users, those with less than 30 years of snus use had a statistically significant elevated risk of having type 2 diabetes (HR=1.34; 95% CI: 1.03 – 1.73). The hazard ratio reported for those with 30 or more years of snus use was not statistically significant (HR=1.17; 95% CI: 0.98–1.39). The authors concluded that high snus consumption increases the risk of developing type 2 diabetes (Carlson et al. 2017).

The third study analyzed incident cases of type 2 diabetes (n=724), and cases of latent autoimmune diabetes of adulthood (LADA) (n=200) along with 699 population-based controls from ANDIS/ANDIU (All New Diabetes in Scania and Uppsala) and ESTRID (epidemiological study of risk factors for LADA and Type 2 diabetes), a sub-study of ANDIS (Rasouli et al. 2017). In addition to this case-control study based on the large-scale register of ANDIS/ANDIU, Rasouli and colleagues (2017) included cross-sectional analyses of HUNT3, a large Norwegian population-based survey performed between 2006 and 2008 that included information of snus use in participants 20 years of age or older (n=21,473 men). In both studies, the prevalence of ever-snus use was around 30% (HUNT (Norway): 28%; ESTRID (Sweden): 30%). Rasouli and colleagues (2017) reported no association between snus use and type 2 diabetes in either study: the odds ratios were 0.96 (95% CI: 0.67–1.37) and 0.91 (95% CI: 0.75–1.10) in Sweden and in Norway, respectively. When analyses were restricted to high snus consumers that were never-smokers, snus use was still not found to be associated with type 2 diabetes. After adjusting for educational level, alcohol consumption, and physical activity in Sweden, the risk for type 2 diabetes in snus users (using 10 or more boxes per year) remained similar: OR=1.02 (95% CI: 0.46–2.26). When investigating the association between LADA and snus use, analyses of the Swedish data yielded an odds ratio of 0.67 (95% CI: 0.24–1.86) among those using five or more boxes per week and 1.01 (95% CI: 0.45–2.29) among those with 10 or more box-years (consuming one box per day for a year). Using the Swedish data, the authors concluded that ever-smokers had an increased risk of type 2 diabetes (OR=1.59; 95% CI: 1.16–2.18) and in heavy smokers the risk was even greater (OR 2.20; 95% CI 1.40 – 3.45). Similar findings were reported in the Norwegian study: in only smokers, the risk for type 2 diabetes in smokers was 1.63 (95% CI: 1.36–1.96).

#### Quality Rating of All Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Eliasson et al. 2004	Weak



Ostenson et al. 2012	Moderate
Persson et al. 2000	Weak
Hergens et al. 2005	Weak
Wandell et al. 2008	Weak
Byhamre et al. 2017	Moderate
Carlsson et al. 2017	Strong
Rasouli et al. 2017	Moderate

### Discussion and Conclusions

The eight studies reporting on the association between snus use and diabetes present conflicting conclusions (Byhamre et al. 2017; Carlsson et al. 2017; Eliasson et al. 2004; Hergens et al. 2005; Ostenson et al. 2012; Persson et al. 2000; Rasouli et al. 2017; Wandell et al. 2008). In a cross-sectional study, Wandell and colleagues (2008) reported that the only risk factors associated with newly diagnosed diabetes in their study of 60-year-old men were waist size and high alcohol consumption. Though this study was population-based and the prevalence of smokers and snus users in the cohort was comparable to the general Swedish population of the same age, one cannot effectively determine causality, as disease and exposure are measured simultaneously. Furthermore, the power to detect a potential association was low, evidenced by limited sample size and imprecise confidence intervals (Wandell et al. 2008). In contrast, Persson et al. (2000) included over 8,000 Swedish men in their study and found approximately a four-fold increased prevalence of type 2 diabetes in exclusive-snus users compared to never-users of tobacco. However, this was based on only four cases of type 2 diabetes in snus users. A cross-sectional analysis of the odds for having diabetes among the controls that participated in a population-based case-control study was not statistically significantly increased among snus users (Hergens et al. 2005).

Eliasson et al. (2004) reported no increased prevalence of diabetes among snus users, with no cases of diabetes observed in a follow-up study. This was based on data from over 3,300 men in Sweden, with adjustment for age and waist circumference (prevalence odds ratios). The findings in this study are limited due to the small number of diabetes cases. Ostenson et al. 2012 reported an association between diabetes and snus use in an analysis of snus users adjusted for smoking, but no significant association in never-smoking snus users. However, Ostenson and colleagues (2012) did not adjust for dietary confounders, the tobacco use and disease was self-reported at a single point in time rather than accounting for disease developing gradually over time. Furthermore, the study was not truly prospective in design; participants who were free of type 2 diabetes at baseline but diagnosed prior to the follow-up exam were not considered in the study.

Published after the 2013 ENVIRON report were two cohort studies: one concluded that there was no association between risk of type 2 diabetes or impaired fasting glucose with snus use (Byhamre et al. 2017) and the other reported that high snus consumption does have an association with developing type 2 diabetes (Carlsson et al. 2017). Both studies had their own limitations. Byhamre and colleagues' (2017) study followed about 1,000 Swedish teens until age 43, but there were only 37 exclusive-snus users at study-end follow-up. The study (Byhamre et al. 2017) adjusted for sex, cumulative smoking, BMI and SES at 16 years, family history, alcohol consumption and physical activity at 43 years, but confounding from changes over time, including socioeconomic status and

fluctuating tobacco habits was a possibility. Carlsson and colleagues (2017) pooled several cohort studies together, with diabetes incidence not assessed uniformly across studies, leading to possible underreporting and undiagnosed cases. Lastly, Rasouli and colleagues (2017) reported on two epidemiology studies in Sweden and Norway, concluding no association between snus use and diabetes or LADA, though there was a small number of diabetes cases among never-smokers (Rasouli et al. 2017).

Based on the conflicting findings of eight epidemiology studies with varying limitations, there is *balanced/mixed evidence for whether an association exists* between snus use and diabetes.

## **2.5.2 Metabolic Syndrome**

### Summary from 2013 ENVIRON Report

Three epidemiology studies investigated the relationship between use of snus and metabolic syndrome (MetSy) (Norberg et al. 2006, Wandell et al. 2008, Gustafsson et al. 2011). One follow-up study suggests that MetSy may be associated with heavy use of snus while the two other studies did not find an association between MetSy and use of snus.

Using data from a population-based longitudinal study of 16,492 adults in Sweden, Norberg and colleagues (2006) found that heavy snus consumption (more than four cans per week) was associated with increased risk of having developed MetSy 10 years later (OR=1.6; 95% CI: 1.26-2.15). Low education, physical inactivity, and former smoking were all associated with increased risk of MetSy after 10 years of follow up. However, the use of four or fewer cans of snus per week was not associated with developing MetSy. Snus use was associated with some individual elements of MetSy (high triglycerides and obesity) but not others (impaired glucose regulation, low HDL cholesterol, and hypertension). A conclusion about temporality of lifestyle habits and disease cannot be made because the study included those with MetSy at baseline. Furthermore, tobacco habits were only assessed at the start of the study, and habits likely changed during the 10-year follow-up period.

The population-based cross-sectional study by Wandell et al. (2008) mentioned previously also examined the effect of snus use and smoking on risk of MetSy among 1,859 men 60 years of age. The prevalence of MetSy was not significantly elevated among any category of snus users (formerly smoking current snus users, former snus users, current snus users, current dual users, and low and high consumption of snus). The number of snus users was low, thus limiting the power of this cross-sectional study (Wandell et al. 2008).

Gustafsson and colleagues (2011b) analyzed data from a Swedish prospective cohort study that enrolled 1,071 participants at age 16. Snus use was assessed at age 43 and, after adjusting for socioeconomic status, smoking, alcohol use, blood pressure, and BMI, it was not a significant independent contributor to the development of MetSy.

### Newly Identified Studies

Since the 2013 ENVIRON report, one study was published investigating the association between snus use and the risk of MetSy (Byhamre et al. 2017). This cohort study enrolled all students who attained 9<sup>th</sup> grade in 1981 in the Swedish municipality of Lulea and followed them until they were 43 years old. 1,001 (94% of those still alive who enrolled in 1981) participants were a part of follow-up in 2008. Byhamre and colleagues (2017) evaluated the cohort at four ages: 16, 21, 30, and 43, and cumulative

snus use was defined as the number of life periods (1-4 corresponding to the periods between the ages at follow-up) with current snus use. After adjusting for sex, cumulative smoking, BMI, and SES at 16 years, family history of diabetes, alcohol consumption and physical exercise at 43 years, the authors concluded no association between MetSy at 43 years old and exclusive snus use at any of the four ages evaluated in the study (odds ratios ranged from 0.95 and 1.15, with confidence intervals ranging from around 0.5 to 2) with never-users of tobacco as the referent group. Furthermore, cumulative snus exposure during any of the life periods (odds ratios for all four periods hovered around 1 and were not statistically significant) and from age 16 through 43 was not associated with developing of MetSy at age 43 (Byhamre et al. 2017), though these calculations included smokers.

This study was limited in its follow-up, as MetSy risk factors may develop later in life than age 43. Though the cohort was relatively large at over 1000 participants at study end, it lacked power due to the small numbers of exclusive snus users and residual confounding from changes in other variables over time is possible. Overall, the study by Byhamre et al. (2017) supports the conclusion that snus use is unlikely to have an association with the development of MetSy.

#### Quality Rating of All Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Byhamre et al. 2017	Moderate
Gustafsson et al. 2011b	Moderate
Norberg et al. 2006	Weak
Wandell et al. 2008	Weak

#### Discussion and Conclusions

Three of the four epidemiology studies (Byhamre et al. 2017, Gustafsson et al. 2011b, Norberg et al. 2006, Wandell et al. 2008) exploring the association between MetSy and snus use identified in this report presented little evidence of a relationship between snus use and MetSy. The largest of the cohort studies (Norberg et al. 2006) reported that snus use of more than 4 cans per week was associated with risk of MetSy 10 years later at follow-up. Though this study is strong in its size and population-based design, the cohort included those with MetSy at baseline and only evaluated snus use at baseline when habits may have changed over the 10 years of follow-up. Gustafsson et al. (2011) and Byhamre et al. (2017) conducted studies using the same cohort of 16-year-olds that were followed until age 43. Both publications concluded no association between MetSy and snus use, though a major limitation of this cohort data is that risk factors for MetSy may manifest later in life than age 43. However, the cross-sectional study of 60-year-old men in Sweden (Wandell et al. 2008) similarly did not find a higher prevalence of MetSy in those who used snus.

Given that three of the four studies identified found no evidence of a relationship between snus use and the risk of metabolic syndrome, including two of moderate quality, there is *limited/suggestive evidence of no association* between snus use and MetSy.

### 2.5.3 Body Weight

#### Summary from 2013 ENVIRON Report

Numerous cross-sectional and prospective studies have examined the issue of body weight and obesity in association with snus and cigarette smoking. Among studies that controlled for past and current smoking, six of the seven found that BMI of snus users were no different than nontobacco users (Aro et al. 2010; Bolinder et al. 1997a (among younger snus users only); Bolinder et al. 1992; Engstrom et al. 2010; Rodu et al. 2004 (prospective analysis only); Sundbeck et al. 2009), while Hansson et al. (2011) observed that snus users were more likely to gain weight or become obese compared to non-users of tobacco, but not among those who took up snus during the follow-up period. Additionally, Rodu et al. (2004) reported a significantly higher BMI of snus users compared to non-users of tobacco in a cross-sectional analysis and Bolinder et al. (1992) reported a higher BMI among those older than 35 years of age. Two of the studies that looked only at exclusive snus users also reported that the waist-to-hip ratio (WHR) of snus users was not different from non-users of tobacco, in contrast to the known relationship between smoking and central adiposity (Audrain-McGovern and Benowitz 2011; Chiolero et al. 2008). Another nearly consistent finding is that former smokers had a higher BMI compared to non-users of tobacco (Aro et al. 2010 (not significantly higher compared to non-users of tobacco but higher than current smokers); Sundbeck et al. 2009) or smokers who quit during follow-up gained weight (Hansson et al. 2011; Rodu et al. 2004; Sundbeck et al. 2009). Weight gain among smokers who quit complicates the relationship between snus and weight gain as snus is often used as a smoking cessation aid so it is therefore difficult to examine the expected contribution of smoking cessation to weight gain independently from any potential contribution of snus use.

The following conclusions can be made about use of snus and body weight:

- There is some evidence that suggests snus may be associated with higher BMI or weight gain, among studies that control for past and current smoking. However, overall, the results are mixed.
- Though the results of the two prospective cohort studies that eliminated the effect that smoking (especially former smoking) has on body weight are contradictory, neither reported an increased risk of becoming overweight or obese among non-tobacco users who began using snus during the follow-up period.

A mechanism of how snus could influence body weight remains to be elucidated. None of the studies investigated the relationship between snuff use and total energy intake, a potential confounder. Though a possible association may exist, additional investigations that account for past smoking, energy intake, and other relevant lifestyle behaviors, and that examine the potential effect of snus on metabolism would help clarify the role of snus, if any, on body weight.

#### Newly Identified Studies

Since publication of the 2013 ENVIRON report, four epidemiological studies examining the relationship between snus use and body weight were published (Bjorkman et al. 2017; Byhamre et al. 2017; Overland et al. 2013; Varga et al. 2013).

Bjorkman et al. (2017), described previously, ran a controlled experiment where 24 snus users of more than two years of daily snus use were tested for cardiovascular risk factors including BMI and body weight before and after six weeks or more following snus cessation. Eleven snus users, also with

more than two years of daily snus use, served as controls and maintained normal habits. Over the snus cessation period, mean body mass in kilograms increased significantly in both groups (snus cessation group:  $1.4 \pm 1.7$ ; control group:  $0.5 \pm 1.1$ ), but between groups, the increase was not statistically significant. There was very little change in BMI from baseline to end of snus cessation in both groups (Bjorkman et al. 2017).

A prospective cohort study, previously described, of sixteen-year-olds from Lulea, Sweden followed through age 43 (Byhamre et al. 2017) examined measures of metabolic syndrome including central obesity, which was defined as waist circumference  $\geq 80$  cm for women and  $\geq 94$  cm for men. Follow-ups were performed in 1983 (age 18), 1986 (age 21), 1995 (age 30), and 2008 (age 43). The BMI at baseline (age 16) did not vary based on snus or smoking use. Byhamre and colleagues (2017) did not find a significant risk increase for central obesity in current snus users who had never smoked compared with never-users of tobacco at any follow-up age: follow-up at age 16 had odds ratio 1.40 (95% CI: 0.83-2.35), age 21 OR=1.24 (95% CI: 0.65-2.34), age 30 OR=1.15 (95% CI: 0.61-2.15), age 43 OR=1.65 (95% CI: 0.76-3.58). These multivariate logistic regression calculations were adjusted for sex, cumulative smoking, BMI at 16 years, socioeconomic status at 16 years, family history of diabetes mellitus, alcohol consumption and physical activity at 43 years (Byhamre et al. 2017).

The third study investigating the association between snus use and body weight changes was a cross-sectional study of over 93,000 adults aged 20-39 in Norway (previously described, Overland et al. 2013). Compared with those who had never used snus, linear regression analysis found that extensive snus users and those who previously used snus were associated with having larger waist circumferences ( $b=1.38$ ; 95% CI: 0.59-2.17;  $b=0.78$ ; 95% CI: 0.13-1.43, respectively). However, those who reported sometimes snus use and daily snus use had contradictory results:  $b=-0.29$ ; 95% CI: -1.04-0.45;  $b=-0.32$ ; 95% CI: -0.98, 0.35, respectively. The category of extensive snus users consisted of any participants who reported current daily snus use, a monthly consumption above the mean, and having used snus for more than five years. These analyses reported above were adjusted for age, smoking, gender, education, physical exercise and frequency of alcohol use. The authors acknowledge that the statistically significant findings are weak and inconsistent, as well as the association between snus use and waist circumference could be due to lifestyle factors or physiological changes. Overland and colleagues (2013) ran a post-hoc analysis with adjustment for age and gender of extensive snus users excluding daily smokers in order to investigate how previous smoking could affect waist circumference. Compared with a group of over 16,000 never-snus users, current extensive snus users who previously smoked ( $n=246$ ) had larger waist circumferences ( $b=1.09$ ,  $p=0.01$ ) and current snus users who had never smoked ( $n=390$ ) did not have this increase in waist size ( $b=1.09$ ,  $p=0.06$ ).

Another cross-sectional analysis examining snus use and body weight was based on data of 16,426 40, 50, and 60-year-olds pulled from the prospective, population-based cohort study GLACIER (Gene-Lifestyle Interactions and Complex Traits Involved in Elevated Disease Risk Study) from 1985 to 2004 (Varga et al. 2013). Using multivariate linear regression models adjusted for age and sex, snus use and BMI were positively related ( $b=0.35$  kg/m<sup>2</sup>, standard error=0.12; 95% CI: 0.12-0.58) when comparing current snus users to never snus users. As expected, when comparing current smokers to never smokers, smoking and BMI were inversely related ( $b=-0.46$  kg/m<sup>2</sup>, standard error=0.08; 95% CI -0.62—0.31,  $p<0.0001$ ). the authors concluded, however, that "it seems more plausible that it is

the obesogenic correlates of snus (i.e., confounders) that underlie the association of snus with obesity, rather than a direct causal effect of snus.”

#### Quality Rating of All Studies

<b>Study</b>	<b>Endpoints</b>	<b>Evidence Quality Rating</b>
Bjorkman et al. 2017	Body mass, BMI	Moderate
Byhamre et al. 2017	Central obesity (aka WC)	Moderate
Overland et al. 2013	Waist circumference	Weak
Varga et al. 2013	BMI	Weak
Aro et al. 2010	BMI	Weak
Bolinder et al. 1992	BMI	Weak
Bolinder et al. 1997a	BMI, waist-hip ratio	Weak
Engstrom et al. 2010	Underweight/Overweight/Obese	Weak
Sundbeck et al. 2009	BMI, WHR, WC	Weak
Hansson et al. 2011	Weight gain, obesity	Moderate
Rodu et al. 2004	Overweight	Moderate

#### Discussion and Conclusions

Because cessation of smoking is strongly linked with body weight changes, only studies that account for smoking are included in the discussion and final conclusions, as was done in the 2013 report.

##### *BMI*

In total, five studies investigated BMI in relation to snus use (Bjorkman et al. 2017, Aro et al. 2010, Varga et al. 2013, Bolinder et al. 1997a, Sundbeck et al. 2009) and results were contradictory. The single clinical trial (Bjorkman et al. 2017) found that mean body mass measured in kilograms increased significantly between baseline and after six weeks’ snus cessation. However, when comparing the controls with the snus cessation group, there was no significant difference in body weight increase (Bjorkman et al. 2017). The authors did not observe a significant change in BMI from baseline to study end in the snus cessation group nor in the controls (Bjorkman et al. 2017). The other four studies examining BMI used cross-sectional analyses, which by design cannot determine temporality or causality due to disease and exposure measurements occurring simultaneously (Aro et al. 2010, Varga et al. 2013, Bolinder et al. 1997a, Sundbeck et al. 2009). Varga and colleagues (2013) found that snus use and BMI were positively related whereas smoking and BMI were inversely related based on information from over 16,000 participants in a population-based study. In a different population-based cross-sectional study, there was no difference in mean BMI among snus users compared with those who had never used tobacco products, though BMI was significantly lower among current smokers compared to the same group of never-users (Aro et al. 2010). The third population-based study (Sundbeck et al. 2009) reported no associations between snus use and overall obesity (as measured by BMI and abdominal obesity) compared with non-users of tobacco. A small cross-sectional study of 143 firefighters similarly found that snus users did not differ significantly from never-users with respect to BMI measurements (Bolinder et al. 1997a).

Four of the five studies examining BMI reported no statistically significant positive association between snus use and BMI (Bjorkman et al. 2017, Aro et al. 2010, Bolinder et al. 1997a, Sundbeck et al. 2009). Based on these results, including those from a single study presenting moderate evidence of no association there is *limited/suggestive evidence of no association* between snus use and BMI.

#### *Underweight/overweight/obese*

In a large cross-sectional study of construction workers, the prevalence of being overweight (BMI>26) was significantly elevated in those aged 36 or older but not among those 35 and younger when compared to non-users (Bolinder et al. 1992). In smokers, the prevalence of being overweight was not different from that of non-users. The prevalence of being underweight (BMI<22) did not differ from snus users to non-users, but among smokers, the prevalence of being underweight was significantly higher (Bolinder et al. 1992). A population-based cross-sectional study presented differing conclusions: snus use was not related to being overweight but being underweight was inversely associated with snus use (Engstrom et al. 2010). However, like Bolinder et al. (1992), smoking was positively associated with being underweight, though smoking was less common among overweight and obese participants. Though this study was strong in its size of over 34,000 men and women, 39% of those recruited did not participate, so selection bias was possible (Engstrom et al. 2010).

A cohort of 9,954 men was followed from 2002 to 2007 and examined exclusive snus use, and exclusive smoking, compared with those who had never used tobacco (Hansson et al. 2011). The authors found that snus use is associated with incident obesity (defined as BMI $\geq$ 30 kg/m<sup>2</sup>) during the study period. However, this study was limited in power due to its small number of obese participants (snus users n=21; smokers n=26). Rodu and colleagues (2004) followed up with 1,650 men at 13 years. Though the prevalence of being overweight (BMI $\geq$ 27 kg/m<sup>2</sup>) at study entry was slightly higher in snus users compared to those who had never used tobacco, the authors did not observe an increased risk of becoming overweight during follow-up of consistent, exclusive snus using men who were not overweight at study entry. Those who were formerly non-users of tobacco and took up snus during follow-up also did not have an increased risk of gaining weight.

The four studies examining the prevalence of being underweight/overweight/obese in snus users reported contradictory findings and each presented shortcomings including potential confounding (Bolinder et al. 1992, Engstrom et al. 2010, Hansson et al. 2011, Rodu et al. 2004). There is *balanced/mixed evidence for an association* between snus use and being or becoming overweight or obese, and *inadequate/insufficient evidence to determine whether an association exists* between snus use and being or becoming underweight.

#### *Waist circumference and waist-to-hip ratio*

Sundbeck and colleagues (2009) examined abdominal obesity in formerly smoking current snus users and found that abdominal obesity (a composite measurement of waist circumference and waist-hip-ratio) was greater in those with higher snus consumption; this positive association with abdominal obesity was not seen in those who used snus exclusively and had never smoked. This study did not account for important potential confounders such as alcohol consumption and energy intake (Sundbeck et al. 2009). Byhamre and colleagues (2017) also found no significant risk for central obesity (measured via waist circumference) in snus users who had never smoked compared with those who had never used tobacco. However, the number of exclusive snus users was small, which limited its statistical power. The authors adjusted for several confounders including alcohol consumption and

physical activity at age 43 (Byhamre et al. 2017). The small cross-sectional study of firefighters (Bolinder et al. 1997a) reported that snus users did not differ from never-users in waist-hip ratio. On the other hand, a larger cross-sectional study (Overland et al. 2013) reported that extensive snus users (consisting of current daily snus users, those who consumed more snus than the average, and those who had more than five years' snus use) and previous snus users were associated with having bigger waist circumferences. However, the authors' results for sometimes snus users were contradictory and not associated with bigger waist size, thus suggesting confounders at play that were not accounted for (Overland et al. 2013). Based on these studies, there is *balanced/mixed evidence for an association* between snus use and waist circumference or waist-to-hip ratio.

#### *Weight gain/weight non-gain/intentional weight loss*

Hansson and colleagues (2011) also measured weight gain over the course of five years and found that stable exclusive snus use during follow up was moderately associated with weight gain (defined as  $\geq 5\%$  increase in body weight) compared with never-users of tobacco as the reference group. Initiation of snus use during follow up was not associated with weight gain, though as mentioned above, the study was limited in power due to the small number of cases. Based on this single moderate quality study, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and incident weight gain.

## **2.6 Gastro Intestinal Effects**

### **2.6.1 Heart burn and Gastroesophageal Reflux Symptoms (GERS), and Peptic Ulcer**

#### Summary from 2013 ENVIRON Report

In a descriptive, cross-sectional study of approximately 40,000 subjects, Bolinder and colleagues (1992) found that Swedish users of "smokeless tobacco" (described as 'mainly moist snuff') did not have an elevated risk of peptic ulcer and that they had a significantly decreased tendency to suffer from heartburn compared to non-users. These findings were based on 5,014 Swedish smokeless tobacco users who had never been regular smokers and 23,885 Swedish participants who had never used any type of tobacco. The reason for the lower risk of heartburn in "smokeless tobacco" users was not clear, but the authors speculated that the high pH of moist snuff (8.5) could be important when saliva is swallowed.

Aro and colleagues (2010) also investigated the relationship between the use of snus and GERS and peptic ulcer. The results from this population-based cross-sectional study of a 2,860 sample of adults from two northern Swedish municipalities indicate that current or former use of snus use is not significantly associated with GERS or overall peptic ulcer disease (along with gastric ulcer and duodenal ulcer) compared to never-users of tobacco among never-smokers.

#### Newly Identified Studies

A single study on the potential relationship between use of Swedish snus and GERS was published since the 2013 ENVIRON report (Lie et al. 2017). Lie and colleagues (2017) conducted a cross-sectional analysis of 58,634 Norwegians living in the Nord-Trøndelag county and reported that while daily snus users, compared to snus never users, had reduced risk of GERS (OR=0.77; 95% CI 0.64-0.93), former snus users, those who used snus to quit or reduce cigarette smoking and those who used snus and cigarettes concurrently all had increased risks of GERS. Additionally, when stratified by age, snus users <30 years of age had an increased risk of GERS but those aged between 50-70 years



had a reduced risk. Noting the increased GERS risk among previous snus users and sub-groups of snus users, the author suggested that snus use could increase the risk of GERS.

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoints</b>	<b>Evidence Quality Rating</b>
Aro et al. 2010	GERS and peptic ulcer	Moderate
Bolinder et al. 1992	Heartburn and peptic ulcer	Weak
Lie et al. 2017	GERS	Weak

#### Discussion and Conclusions

The new study published by Lie et al. (2017) provides some evidence that there may be an association between snus use and increased risk of GERS. However, the evidence is not entirely consistent and relies on the assumption that the increased risk in former users and decreased risk in current daily snus users were a product of survivorship bias whereby those who developed GERS as a result of snus use stopped using snus. In contrast, evidence from both Aro and colleagues (2010) and Bolinder and colleagues (1992) is not suggestive of a relationship between snus use and peptic ulcer or GERS/heartburn. Given the limitations presented by all three cross-sectional studies, however, the evidence is *inadequate/insufficient to determine whether an association exists* between snus use and peptic ulcer or GERS/heartburn.

### **2.6.2 Crohn's Disease and Ulcerative Colitis**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Persson and colleagues (1993) evaluated the relationship between the two types of inflammatory bowel disease (IBD), Crohn's Disease (CD) and ulcerative colitis (UC), and snus and also examined the role of cigarette smoking as a confounding or synergistic factor in the development of IBD. In this study, use of snus among never-smokers was not associated with any increase in risk of IBD. Among all participants (including those who were former or current smokers), ever-use of snus was associated with a two-fold increase in relative risk of both CD (RR=2.1; 95% CI: 1.0-4.6) and UC (RR=2.2; 95% CI: 1.1-4.4) after adjustment for age and cigarette smoking, but not for other potentially important factors that could be related to UC. However, only the finding for UC was marginally statistically significant, and was no longer significant when the analysis was restricted to never-smokers.

More recently, Carlens and colleagues (2010) conducted a cohort study, and examined the relationship between the use of snus and UC and CD among 277,777 male construction workers in Sweden. In this study, ever use of snus, adjusted for smoking, or among never-smokers was not associated with risk of UC (RR=1.1; 95% CI: 0.9-1.2 and RR=1.0; 95% CI: 0.8-1.2 respectively). With respect to CD, Carlens et al. found that ever use of snus, adjusted for smoking, or among never smokers, was not associated with risk of CD (RR=0.9; 95% CI: 0.8-1.1 and RR=1.0; 95% CI: 0.8-1.4 respectively). The authors also reported that a dose-response relationship of the amount of snus used was not observed.

#### Quality Rating of all Studies

Study	Endpoints	Evidence Quality Rating
Persson et al. 1993	Ulcerative Colitis and Crohn's Disease	Moderate
Carlens et al. 2010	Ulcerative Colitis and Crohn's Disease	Strong

#### Discussion and Conclusions

A case-control and a cohort study examined the relationship of UC and CD with oral moist snuff and cigarette smoking in Sweden. These studies found no increased risk of CD or UC associated with snuff use when the analysis was limited to never-smokers. Thus, the evidence supports a conclusion of *limited/suggestive evidence of no association* between snus use and risk of CD and UC.

### **2.6.3 Irritable Bowel Syndrome**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Aro and colleagues (2010) also investigated the relationship between the use of snus and irritable bowel syndrome (IBS). The results indicate that current or former use of snus among never-smokers is not significantly associated with IBS compared to never-users of tobacco.

#### Quality Rating of all Studies

Study	Evidence Quality Rating
Aro et al. 2010	Moderate

#### Discussion and Conclusions

The results of a sole cross-sectional study indicate that current or former use of snus among never-smokers is not associated with irritable bowel syndrome (IBS) compared to never-users of tobacco. Based on this single study, however, the evidence is *inadequate/insufficient to determine whether an association exists* between snus use and risk of IBS.

### **2.6.4 Celiac Disease**

#### Summary from 2013 ENVIRON Report

No studies on celiac disease were previously included in the 2013 ENVIRON report.

#### Newly Identified Studies

A single study on the potential relationship between use of Swedish snus and Celiac disease was published since the 2013 ENVIRON report (Ludvigsson et al. 2014). In an analysis of 199,185 participants from the Swedish Construction Workers' cohort, Ludvigsson and colleagues (2014) reported that ever use of snus was not associated with risk of celiac disease (RR=1.0; 95% CI: 0.78-1.28) after adjusting for age, sex, decade, and tobacco smoking.

#### Quality Rating of all Studies

Study	Evidence Quality Rating
Ludvigsson et al. 2014	Strong

### Discussion and Conclusions

Although the authors did not evaluate an exclusive group of snus users, tobacco smoking was not associated with Celiac disease in this study, so potential confounding by smoking was not a major concern. Given the large sample size and prospective design of this study, the evidence was rated as strong, with the authors reporting no association between snus use and celiac disease. Therefore, this study provides *limited/suggestive evidence of no association* between snus use and Celiac disease.

## **2.6.5 Other Gastrointestinal Symptoms and Effects**

No new studies were identified since publication of the 2013 ENVIRON report.

### Quality Rating of all Studies

<b>Study</b>	<b>Endpoints</b>	<b>Evidence Quality Rating</b>
Aro et al. 2010	Gastrointestinal symptoms including dyspepsia, epigastric pain, abdominal pain, <i>H. pylori</i> infection, and esophagitis	Moderate

### Discussion and Conclusions

Aro and colleagues (2010) investigated the relationship between the use of snus and other gastrointestinal symptoms including dyspepsia, epigastric pain, abdominal pain, *H. pylori* infection, and esophagitis. The results indicate that current or former exclusive use of snus is not significantly associated with any of these symptoms compared to never-users of tobacco. However, current use of snus was significantly associated with hyperplasia of the basal cell layer (OR=1.74; 95% CI: 1.02-3.00) and with elongation of papillae of the squamous epithelium at the esophago-gastric junction (OR=1.79; 95% CI: 1.05-3.05). Given that there was only a single cross-sectional study available on each of these endpoints, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and risks of these other gastrointestinal effects.

## **2.7 Pregnancy Outcomes and Reproductive Effects**

### **2.7.1 Effects on Infants**

#### Summary from 2013 ENVIRON Report

The Swedish Medical Birth Register was used to examine birth outcomes in a large number of pregnancies. Daily use of snus during pregnancy is associated with a modest reduction in average birth weight (though less than smoking), small-for-gestational-age birth, and increased risk of preterm delivery, stillbirth, and neonatal apnea.

These conclusions are consistent with the recent review by Rodu (2011), who also noted that while any form of nicotine should be avoided during pregnancy, the highest risks for the developing baby are associated with smoking.

#### Newly Identified Studies

No new studies for endpoints including small for gestational age, and neonatal apnea.

### *Stillbirths and Early Neonatal Mortality*

A single study on the potential relationship between use of Swedish snus during pregnancy and risk of stillbirths was published since the 2013 ENVIRON report (Baba et al. 2014). In an updated analysis of the Swedish Medical Birth Register, Baba and colleagues (2014) reported a higher risk of stillbirth among women who used snus during the first trimester (OR=1.43; 95% CI: 1.02-1.99), with no effect of snus use on risk of stillbirth among the women who stopped using snus prior to the first antenatal visit (OR=0.73; 95% CI: 0.50-1.06).

Baba et al. (2014) also examined early neonatal mortality, defined as deaths occurring during the first week of life, and found that risk of nearly neonatal mortality was not elevated among those who used snus during the first trimester (OR=0.64; 95% CI: 0.30-1.37) or those who stopped using snus prior to the first antenatal visit (OR=1.15; 95% CI: 0.68-1.3).

### *Heartbeat Variability*

A single prospective study on the potential relationship between use of Swedish snus during pregnancy and infant heartbeat variability was published in 2017 (Nordenstam et al. 2017). Nordenstam and colleagues (2017) reported that compared to the 19 infants of women who did not use tobacco or nicotine products, the 23 infants of women who used snus during pregnancy showed a higher Low Frequency to High Frequency ratio ( $p=0.006$ ), but did not differ in electrocardiogram readings.

### *Oral Clefts*

A single study on the potential relationship between use of Swedish snus during pregnancy and risk of oral clefts was published in 2014 (Gunnerbeck et al. 2014). Using the Swedish Medical Birth register data, Gunnerbeck and colleagues reported that the risk of all oral cleft malformations was increased among infants of women who reported use of snus in the first trimester compared to infants of women who did not use snus in the first trimester (OR=1.48; 95% CI: 1.00-2.21), though this finding was of borderline statistical significance. This appeared to be primarily driven by the increased odds of cleft lips (OR=1.61; 95% CI: 1.00-2.61) and not cleft palates (OR=1.26; 95% CI: 0.63-2.55) (Gunnerbeck et al. 2014). In contrast, the odds of all oral cleft malformations (OR=0.71; 95% CI: 0.44-1.14), including cleft lip (OR=0.77; 95% CI: 0.44-1.37) and cleft palates (OR=0.59; 95% CI: 0.24-1.43) were not elevated among infants of women who stopped using snus by 15 weeks gestation. No differences in rates of other malformations among infants with oral clefts were observed between infants of women who used snus in the first trimester and infants of women who did not use snus.

### *Preterm Birth*

A single study on the potential relationship between use of Swedish snus during pregnancy and risk of preterm birth was published since the 2013 ENVIRON report (Dahlin et al. 2016). Using the Swedish Medical Birth register data, Dahlin and colleagues (2016) reported that pregnant women who reported snus use in the first trimester had elevated risk of extreme premature birth (OR=1.58; 95% CI: 1.14-2.21), very premature birth (OR=1.25; 95% CI: 0.98-1.59), and moderately premature birth (OR=1.21; 95% CI: 1.11-1.31), defined as <28 weeks, 28-31 weeks, and 32-36 weeks, respectively. In contrast, women who used snus 3 months prior to the pregnancy but had stopped prior to the first antenatal visit did not have elevated risk of extreme premature birth (OR=0.78; 95% CI: 0.52-1.16), very premature birth (OR=0.90; 95% CI: 0.71-1.15), or moderately premature birth (OR=0.95; 95% CI: 0.88-1.02).

### *Birthweight*

Two studies on the potential relationship between use of Swedish snus during pregnancy and birthweight were published since the 2013 ENVIRON report (Juarez and Merlo 2013, Rygh et al. 2016).

Juarez and Merlo (2013) conducted an analysis of the Swedish Medical Birth Register using both a conventional observational approach and a “quasi-experimental” approach that examined sibling birthweights from sequential pregnancies. Compared to infants of women who never used snus, infants of women who used snus in both the first and third trimester were 47g lighter on average. However, infants of women who used snus in either the first or third trimester alone had similar birthweights compared to unexposed infants. The quasi-experimental sibling analysis included 144,017 mothers with two sequential pregnancies and reported similar results where infants of women who used snus during both pregnancies had lower birthweight compared to infants of women who did not use snus during either pregnancy.

Rygh and colleagues (2016) conducted an analysis of 10,583 births from the Sørlandet Hospital in Norway and reported that there were no statistically significant difference in birthweight between infants of women who used snus compared to infants of women who did not use snus. However, it is not clear what the authors defined as snus use in this analysis, nor were there other details on the methodology of the analysis.

### *Apgar Score*

A single study on the potential relationship between use of Swedish snus during pregnancy and Apgar score, a measure of a newborn infants’ health, in the infants was published in 2016 (Rygh et al. 2016). Rygh and colleagues (2016), described previously, reported that there was no statistically significant difference in Apgar scores between infants of women who used snus compared to infants of women who did not use snus. However, it is not clear what the authors defined as snus use in this analysis, nor were there other details on the methodology of the analysis.

### Quality Rating of all Studies

<b>Study</b>	<b>Endpoints</b>	<b>Evidence Quality Rating</b>
England et al. 2003	Birth weight, small for gestational age, and preterm birth	Moderate
Baba et al. 2012a	Small for gestational age	Strong
Baba et al. 2012b	Preterm birth	Strong
Baba et al. 2014	Stillbirth, early neonatal mortality	Strong
Dahlin et al. 2016	Preterm birth	Strong
Gunnerbeck et al. 2011	Neonatal apnea, small for gestational age, and preterm birth	Strong
Gunnerbeck et al. 2014	Oral clefts	Moderate
Juarez and Merlo 2013	Birthweight	Strong
Nordenstam et al. 2017	Heart rate variability	Weak
Rygh et al. 2016	Birthweight, Apgar score	Weak

Wikstrom et al. 2010a	Preterm birth	Strong
Wikstrom et al. 2010b	Stillbirth, small for gestational age	Strong

## Discussion and Conclusions

### *Stillbirths and Early Neonatal Mortality*

With the new study published by Baba and colleagues (2014), two studies from the Swedish Birth Registry now report that snus use in the first trimester is associated with elevated risk of stillbirth (Wikstrom et al. 2010b, Baba et al. 2014). However, this new publication by Baba and colleagues (2014) only provided a limited update to the earlier publication by Wikstrom and colleagues (2014). Given the strong quality of the studies, however, we conclude that there is *limited/suggestive evidence of an association* between maternal snus use in the first trimester and increased risk of stillbirth.

A single strong study that evaluated the association between snus use and risk of early neonatal mortality reported no association (Baba et al. 2014), providing *limited/suggestive evidence of no association*.

### *Heartbeat Variability*

A single new study reported that the Low Frequency to High Frequency Ratio in the infants of women who used snus during pregnancy was higher than that of the infants of women who did not use nicotine products during pregnancy (Nordenstam et al. 2017), but it was of weak quality due to the small number of participants in the study as well as the lack of control for potential confounders. Together with the observation that no differences in Low Frequency, High Frequency, and other electrocardiogram measures were noted between groups, our overall conclusion is that there is *inadequate/insufficient evidence to determine whether an association exists* between snus use during pregnancy and subsequent altered heartrate variability in infants.

### *Oral Clefts*

A single new study reported an increased risk of oral clefts, in particular cleft lip associated with maternal snus use in the first trimester (Gunnerbeck et al. 2014), although this finding was of borderline statistical significance, and other specific malformations, such as cleft palate, were not statistically significantly increased. However, the numbers of infants with specific malformations born to snus users were small. Overall, we conclude that there is *inadequate/insufficient evidence to determine whether an association exists* between maternal snus use in the first trimester and increased risk of oral clefts.

### *Preterm Birth*

With the new study published by Dahlin and colleagues (2016), five studies from the Swedish Birth Register now report that snus use in the first trimester is associated with elevated risk of preterm birth (England et al. 2003, Wikstrom et al. 2010a, Gunnerbeck et al. 2011, Baba et al. 2012b, Dahlin et al. 2016). Similar to the stillbirth data, all publications on this topic came from the same cohort with overlapping participants. However, given the consistency of the results, large representative samples, as well as the overall quality of the studies, we conclude that there is *limited/suggestive evidence of an association* between maternal snus use in the first trimester and increased risk of preterm births.

### *Birthweight*

The findings reported in the two new studies on maternal Swedish snus use and infant birthweight were mixed. Juarez and Merlo (2013) observed a decrease in birthweight associated with consistent snus use in the first and third trimester using the Swedish Birth Register, consistent with the prior study by England and colleagues (2003) of the same cohort. However, Rygh and colleagues (2016) reported that in their cohort of 10,583 births from Norway, no differences in birthweight were observed between infants of women who used snus during pregnancy compared to infants of women who did not use snus. However, the Rygh and colleagues (2016) did not report the methodology behind this analysis, which limits the interpretation of their results. Ultimately, given the relatively strong quality of the Swedish Birth Register studies, we conclude that there is *limited/suggestive evidence of an association* between maternal snus use and birthweight.

### *Small for Gestational Age*

Being small for gestational age was defined as having a birth weight that was more than 2 standard deviations below the mean birth weight for gestational age, according to gender-specific Swedish fetal growth curves. The risk of having an SGA baby among snuff users was examined by England and colleagues (2003), and was found to be similar to that of nonusers of tobacco (OR=1.25; 95% CI: 0.72-2.17). By comparison, the risk was significantly increased among cigarette smokers (OR=2.99; 95% CI: 2.48-3.61). In the first expanded study, Wikström and colleagues (2010b) again observed that snuff use during pregnancy is not significantly associated with being SGA (OR = 1.17; 95% CI: 0.98-1.39). In the most recent expanded study, Baba and colleagues (2012a) concluded that both smoking, and to a lesser extent, use of snuff during pregnancy increased the risk of an SGA birth. The authors noted that both nicotine and tobacco combustion products are involved in the mechanisms by which maternal tobacco use during pregnancy increases the risk of SGA birth, and that products containing nicotine should be avoided during pregnancy. Women who used snuff (OR = 1.26; 95% CI: 1.09-1.46) or smoked (OR = 2.55; 95% CI: 2.43-2.67) during early pregnancy faced a significantly increased risk of SGA. Snuff use had a stronger association with preterm SGA (OR = 1.50; 95% CI: 1.13-1.98) than term SGA (OR = 1.21; 95% CI: 1.02-1.43), whereas the opposite was true for smoking (Preterm SGA OR = 1.85; 95% CI: 1.67-2.06, Term SGA OR = 2.76; 95% CI: 2.62-2.91). Women who stopped using snuff before their first visit to antenatal care had no increased risks of preterm or term SGA, and women who stopped using snuff later during pregnancy had no increased risk of term SGA. Given the relatively strong quality of the most recent and expanded study of the Swedish Medical Birth Register, we conclude that there is *limited/suggestive evidence of an association* between maternal snus use and small for gestational age.

### *Apgar Score*

Given that the sole study that evaluated the association between maternal snus use and infant Apgar score presented weak evidence of no association with snus use, or even methodology associated with the analysis, there is *inadequate/insufficient evidence to determine whether an association exists*.

### *Neonatal Apnea*

In an analysis of the Swedish Medical Birth Register, snuff use during pregnancy was significantly associated with an increased risk of neonatal apnea (OR = 1.96; 95% CI: 1.30-2.96) following adjusted for maternal age, height, parity, education, and tobacco use. Model 2 was further adjusted for cesarean delivery, gender, gestation age, and small for gestational age (Gunnerbeck et al. 2011).

Given the relatively strong quality of the Swedish Birth Register studies, we conclude that there is *limited/suggestive evidence of an association* between maternal snus use and neonatal apnea.

### 2.7.2 Maternal Effects

No new studies were identified since publication of the 2013 ENVIRON report.

#### Quality Rating of all Studies

Study	Endpoints	Evidence Quality Rating
England et al. 2003	Preeclampsia	Moderate
Wikstrom et al. 2010b	Antenatal Bleeding Preeclampsia	Strong
Wikstrom et al. 2010c	Preeclampsia Gestational Hypertension	Strong

#### Discussion and Conclusions

##### *Antenatal Bleeding*

Wikström and colleagues (2010b) investigated the relationship between the use of snuff during pregnancy and antenatal bleeding and reported that snuff use was not statistically significantly associated with antenatal bleeding (OR=1.15; 95% CI: 0.92-1.44). Given that this study presented strong evidence of no association, there is *limited/suggestive evidence of no association* between snuff use during pregnancy and antenatal bleeding.

##### *Preeclampsia*

England and colleagues (2003) reported that daily users of snuff were at significantly increased risk of preeclampsia compared to non-users of tobacco (OR=1.58; 95% CI: 1.09-2.27). In the expanded study of the same cohort, Wikström and colleagues (2010b) found that reported snuff use was not statistically significantly associated with preeclampsia (OR=1.11; 95% CI: 0.97-1.28). In addition, snuff use was not associated with the severity of preeclampsia. Given the strong evidence provided by Wikström and colleagues (2010b,c), there is *limited/suggestive evidence of no association* between snuff use during pregnancy and preeclampsia, but the evidence is somewhat inconsistent and came from a single cohort.

##### *Gestational Hypertension*

Wikström and colleagues (2010c) found that snuff use during pregnancy was not associated with risk of gestational hypertension (OR=0.89; 95% CI: 0.68-1.15). Given that this study presented strong evidence of no association, there is *limited/suggestive evidence of no association* between snuff use during pregnancy and gestational hypertension.

### 2.7.3 Effects on Male Fertility

#### Summary from 2013 ENVIRON Report

A single cross-sectional study does not suggest that the use of snus is associated with reproductive parameters in adolescent males (Richthoff et al. 2008). Though the authors' primary focus was on smoking, snus' potential association with male reproductive factors was investigated because it might have an impact directly or as a confounder or an effect modifier. None of the reproductive parameters



(semen parameters, seminal biochemical biomarkers, hormone levels) investigated were associated with snus use. The authors concluded that since tobacco smoking was associated with negative impacts on male reproductive parameters, it is unlikely that tobacco itself causes these impacts but rather the compounds that are released by smoking.

#### Newly Identified Studies

A single study on the potential relationship between use of snuff and male semen parameters was published since the 2013 ENVIRON report (Parn et al. 2015). Parn and colleagues (2015) reported that compared to 43 snuff non-users, 17 snuff users had decreased sperm concentration, total sperm count, motile sperm concentration, total motile sperm count, and percent motile sperm ( $p < 0.05$ ) in bivariate analyses. Given the known association between cigarette smoking and diminished semen quality, the observed decrease in semen quality among snuff users could have been confounded by past or current cigarette smoking.

#### Quality Rating of all Studies

Study	Evidence Quality Rating
Richthoff et al. 2008	Weak
Parn et al. 2015	Weak

#### Discussion and Conclusions

Both studies that evaluated the association between snus use and semen parameters were of weak quality due their small sample size, cross-sectional design, and inability to control for smoking status. Therefore, despite the associations observed by Parn and colleagues (2015), there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and effects on male fertility.

## **2.8 Other Health Effects**

### **2.8.1 Acoustic Neuroma**

#### Summary from 2013 ENVIRON Report

No studies on acoustic neuroma were previously included in the 2013 ENVIRON report.

#### Newly Identified Studies

A single study that investigated the potential relationship between Swedish snus use and acoustic neuroma was published since the 2013 ENVIRON report (Palmisano et al. 2012). Palmisano et al. (2012) conducted a population-based case-control study with 451 patients with acoustic neuroma and 710 controls matched on gender, region and age. Of the acoustic neuroma patients, 78 were snus users, and 152 were non-users; in the control group 119 were snus users and 239 were non-users. Due to the low rate of female snus users (10 female users were identified in study population), only male users were used for analyses involving snus users. Using logistic conditional regression, odds ratios were estimated for ever-snus users, former snus users, and current snus users compared with never-users. Following adjustment for highest level of education and smoking status, all odds ratios for these snus user comparisons were around 1, indicating no statistically significant risk of developing acoustic neuroma. The authors also examined the potential effect of age of initiation, years since starting, total years, and years since cessation of snus use. Analyses of these subgroups also yielded

odds ratios close to 1, supporting the conclusion that snus use has neither a positive nor negative relationship with acoustic neuroma.

#### Discussion and Conclusion

This study had some potential selection bias in that 65% of recruited controls participated, compared with the higher participation rate of 84% among cases. A notable limitation of this study was that it did not include analyses among exclusive snus users, likely due to the relatively low number of study participants, although odds ratios were adjusted for smoking status. The quality of the evidence presented in this study was rated as moderate. Although the authors of this study noted that they “observed no evidence of a role for snuff tobacco consumption in acoustic neuroma etiology,” the evidence from this single, moderate study is *inadequate/insufficient to determine whether an association exists*.

### **2.8.2 Acute Adverse Symptoms**

#### Summary from 2013 ENVIRON Report

No studies on acute adverse symptoms were previously included in the 2013 ENVIRON report.

#### Newly Identified Studies

One study that investigated potential acute adverse symptoms associated with Swedish snus use was published since the 2013 ENVIRON report (Ozga et al. 2016). This was a pilot study, described previously, involving 11 never-tobacco users (defined as <100 uses/lifetime) who consumed six pouches of Swedish snus in ascending doses within a single session. Each pouch was consumed for 20 minutes with 25 minute pauses between snus pouches. Pre- and post-pouch assessments of drug effects and physiological response were measured to determine differences across dose groups. Subjective effects were measured using visual analog scale items via the Direct Effects of Nicotine Scale (DENS) and the Direct Effects of Tobacco Scale (DETS). Each participant consumed pouches containing 0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg of nicotine. Participants were asked to characterize 10 subjective effects with each dose: nausea, dizziness, lightheadedness, nervousness, sweatiness, headache, excessive salivation, heart pounding, confusion, and feeling weak. Out of these 10 measures, excessive salivation was the only measure that was significant for a main effect of time. Pre-pouch excessive salivation rated, on average, 6.7 and post-pouch was rated 20.6. The authors concluded that “the lack of reliable subjective effects may be the product of the dosing regimen or the relatively small sample size.” In addition to small sample size, the successive administration of pouches could have led to “carryover effects” from nicotine in previous doses.

#### Discussion and Conclusions

The new study (Ozga et al. 2016) of 11 never-users of tobacco measuring physiological and subjective effects of Swedish snus provides moderate evidence that use of Swedish snus can result in excessive salivation, which is noted as a significant subjective effect, however the very small sample size is a major limitation of this study. Overall, there is *inadequate/insufficient evidence to determine whether an association exists* between use of Swedish snus, and the subjective symptoms examined in this study.

### **2.8.3 All-Cause Mortality**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Two cohort studies have examined the relationship between the use of snus and all-cause mortality. Bolinder and colleagues (1994) investigated this relationship among 84,781 Swedish construction workers, and found a significant association between exclusive use of snus and all-cause mortality (adjusted for age and region of origin) among all subjects (RR=1.4; 95% CI: 1.3-1.8), and those aged 35-54 (RR=1.9; 95% CI: 1.6-2.4) at study entry, but not among subjects aged 55-65 (RR=1.2; 95% CI: 1.0-1.3) at study entry.

Roosaar and colleagues (2008) also evaluated the effects of the use of snus on all-cause mortality among 9,976 men from Uppsala County, Sweden. Ever daily use of snus (adjusted for smoking) was marginally significantly associated with an increased risk in all-cause mortality (HR=1.10; 95% CI: 1.01-1.21). Ever daily use of snus among never-smokers was also marginally significantly associated with an increased risk of all-cause mortality (HR=1.23; 95% CI: 1.09-1.40). Hazard ratios were adjusted for age, calendar period, area of residence, and alcohol consumption.

#### Quality Rating of all Studies

Study	Evidence Quality Rating
Bolinder et al. 1994	Moderate
Roosaar et al. 2008	Moderate

#### Discussion and Conclusions

While the overall hazard ratios among all subjects from both studies suggest a potential association between the use of snus and mortality from any cause, the evidence does not raise to the level of sufficient evidence of an association. Bolinder et al. (1994) did not account for any potential confounders such as lifestyle factors (e.g., alcohol consumption), and while Roosaar et al. (2008) adjusted for alcohol consumption, the authors did not adjust for other potentially important confounders such as dietary pattern, physical activity, BMI, or socioeconomic status. Given the myriad of potential causes of mortality, more evidence is clearly needed to establish a potential relationship with snus use. However, overall, the available studies currently provide *limited/suggestive evidence of an association* between snus use and all-cause mortality.

### **2.8.4 Amyotrophic Lateral Sclerosis (ALS)**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Fang and colleagues (2006) used data from the Swedish construction workers cohort to evaluate the relationship between snus use, cigarette smoking and the development of ALS. The analysis involved 280,558 men who were followed for an average of 19.6 years. At study initiation, 13.6% of the participants were pure snuff users, 37.7% were pure smokers, and 17.3% were mixed snuff users and smokers. There was no increased risk of ALS among any group of tobacco users, including pure snus users (RR=0.6; 95% CI: 0.3-1.5); cigarette smokers (RR=0.7; 95% CI: 0.5-1.1); or mixed snus users and smokers (RR=0.9; 95% CI: 0.6-1.4), after adjusting for age and county of residence. The authors concluded that this study provides no evidence that tobacco use is associated with increased risk of ALS.

#### Discussion and Conclusions

This large cohort study (Fang et al. 2006) had many strengths, including a high prevalence of snus use, long and almost-complete follow-up of an average of 19.6 years, and adjustment for age and country of residence. However, the authors did not adjust for some potential confounders, such as socioeconomic status or alcohol consumption. Furthermore, tobacco habits were assessed only at study entry, and changes over time could affect the results. The number of ALS cases among snus users were low (six ALS cases in pure snus users, 30 cases in mixed snus/smokers, and 69 in the smoking-only group). Given these weaknesses, the evidence from this single cohort study is of moderate quality and thus there is *inadequate/insufficient evidence to determine whether an association exists*.

### **2.8.5 Chronic Pain Intensity**

#### Summary from 2013 ENVIRON Report

Jakobsson (2008), using a cross-sectional study design, evaluated the relationship between tobacco use and pain intensity among 384 male and female participants from southern Sweden, who reported experiencing chronic pain for a duration of at least 3 months. At study initiation, 12.5% reported ever using snuff, while 52.1% reported ever smoking cigarettes. The author concluded that there was not significantly higher pain intensity among those who used moist snuff compared with those who did not.

#### Newly Identified Studies

One study investigating the relationship between snus use and pain intensity was published since the 2013 ENVIRON report (Jakobsson and Larsson 2014). The cross-sectional study included 2,000 randomly selected people aged 65 years or older living in Sweden and administered a postal questionnaire in 2011 with questions about demographic data, living conditions, tobacco use, health, and chronic pain (defined as pain lasting three months or longer) (Jakobsson and Larsson 2014). Most respondents (90.1%) were never snus users, about 5% were former snus users, 3.5% were daily snus users, and <1% were occasional snus users. With a 57% response rate (n=1,141), the study performed multiple linear regression analyses identifying variables associated with pain intensity stratified by gender and frequency of snus use. Snus use and pain intensity were not associated for neither men nor women. However, older age and smoking daily were associated with higher pain intensity among both men and women.

#### Discussion and Conclusions

Based on the two studies exploring the relationship between snus use and pain intensity (Jakobsson 2008; Jakobsson and Larsson 2014), there is no association between snus use and pain intensity. However, both studies were cross-sectional in nature, so a causal relationship between exposure and effect cannot be determined using these studies alone. Furthermore, it is possible that selection and information biases, common features in this type of study design, may have been present and biased the results toward the null. Similarly, misclassification of exposure or outcome also may have skewed the results. Due to these limitations, the quality of evidence from these studies was rated as weak, and there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and chronic pain.

### **2.8.6 Complications after Hernia Surgery**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

An analysis of the Swedish construction worker cohort sought to determine whether smoking, use of snus, or obesity affected the outcome of surgery (Lindstrom et al. 2007). The participants were 12,697 male construction workers who had undergone a first-time inguinal hernia repair. The overall complication rate following this surgery was low (2.9%). Snus use was not associated with significantly increased risk of postoperative complications, nor was it associated with any increase in the mean length of hospitalization. In contrast, current smokers had a 34% increased risk of postoperative complications compared to never-smokers, although their length of hospitalization was unaffected. The authors concluded that use of snus does not appear to affect the complication rate after hernia surgery.

#### Discussion and Conclusions

This single study (Lindstrom et al. 2007) is strong owing to its large size and prospectively collected data on tobacco use. There was likely some misclassification of study results due to failure of complete registration in the Swedish inpatient register. This is evidenced by the reported low overall rate of complications; however, the study results are likely unaffected since the misclassification of outcomes is likely nondifferential (about the same in the exposed and unexposed groups). The results were adjusted for age, calendar period, BMI, and acute surgery. Based on this study of strong quality, there is *limited/suggestive evidence of no association* between snus use and complications after hernia surgery.

### **2.8.7 Delayed Bone Healing**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

An analysis of the Swedish construction worker cohort was carried out to assess the effect of snus use and smoking on the time for bone healing (W-Dahl and Toksvig-Larsen 2007). The participants were 175 male patients who were subsequently operated on by tibial osteotomy using the hemicallotaxis technique. The cohort comprised of 41 smokers, 21 oral snuff users, and 113 non-smokers/non-snus users, with habits documented preoperatively. There were no cases of delayed bone healing among snus users and the authors concluded that snus does not have the negative effects—such as delayed bone healing and increased risk of post-operative complications—associated with cigarette smoking.

#### Discussion and Conclusions

W-Dahl and Toksvig-Larsen (2007) found no evidence for delayed healing among oral snus users in a population of 175 male hospital patients who were operated on for knee deformity by tibial osteotomy. The results were adjusted for age, size of correction, and simultaneous bilateral surgery. However, limitations of the cohort study include the fact that there was no information on amount or duration of snus use or smoking, so dose-response analyses were not possible. With only this small cohort study presenting moderate quality evidence on the association between snus use and bone healing, there is *inadequate/insufficient evidence to determine whether an association exists*.

### **2.8.8 Gallstone Disease**

#### Summary from 2013 ENVIRON Report

No studies on gallstone disease were previously included in the 2013 ENVIRON report.

### Newly Identified Studies

A single cohort study of 58,402 participants from the Swedish Twin Registry examined the associations between smoking and smoke-free tobacco with gallstone disease (Katsika et al. 2007). 1,666 cases of twins with gallstone disease were reported. No significant associations were reported between current or previous smoke-free tobacco use and gallstone disease (OR=1.05; 95% CI: 0.49-2.23 and OR=0.62; 95% CI: 0.37-1.04). Conditional logistic regression analyses comparing cases to unaffected co-twins were also performed involving 1,527 gallstone disease cases where the same-sex co-twin did not have a history of gallstone disease. The odds ratios among twin pairs of having gallstone disease were not significant with previous or current use of smoke-free tobacco and were similar to the results for the overall cohort.

### Discussion and Conclusions

The cohort study conducted by Katsika and colleagues (2007) had limited data on tobacco habits, especially in regard to smoke-free tobacco. Data on smoke-free tobacco was missing on approximately half of participants. Because of this major limitation, the power of the statistical analyses was low with only seven exposed cases in the overall cohort study. Furthermore, odds ratios were not adjusted for any potential confounders. The evidence presented in this study is weak, and provides *inadequate/insufficient evidence to determine whether an association exists* between snus use and gallstone disease.

## 2.8.9 General Health

### Summary from 2013 ENVIRON Report

With respect to general health, Lee (2011) summarized two cross-sectional studies that investigated the relationship between the use of snus and general health outcomes that included frequent sick leave, long leave, and “best general health” (assessed by five indicators). Among these three outcomes, snuff use was significantly associated only with long leave. Another cross-sectional study reported that prevalence of snuff use was not significantly associated with poor or very poor self-rated health (Engstrom et al. 2010). Again, causality cannot be determined in these cross-sectional studies.

The two cross-sectional studies that Lee et al. (2011) summarized in his review included Bolinder et al. (1992) (frequent and long sick leave), and Halling et al. (2007) (“best general health”, assessed by five indicators). The Bolinder et al. (1992) study and results were summarized in Appendix Q-1, and Halling et al. (2007) was not specifically cited or discussed in detail in the 2013 ENVIRON report. Therefore, these studies are discussed here, along with a newly identified study conducted by Eriksson and Ng (2015).

### Newly Identified Studies

Bolinder et al. (1992) conducted a cross-sectional survey that involved 37,722 men from the Swedish Construction Worker cohort who received health examinations between 1971 and 1974. Among exclusive snus users that had never smoked cigarettes, snus use was significantly associated with long sick leave (OR=1.2; 95% CI: 1.1, 1.2), but not frequent sick leave (OR=1.1; 95% CI: 1.0, 1.2) following adjustment for age. Halling et al. (2007) also conducted a cross-sectional study involving 50- and 60-year old Swedes in two counties. Following adjustment for age, gender, place of living, social life, work, education, and marital status, snus use was not associated with “best general health”, as assessed by a health index encompassing five items, compared to never-users of tobacco.

Eriksson and Ng (2015) conducted a cross-sectional analysis of the potential relationship between snus use and self-reported health as part of a cohort study of 33,621 men and women who participated in the Vasterbotten Intervention Program. The primary research focus of the study involved how changes in access to social capital influenced self-rated health in middle-aged men and women over time, however, snus was included as a covariate, and examined separately. Though no data were shown, and there was no control for potential confounders, the authors reported that men and women who were current snus users had higher odds of reporting poor self-rated health compared to those who did not smoke or use snus at baseline. No associations were observed during follow-up visits.

### Quality Rating of all Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Bolinder et al. 1992	Weak
Engstrom et al. 2010	Weak
Eriksson and Ng 2015	Weak
Halling et al. 2007	Weak

### Discussion and Conclusions

The new study published by Eriksson and Ng (2015) provides weak evidence of an association between snus use and general, self-reported health. Results among the other three available studies were mixed, and all consisted of a cross-sectional study design for which temporality cannot be determined. Bolinder et al. (1992) was the only other author to report a statistically significant association between snus use and measures of general health (frequent and long sick leave), though the results were adjusted only for age. Overall, the available studies provide *inadequate/insufficient evidence to determine whether an association exists* between snus use and general health measures.

## **2.8.10 Groin Hernias**

### Summary from 2013 ENVIRON Report

No studies on groin hernias were previously included in the 2013 ENVIRON report.

### Newly Identified Studies

A single study that investigated the potential relationship between groin hernia repair and snus use was published since the 2013 ENVIRON report (Hemberg et al. 2017). The population-based longitudinal cohort study consisted of 102,857 adults from Vasterbotten county in Sweden whose data was collected between 1989 and 2013 in the Vasterbotten Intervention Study. 100,741 adults over the age of 40 were included for analysis. When compared to never-users of the same sex in multivariate Cox regression analyses, the hazard ratios all hovered around 1 and were statistically insignificant for all comparison groups: former snus users, <4 boxes per week, and 4 or more boxes per week. The authors concluded that "tobacco [snus] use is not a risk factor for requiring a groin hernia repair."

### Discussion and Conclusions

A major limitation of the Hemberg et al. (2017) study is that the analyses of snus use did not adjust for smoking or age, which are associated with risk of groin hernia repair. The methodology of the study was unclear in that it lacked information on timing of exposure and outcome assessments. Though the study has adequate power due to its large population size, the data originated from an intervention program wherein individuals may change habits due to counseling while in the program. Furthermore, the intervention program involves only those older than 40, so participants who underwent groin hernia repair prior to joining the program were excluded. Lastly, the study does not address the association between snus use and groin hernias that may or may not require surgery. This single, moderate quality study provides *inadequate/insufficient evidence to determine whether an association exists*.

## **2.8.11 Multiple Sclerosis**

### Summary from 2013 ENVIRON Report

Although study findings from two studies on multiple sclerosis were summarized in the 2013 ENVIRON report (Carlens et al. 2010; Hedstrom et al. 2009), standardized conclusions were not provided. A discussion of the new studies as well as standardized conclusions that consider the old and new evidence are provided below.

### Newly Identified Studies

Two studies that investigated the relationship between multiple sclerosis (MS) and Swedish snus use were published since the 2013 ENVIRON report (Gustavsen et al. 2014; Hedström et al. 2013). The



smaller of these studies was a case-control study consisting of 756 MS patients in Norway and 1,090 healthy controls selected from the Norwegian Bone Marrow Donor Registry (Gustavsen et al. 2014). The study was conducted between 2011 and 2012, and analyses were split into two groups: those who were carriers of the HLA-DRB1\*15:01 gene (positively associated with MS) and those who were not carriers. Overall, 11.4% of MS patients reported using snus vs. 15.6% among controls. The odds ratio of ever-snus users who were carriers of the HLA-DRB1\*15:01 gene trended lower (0.60; 95% CI 0.27-1.32) than the odds of ever-snus users who were not carriers of the gene (0.88; 95% CI 0.39-2.0). Snus users included those who smoked, but analyses were adjusted for smoking. The authors reported a significant decreased risk of MS among snus users who were carriers of the HLA-DRB1\*15:01 gene (OR 0.41; 95% CI 0.22-0.77), but this association was only seen in unadjusted analysis. Selection bias of the controls is likely present as bone marrow donors may be healthier than the general population (Gustavsen et al. 2014).

A pooled case-control study of 17,320 Swedish adults (7883 cases and 9437 controls) similarly found a decreased risk of developing MS in snus-users compared with those who had never used snus (Hedström et al. 2013). The 2005-2012 study captured snus use in use categories: <5 packet-years, 5-10 packet years, and >10 packet-years, with the referent group as non-users of snus. The odds ratio of developing MS was lower in those who had greater cumulative snus use (0.85 in those with less than 5 packet-years of use, 0.77 in those with 5-10 packet-years of use, and 0.57 in those who had greater than 10 packet-years of use). When stratified by sex and packet-years, the odds ratio for developing MS was lower in those with over 10 packet-years of use compared with those with only 5-10 packet-years. Notably, the study reported odds ratios for never smokers with 5-10 packet-years and more than 10 packet-years. The odds ratio was lower in never-smokers with more than 10 packet-years (0.45) compared to that of never-smokers with 5-10 packet-years (0.87). Current users who were also smokers had greater positive odds (1.19) of developing MS compared with those who used to smoke (1.42). These risk estimates are all statistically significant, with the exception of those reported for female snus users only. However, the authors note that only the results from unmatched analyses are reported due to the matched analyses being statistically insignificant, though trends were similar (Hedström et al. 2013).

#### Quality Rating of all Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Carlens et al. 2010	Strong
Hedstrom et al. 2009	Moderate
Hedstrom et al. 2013	Moderate
Gustavsen et al. 2014	Moderate

#### Discussion and Conclusions

The two new studies (Hedstrom et al. 2013; Gustavsen et al. 2014) support the findings from the 2013 ENVIRON report in which two studies reported no association between snus use and development of MS (Carlens et al. 2010; Hedstrom et al. 2009). A case-control study (Hedstrom et al. 2009) found a significant lower risk of developing MS in snuff users who smoked, after adjusting for age, sex, ancestry, residential area and smoking. The second study was a cohort of 277,777 males from the Swedish Construction Workers Cohort and found that ever use of snus was not associated with risk of MS after adjusting for smoking. However, the risk was marginally statistically significantly

increased among never-smoking snus users (Carlens et al. 2010), though no dose-response relationship was observed. The authors also noted that the increased risk among exclusive snus users may have been due to chance. Together, the four studies, all with significant power and results but with study-specific limitations, show *limited/suggestive evidence of no association* between snus use and MS.

## **2.8.12 Musculoskeletal Disorders**

### Summary from 2013 ENVIRON Report

No new studies were identified since publication of the 2013 ENVIRON report. Previously reviewed studies reported an increased risk of injury proneness (Heir and Eide 1997), disability pension due to musculoskeletal diagnosis (Bolinder et al. 1992), and disability pension due to neck or low back pain (Holmberg and Thelin 2006), and low back pain (Mattila et al. 2008) in snus users. However, Bolinder et al. (1992) also did not report an increased risk of low back pain in never-smoking snus users compared with non-tobacco users. Other results reported by Bolinder et al. (1992), pain in leg while walking, were not discussed in the 2013 ENVIRON report, but were summarized in Appendix Q-1, and are discussed here.

Heir and Eide (1997) investigated injury proneness in a prospective study of 480 male military conscripts. Snuff use was associated with a significantly increased risk of proneness to musculoskeletal injuries during training, adjusted for age and fitness (OR=2.31; 95% CI: 1.34- 3.99).

Bolinder and colleagues (1992) conducted a cross-sectional study among 37,722 Swedish construction workers and examined the prevalence of disability pension for musculoskeletal diagnoses among snus users. The risk of disability pension for musculoskeletal diagnoses was significantly increased in never-smoking snus users at both age 46-55 years (OR=2.8; 95% CI: 1.6-4.8) and 56-65 years (OR=1.5; 95% CI: 1.2-1.8). Bolinder and colleagues (1992) also examined the prevalence of low back pain within the past year among the 37,722 male Swedish construction workers. Among never-smoking snus users, the prevalence of low back pain within the past year was not significantly elevated (OR=1.1; 95% CI: 1.0-1.2). Furthermore, Bolinder et al. (1992) reported that the risk of having pain in leg while walking was slightly significantly increased in snus users compared with non-tobacco users (OR=1.2; 95% CI: 1.2-1.4). The analyses presented by Bolinder et al. (1992) were either stratified by age groups, or adjusted for age only.

Holmberg and Thelin (2006) examined long-term health outcomes associated with neck and back pain in a prospective cohort study of 1,347 Swedish farmers and rural non-farmers. They found that neck or low back pain at study entry was a significant predictor of consultation with a primary care doctor and sick leave during 12 years of follow-up. Snuff use was considered as a possible confounder; surprisingly, it was identified as a strong independent predictor of disability pension due to neck or low back pain (OR=3.46; 95% CI: 1.35-8.84). There is little information on snuff use and musculoskeletal symptoms; the authors note that this finding must be interpreted cautiously, and that further research is warranted.

Mattila and colleagues (2008) investigated low back pain in a cross-sectional study of 7,040 Finnish, male military conscripts. A significantly increased prevalence of low back pain was observed among smokeless tobacco users (not specified as Swedish snus), adjusted for age, perceived health, and disease during the past year (OR=1.4; 95% CI: (1.2-1.7).

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Heir and Eide 1997	Proneness to musculoskeletal injuries	Weak
Bolinder et al. 1992	Disability pension for musculoskeletal diagnoses, low back pain within past year	Weak
Holmberg and Thelin 2006	Disability pension due to neck or low back pain	Moderate
Mattila et al. 2008	Low back pain	Weak

#### Discussion and Conclusions

Of the four studies reporting on musculoskeletal disorders, two were cross-sectional studies (Bolinder et al. 1992; Mattila et al. 2008) and thus temporality of exposure and effect cannot be deduced based on the evidence. The small prospective cohort study of male military conscripts (Heir and Eide 1997) controlled for age and fitness, but confidence intervals were wide, and results were not adjusted for smoking. In a cohort study with 12 years of follow-up, Holmberg and Thelin (2006) identified a three-fold risk in disability pension due to neck or low back pain in snus users compared with non-users. Though this study (Holmberg and Thelin 2006) was moderate in its study design, the population was limited to a population of farmers and rural non-farmers and the results may not be appropriately representative of the general Swedish population. Based on the results of these four studies (Bolinder et al. 1992; Mattila et al. 2008; Heir and Eide 1997; Holmberg and Thelin 2006), there is *inadequate/insufficient evidence to determine whether an association exists between snus use and various measures of musculoskeletal disorders.*

### **2.8.13 Pain and Post-operative Nausea and Vomiting Following Surgery**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Brattwall and colleagues (2010) examined the effects of snus use and smoking on pain and post-operative nausea and vomiting (PONV) following common day surgical procedures. The authors followed 355 patients during recovery and the first day at home, and found that PONV was significantly reduced during the early post-operative period among tobacco users (which included smokers and snus users). With respect to post-operative pain, no significant impact on incidence was observed for regular tobacco use. The number of regular tobacco users was not sufficient for further sub-group analyses of snus use or smoking individually.

#### Discussion and Conclusions

This single weak study exploring the effects of snus use on pain and PONV following surgery did not include analyses of snus use and smoking individually (Brattwall et al. 2010). The study lacks adjustment for smoking and thus does not evaluate snus exposure effectively. There is *inadequate/insufficient evidence to determine whether an association between snus use and pain and PONV.*

### 2.8.14 Parkinson's disease

#### Summary from 2013 ENVIRON Report

No studies on Parkinson's disease were previously included in the 2013 ENVIRON report.

#### Newly Identified Studies

Two studies that investigated the relationship between Swedish snus use and Parkinson's disease were published since the 2013 ENVIRON report (Liu et al. 2017, Yang et al. 2016). Starting in 1973-1974, a cohort of 20,333 residents free from Parkinson's disease, 15 years of age or older in Uppsala County, Sweden, was followed until 2012 (Liu et al. 2017). The authors reported that use of Swedish snus was associated with a reduced risk of developing Parkinson's disease in males (the association in females was not reported). With the referent group of those who never used tobacco daily, the hazard ratios for exclusive ever snus users of 10 years or less and more than 10 years were below 1: 0.51 (95% CI: 0.2-1.49) and 0.5 (95% CI: 0.23-1.1), respectively. When stratified by amount of snus use, snus use of 10 grams or less per day was associated with lower risk of Parkinson's disease (HR 0.33 95% CI 0.12-0.91) compared to more than 10 grams per day (HR 0.76 95% CI 0.35, 1.66) (Liu et al. 2017).

The second study (Yang et al. 2016) pooled seven cohort studies for a total of 351,640 participants followed from 1978 to 2013 in Sweden, with a mean follow-up of 16.1 years. Among men who had never smoked, ever-snus users had a statistically significant lower risk of Parkinson's disease compared with never-snus users (pooled hazard ratio 0.41; 95% CI: 0.28-0.61). This large cohort study also showed an inverse dose-response relationship between snus use and Parkinson's disease risk: light snus use (less than two cans per week) and moderate-heavy snus use (two or more cans per week) resulted in hazard ratios of 0.71 (95% CI: 0.35-1.43) and 0.41 (95% CI: 0.19-0.90), respectively, with never tobacco users (n=550) as the referent group (Yang et al. 2016).

#### Quality Rating of All Studies

Study	Evidence Quality Rating
Liu et al. 2017	Strong
Yang et al. 2016	Strong

#### Discussion and Conclusions

The two studies exploring the association between Parkinson's disease and snus use in this report were large cohort studies with sufficient statistical power (Liu et al. 2017, Yang et al. 2016). Both studies concluded that the use of Swedish snus was associated with a reduced risk of developing Parkinson's disease. There was a possibility of misclassification of exposure in both studies, as snus exposure was measured at baseline and may have changed over time. In this study (Yang et al. 2016), there was also a relatively small number of exposed cases. Based on the above two studies reporting a decreased risk of Parkinson's disease among snus users, there is *limited/suggestive evidence of an inverse association*.

### 2.8.15 Psychiatric Disorders

#### Summary from 2013 ENVIRON Report

Though some studies suggest snus may be associated with psychiatric disorders, this has not been universally observed, and all the studies are cross-sectional in nature, and simply report an

association; causality, including the issue of temporality cannot be determined based on these studies alone. Other results reported by Bolinder et al. (1992), involving “nervous problems,” were not discussed in the 2013 ENVIRON report, but were summarized in Appendix Q-1 of that report. Bolinder et al. (1992), as well as newly identified studies are summarized and discussed below.

#### Newly Identified Studies

Identified in the 2013 ENVIRON report, Bolinder et al. (1992) reported a large cross-sectional study of male construction workers who received health examinations during 1971 through 1974. After excluding participants who used more than one type of tobacco product or were former smokers, 37,722 people were included in the analyses. The odds of having nervous problems was 20% higher (statistically significant) in those who used snus exclusively compared to non-tobacco users (95% CI 1.1-1.4). The term “nervous problems” is not defined. Due to the cross-sectional nature of the study, temporality cannot be determined. Furthermore, there was no adjustment for any potential confounders other than age, thus, the study is classified as having weak evidence for the relationship between snus and nervous problems.

The association between Swedish snus use and psychiatric disorders was reported in two studies published since the 2013 ENVIRON report. Munafo et al. (2016) investigated the potential relationship between snus use and non-affective psychosis and schizophrenia in a cohort study of 227,117 Swedish men from multiple national registers without a non-affective psychosis or schizophrenia diagnosis. The average age at conscript was 18.2 years and the age at the end of follow up was 26.1 years. After adjusting for smoking, snus users had an elevated risk of non-affective psychosis (HR=1.22; 95% CI: 1.00-1.48), though not statistically significant. For those who use snus exclusively, the risk of developing non-affective psychosis was statistically significantly elevated (HR=1.38; 95% CI 1.09-1.75). Hazard ratios for schizophrenia were not statistically significantly increased (Munafo et al. 2016).

Pedersen and von Soest (2014) reported on the relationship between snus use and depressive symptoms in two (2002 and 2010) pooled population-based cross-sectional studies of 6,217 Norwegian 16- and 17-year-olds. Compared with the group with no tobacco use, the risk of having depressive symptoms were significantly elevated in those with daily snus use (OR: 1.27; 95% CI 1.06-1.51,  $p < 0.05$ ) (Pedersen and von Soest 2014).

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Bolinder et al. 1992	Nervous problems	Weak
Edwards et al. 2011	Major depression	Weak
Engstrom et al. 2010	Psychological distress	Weak
Munafo et al. 2016	Non-affective psychosis and schizophrenia	Moderate
Pedersen and von Soest 2014	Depressive symptoms	Weak

## Discussion and Conclusions

### *Non-affective Psychosis and Schizophrenia*

The cohort study (Munafo et al. 2016) of over 200,000 Swedish men found that there was a significant elevated risk of developing non-affective psychosis and a nonsignificant, elevated risk of schizophrenia. However, due to the relatively low number (n=36) of exposed cases compared to the total cohort enrolled (227,117) and the reference group and follow-up period not precisely defined, this study is limited in its quality of evidence. Based on this single moderate study, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and non-affective psychosis or schizophrenia.

### *Nervous Problems and Psychosocial Distress*

Two cross-sectional studies explored the potential association between Swedish snus and the development of nervous problems and psychological distress (Bolinder et al. 1992 and Engstrom et al. 2010, respectively). Bolinder and colleagues (1992) reported a statistically significant increase in risk of nervous problems compared with non-tobacco users. However, due to the cross-sectional nature of the study design, the temporality of exposure to Swedish snus and development of nervous problems cannot be determined. In contrast, Engstrom et al. (2010) reported a cross-sectional study which concluded that psychological distress and the use of Swedish snus was not significantly associated with psychosocial distress, as measured by the General Health Questionnaire (GHQ-12). Based on these two cross-sectional studies alone, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and these psychiatric endpoints.

### *Major Depression and Depressive Symptoms*

Both studies investigating major depressive or depressive symptoms identified in this and the previous 2013 ENVIRON report conveyed a significant association with the prevalence of snus use (Edwards et al. 2011; Pedersen and von Soest 2014). However, both studies presented limitations: the main limitation being that the studies are cross-sectional and thus temporality cannot be elucidated. Edwards et al. (2010) did not adjust for smoking nor other types of potential confounders including neuroticism and socioeconomic status. The study of Norwegian adolescents (Pedersen and von Soest 2014) had a restrictive age group, and though response rates were high (91.0% in 2002 and 84.3% in 2010), the difference in response rates indicates that a proportion of the population is missed that may or may not be more disposed to using snus. Given these two small cross-sectional studies, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and major depression or depressive symptoms exists.

## **2.8.16 Respiratory Symptoms and Death**

### Summary from 2013 ENVIRON Report

Roosaar and colleagues (2008) found that ever daily use of snus (adjusted for smoking and among never-smokers) was significantly associated with an increased risk of death from respiratory disease among men aged 80 or older. The authors noted that the mechanisms of the observed excess risk of respiratory deaths in this age group could possibly be due to confounding from smoking and remain to be established.

### Newly Identified Studies

Three studies that investigated the relationship between respiratory symptoms and snus use were published since the 2013 ENVIRON report (Bjorkman et al. 2017; Gudnadottir et al. 2017; Zandonai et al. 2016). Bjorkman and colleagues (2017) designed a clinical trial with 42 otherwise healthy snus users with over two years of daily use and doing regular exercise three or more times a week. Twenty-four patients were measured before and after stopping use of snus for over six weeks, and 11 snus users served as controls and continued their usual daily use. The peak value respiratory measurements were taken during maximal running tests:  $\text{VO}_2\text{max}$ , time to exhaustion, peak heart rate, volume of expired air, respiratory exchange ratio, blood lactate, and rating of perceived exertion for breathing and legs. The arithmetic means between the snus cessation group and the controls were not significantly different for any of these measurements, except for time to exhaustion ( $P<0.000$ ) and blood lactate ( $p=0.02$ ). Notably, the authors concluded that endurance exercise performance ( $\text{VO}_2\text{max}$  and maximal endurance time) was not affected by prolonged snus use (Bjorkman et al. 2017).

Gudnadottir et al. (2017) conducted a cross-sectional study of over 25,000 adult respondents who were randomly selected for a questionnaire in the Global Allergy and Asthma European Network survey in four Swedish cities in 2008. The participants were divided into three exposed groups: nonsmoking current daily snus users for six or more months, dual daily users (snus and smoking), former snus users who never smoked, and were compared with two groups: currently tobacco-free including former smokers and tobacco-free never-smokers. Analyses were adjusted for gender, age, BMI, study center, educational level, and physical activity. The risks of having some asthmatic symptoms (particularly wheezing and night-time chest tightness), chronic bronchitis, and chronic rhinosinusitis were significantly increased ( $p<0.05$ ) in both nonsmoking current snus users and dual users when compared with currently tobacco-free participants (Gudnadottir et al. 2017). Risk of asthma and allergic rhinitis was significantly increased among nonsmoking current snus users (OR 1.51; 95% CI: 1.28-1.77; OR 1.17; 95% CI: 1.05-1.3), but not in dual users (OR 0.93; 95% CI: 0.65-1.33; OR 0.92; 95% CI: 0.75-1.13). With tobacco-free never-smokers as the reference group, never-smoking current snus users had increased risk of asthma (OR 1.49; 95% CI: 1.2-1.85), chronic bronchitis (OR 1.47; 95% CI: 1.21-1.78), chronic rhinosinusitis (OR 1.37; 95% CI: 1.11-1.7), and asthmatic symptoms. Overall, the authors reported an association between risk of asthma and current snus use, but observed no increased risk among smokers or dual users. For asthmatic and other respiratory symptoms, there was also an increased risk among snus users as well as among smokers and dual users (Gudnadottir et al. 2017).

Zandonai et al. (2016) conducted a double-blind, randomized crossover clinical trial in which 12 healthy male non-tobacco users used snus or a placebo during exercise. No significant differences between snus or snus placebo were observed for volume of expired air,  $\text{VO}_2$ , nor  $\text{VCO}_2$ . Furthermore, the mean respiratory exchange ratio ( $1.03\pm0.04$ ) during exercise was the same for snus and placebo (Zandonai et al. 2016).

### Quality Rating of All Studies

Study	Endpoint(s)	Evidence Quality Rating
Bjorkman et al. 2017	Respiratory measures	Strong
Gudnadottir et al. 2017	Asthma, asthmatic symptoms, chronic	Weak

	bronchitis, allergic rhinitis, chronic rhinosinusitis	
Roosaar et al. 2008	Respiratory death	Moderate
Zandonai et al. 2016	Respiratory responses (VE, VO <sub>2</sub> , VCO <sub>2</sub> )	Moderate

## Discussion and Conclusions

### *Respiratory Performance During Exercise*

Two clinical studies tested participants on respiratory performance during exercise (Bjorkman et al. 2017, Zandonai et al. 2016). One clinical trial had snus users stop using for a period of time (Bjorkman et al. 2017) so misclassification of exposure may have occurred due to participants' modification of behavior during follow-up. Snus abstinence was only tested at the very end of cessation, not throughout (Bjorkman et al. 2017). The second clinical trial (Zandonai et al. 2016) was limited in its sample size (only 12 participants). Despite these limitations, these clinical studies on snus use and respiratory performance provide *limited/suggestive evidence of no association* between snus use and respiratory performance during exercise.

### *Asthma and Other Respiratory Issues*

Gudnadottir and colleagues (2017) conducted a large cross-sectional study of over 25,000 Swedish adults but the nature of the study design prevents any conclusion regarding the temporal relationship between snus use and the respiratory outcomes investigated. Furthermore, some analyses were based upon a tobacco-free comparison group that in actuality included nearly 27% former smokers and thus does not represent a true tobacco-free group (Gudnadottir et al. 2017). Based on this single cross-sectional study, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and asthma, asthmatic symptoms, chronic bronchitis, allergic rhinitis, or chronic rhinosinusitis.

### *Respiratory Death*

The population-based cohort study conducted by Roosaar et al. (2008) is strong in its design (over 220,000 person-years), but did not adjust for confounding by dietary pattern, physical activity, and socioeconomic status that could have shifted the relative risks in any direction. Statistical imprecision is a second limitation, since the exposed cases were few and resulted in risk estimates with wide confidence intervals (Roosaar et al. 2008). This single cohort study lacked important information on covariates and provides *inadequate/insufficient evidence to determine whether an association exists* between snus use and respiratory death.

## **2.8.17 Rheumatoid Arthritis**

### Summary from 2013 ENVIRON Report

The cohort study conducted by Carlens and colleagues (2010) investigated the relationship between tobacco smoking and snus use and rheumatoid arthritis. Ever use of snus (adjusted for smoking) was not associated with risk of rheumatoid arthritis (RR=1.0; 95% CI: 0.9-1.2), nor was the use of snus among never-smokers associated with risk of rheumatoid arthritis (RR=1.2; 95% CI, 0.8-1.8). Smoking was significantly associated with an increased risk of developing rheumatoid arthritis.



### Newly Identified Studies

Two studies that investigated the association between Swedish snus use and rheumatoid arthritis were identified since the 2013 ENVIRON report (Andersson et al. 2013; Jiang et al. 2014). Andersson et al. (2013) examined 2,800 patients enrolled from 1992-2005 and followed through 2010 in a longitudinal observational study of participants with early rheumatoid arthritis in southern Sweden. Fifty-one snus-using patients were identified and compared with 49 never-smoking controls using a composite score called the DAS28 (Disease Activity Score using 28-joint count) measuring the number of swollen and tender joints, erythrocyte sedimentation rate, and patient's global assessment. The snus users had statistically significant lower mean DAS28 scores ( $p=0.001$ ) at 3 months' (2.0) and 6 months' follow-up (2.1), but not after 1, 2, or 5 years compared with never smokers (3 months: 3.7; 6 months: 3.2). These mean scores were statistically significantly different between snus users and never-smokers only after adjustment for socioeconomic class, disease duration, and number of previous disease-modifying anti-rheumatic drugs and biologics (Andersson et al. 2013). When comparing snus users with current smokers, clear trends were not evident.

The second study exploring the connection between snus use and rheumatoid arthritis was a case-control study consisting of 1,998 cases and 2,252 controls over the study period 1996 to 2006 (Jiang et al. 2014). The study calculated the odds ratios for three outcomes (rheumatoid arthritis, anti-citrullinated protein/peptide antibody positive rheumatoid arthritis, and anti-citrullinated protein/peptide antibody negative rheumatoid arthritis) in varying groups of snus users: ever, current, and former snus users, combined with never smoking, ever smoking, or [combined] light, former or never smoking habits. All odds ratios hovered around 1 and were not statistically significant. They were calculated using unconditional logistic regression models and were adjusted for cigarette smoking, alcohol consumption, and matching variables (Jiang et al. 2014).

### Quality Rating of all Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Carlens et al. 2010	Strong
Andersson et al. 2013	Weak
Jiang et al. 2014	Moderate

### Discussion and Conclusions

Two of the three studies evaluating snus use and rheumatoid arthritis concluded that there was no association (Jiang et al. 2014, Carlens et al. 2010). Jiang and colleagues' (2014) population-based case-control study enrolled incident rheumatoid arthritis cases with limited potential for selection bias as evidenced by high participation rates. The study lacked information on intensity of snus use (Jiang et al. 2014). The magnitude of selection and information biases that are common in case-control studies cannot be determined and may have skewed the results toward the null. The high-powered, prospective study conducted by Carlens et al. (2010) followed a large cohort of 277,777 male construction workers with relatively high prevalence of exposure, with long follow-up (mean 20 years) and limited recall and information bias. However, snus use was only estimated from a single visit and potential changes in tobacco habits were not recorded over time (Carlens et al. 2010).

One study reported a slight inverse relationship between snus use and rheumatoid arthritis as measured by composite measurement DAS28 (Andersson et al. 2013) that was no longer present at 1,

2, or 5 years' follow-up. Potential misclassification and recall bias were present because snus use was assessed retrospectively. Furthermore, the sample size was small at only 51 snus users and 49 never-smoking controls (Andersson et al. 2013). Based on a strong and moderate study showing a lack of an association between rheumatoid arthritis and snus use (Carlens et al. 2010, Jiang et al. 2014), and the single smaller study that concluded an inverse relationship using a composite scoring system early on in follow-up, there is *limited/suggestive evidence of no association* between snus use and rheumatoid arthritis.

### **2.8.18 Sarcoidosis**

No new studies were identified since publication of the 2013 ENVIRON report.

#### Summary from 2013 ENVIRON Report

Carlens and colleagues (2010) also examined the relationship between tobacco smoking and snus use and sarcoidosis. Ever use of snus, adjusted for smoking, or among never-smokers was not associated with increased risk of sarcoidosis (RR=0.9; 95% CI: 0.8-1.5 for both). However, smoking was protective against developing sarcoidosis, which the authors note is consistent with findings from other studies.

#### Discussion and Conclusions

This cohort study (Carlens et al. 2010) was limited in its measure of exposure: tobacco habits were only measured at study entry but potential changes in tobacco habits over time could influence the results. Furthermore, due to the "healthy worker effect" in that construction workers may have specific exposures and characteristics which would restrict the generalizability of the results. However, this study provided strong evidence overall, and based on this single large study, there is *limited/suggestive evidence of no association* between snus use and risk of sarcoidosis.

### **2.8.19 Skin Conditions**

#### Summary from 2013 ENVIRON Report

Wolk and colleagues (2009) investigated the relationship between a variety of risk factors, including smoking and smokeless tobacco use and plaque psoriasis in a case-control study in Stockholm, Sweden. No association was observed between current snus use and plaque psoriasis (OR=1.0; 95% CI: 0.6-1.9).

#### Newly Identified Studies

One study that investigated the relationship between Swedish snus use and skin conditions was published since the 2013 ENVIRON report (Wrangsjo et al. 2015). Wrangsjo and colleagues (2015) conducted a cross-sectional study of 47,931 randomly chosen adults from the Stockholm, Sweden population register in 2006. With a response rate of 58%, participants self-reported on their snus use, smoking, hand eczema and doctor-diagnosed psoriasis. After adjustment for potential confounders (stress, obesity, physical exercise) there was a statistically significant inverse association between daily exclusive snus use and reported hand eczema (prevalence proportion ratio 0.813; 95% CI 0.686-0.964,  $p=0.017$ ) with the non-tobacco users as the referent group (Wrangsjo et al. 2015). In dual users (snus and smoking), the prevalence proportion ratio showed a slight positive association but was not statistically significant (PPR=1.187; 95% CI: 0.851-1.655,  $p=0.313$ ). The authors concluded that there was no positive association between snus use and hand eczema. Only 3.3% of

respondents had doctor-diagnosed psoriasis, and with no potential confounders reported, there was no association reported between psoriasis and exclusive snus use (PPR=1.064; 95% CI 0.861-1.316,  $p=0.566$ ).

#### Quality Rating of all Studies

Study	Endpoint(s)	Evidence Quality Rating
Wolk et al. 2009	Plaque psoriasis	Moderate
Wrangsjo et al. 2015	Hand eczema, psoriasis	Moderate

#### Discussion and Conclusions

The authors of two population-based studies in Sweden both concluded that there was no association between snus use and the development of psoriasis or eczema (Wolk et al. 2009, Wrangsjo et al. 2015). The case-control study (Wolk et al. 2009) was well designed; odds ratios were adjusted for age, sex, post code, body mass index, weight gain, alcohol, and smoking and the response rate was 88%. However, potential selection bias as a part of the case-control design cannot be fully accounted for, and the study was moderately-sized with less than 400 cases. Wrangsjo and colleagues (2015) performed a large cross-sectional study, but the response rate was low (58%), and temporality between exposure and outcome cannot be determined. Based on the two studies investigating psoriasis and hand eczema summarized above, there is *limited/suggestive evidence of no association* between snus use and these skin conditions.

## **2.8.20 Sleeping Problems**

#### Summary from 2013 ENVIRON Report

Although Bolinder et al. (1992) investigated the association between snus use and sleeping disturbances, these results were not discussed in the 2013 ENVIRON report, but were summarized in Appendix Q-1, and are discussed below along with newly identified studies.

#### Newly Identified Studies

Bolinder and colleagues (1992) conducted a large cross-sectional study of male Swedish construction workers, previously described in Section 2.8.9 General Health. Compared with non-tobacco users, both snus users and smokers (15 or more cigarettes per day) had significantly elevated odds of reporting sleeping disturbances: snus users OR 1.2; 95% CI 1.1-1.4; smokers OR 1.8; 95% CI 1.7-2.0 (Bolinder et al. 1992).

Two cross-sectional studies that evaluated the potential association between snus use and sleeping problems were published since the 2013 ENVIRON report (Gudnadottir et al. 2017, Pettersson et al. 2016). The larger study (Gudnadottir et al. 2017) included 26,697 respondents aged 16 to 75 years from four Swedish cities who were randomly selected for a postal questionnaire in the Global Allergy and Asthma European Network survey in 2008. The authors concluded that snus users had an increased risk of some sleep problems (snoring, difficulty initiating sleep, excessive daytime sleepiness) but decreased risk of difficulty maintaining sleep, compared to current tobacco-free respondents not excluding former smokers. Non-smokers who had been using snus daily for six months or more had a significantly higher risk ( $p<0.05$ ) of snoring (OR=1.41; 95% CI: 1.25-1.58), difficulty initiating sleep (OR=1.76; 95% CI: 1.56-1.99), excessive daytime sleepiness (OR=1.18; 95% CI: 1.07, 1.31), and use of medication for sleeping problems (OR=1.33; 95% CI: 1.07-1.65).

than tobacco-free former and never-smokers. The nonsmoking daily snus group had a decreased risk of difficulty maintaining sleep than current tobacco-free participants (OR=0.74; 95% CI: 0.66-0.83). Similar findings were reported for dual users (snus and smoking). Another exposed group were never-smokers who use snus daily for at least six months. Compared with tobacco-free never-smokers, snus users had significantly greater risk ( $p<0.001$ ) of snoring (OR=1.53; 95% CI: 1.29-1.82), and difficulty initiating sleep (OR=1.71; 95% CI: 1.44, 2.03), and significantly decreased risk ( $p<0.001$ ) of having difficulty maintaining sleep (OR=0.71; 95% CI: 0.59-0.84) and early morning awakening (OR=0.83; 95% CI: 0.67-1.04).

The second cross-sectional study consisted of 1,080 Swedish veterans from Kosovo and Afghanistan and 26,723 Swedes from a general population sample (Pettersson et al. 2016). Of the military participants, 297 were snus users while 2,886 of the general population sample used snus; veterans were three times more likely to use snus compared with Swedish civilians. The study combined veterans and the general population to evaluate sleep problems in the form of snoring, difficulty inducing sleep, difficult maintaining sleep, early morning awakenings, insomnia, and excessive daytime sleepiness, and adjusted for military assignment, age, sex, BMI, asthma, history, smoking history, educational level, and physical exercise. When daily snus users were compared against non-snus users, daily snus users had a statistically significant higher risk of having the following sleep problems: snoring (OR=1.28; 95% CI: 1.15-1.41), difficulty inducing sleep (OR=1.65; 95% CI: 1.48-1.83), excessive daytime sleepiness (OR=1.11; 95% CI: 1.02-1.22). Pettersson and colleagues calculated statistically significant lower risk of early morning awakenings (OR=0.81; 95% CI: 0.72-0.92) and difficulty maintaining sleep (OR=0.74; 95% CI: 0.67-0.82) in daily snus users compared with non-snus users.

#### Quality Rating of all Studies

<b>Study</b>	<b>Evidence Quality Rating</b>
Bolinder et al. 1992	Weak
Gudnadottir et al. 2017	Weak
Pettersson et al. 2016	Weak

#### Discussion and Conclusions

The three studies exploring the relationship between snus use and sleeping problems found that there may be a positive association for some sleeping issues and no association for others (Bolinder et al. 1992, Gudnadottir et al. 2017, Pettersson et al. 2016). Gudnadottir and colleagues (2017) reported that snus users specifically had increased risk of snoring, difficulty initiating sleep, excessive daytime sleepiness and decreased risk in other issues including difficulty maintaining sleep and early morning awakening in some groups. This is supported by the Pettersson et al. study wherein it was reported that there was evidence for an association between snus use and snoring, difficulty inducing sleep, and excessive daytime sleepiness and a decreased risk for difficulty maintaining sleep and early morning awakenings. However, due to the cross-sectional design of the studies, and inconsistent results for different types of sleeping issues, there is *inadequate/insufficient evidence to determine whether an association exists* between snus use and sleeping problems.

## **2.8.21 Survival Following a Cancer or MI Diagnosis**

### Summary from 2013 ENVIRON Report

The 2013 ENVIRON report included summary tables (Appendix H and Q-3) of data from the Nordenvall et al. (2013) study (previously cited as Nordenvall et al. 2012), but did not include a discussion in the report. The 2013 EVIRON report also had not identified relevant sensitivity analyses conducted by Hergens et al. (2007), which are relevant to the endpoint of survival following a non-fatal MI event. Nordenvall et al. (2013) and Hergens et al. (2007), as well as two newly identified studies (Arefalk et al. 2014; Wilson KM et al. 2016) are summarized and discussed below.

#### Newly Identified Studies

Hergens and colleagues (2007) extended the follow-up of the Swedish Construction Worker cohort through 2003 and examined mortality amongst those who experienced a nonfatal myocardial infarction during follow-up as part of a sensitivity analysis in the study. Information on “snuff” use was obtained from follow-up visits starting in 1978 as snuff use data before that date was deemed incomplete. Overall risk of dying from all causes following a non-fatal MI event was statistically significantly increased (RR=1.38; 95% CI: 1.11–1.71) among never smoking ever snus users, compared to never-users of tobacco, following adjustment for age, BMI, and region of residence.

Nordenvall et al. (2013) examined a subgroup of 40,230 men from the Swedish Construction Worker cohort that developed cancer during the study. Tobacco use information was collected from 1971 – 1992, and participants were followed until 2007 through the use of population and health registers. The cohort included 1,946 exclusive snus users and 9,578 never-users of any tobacco. Compared to never use of any tobacco at study entry, exclusive snus use was associated with a modest increased risk of death from any cause (HR=1.13; 95% CI: 1.05, 1.20), death from cancer at the same site as the primary cancer (HR=1.15; 95% CI: 1.05, 1.26), and death from causes other than cancer (HR=1.12; 95% CI: 1.01, 1.25). Hazard ratios were adjusted for age at cancer diagnosis, calendar period of diagnosis, cancer site, and BMI at study entry.

Wilson et al. (2016) examined a subgroup of 9,582 men from the same cohort who developed prostate cancer during the follow-up period through 2007. This cohort included 460 exclusive snus users and 2,762 never-users of any tobacco. Compared to never-users of any tobacco at study entry, exclusive snus use was associated with a modest increased risk of death from prostate cancer (HR=1.24; 95% CI: 1.03, 1.49) and death from any cause (HR=1.19; 95% CI: 1.04, 1.37). Hazard ratios were adjusted for age, time period of diagnosis, BMI, and time between examination and diagnosis.

Arefalk and colleagues (2014) followed a cohort of 20,911 MI patients who were admitted to a Swedish coronary care unit between 2005 and 2009 to investigate the effects of quitting snus on cardiovascular mortality and events. The population included 1,799 post-MI snus users and 675 post-MI snus quitters; comparisons were limited by the lack of exclusive snus users and never-users of snus. The risk of mortality from any cause among post-MI snus quitters following an MI event was reduced by almost half (HR: 0.55; 95% CI 0.31, 0.99) compared to those who continued to use snus in a model (Model D) adjusted for age, sex, smoking exposure, diabetes mellitus, hypertension, blood pressure, BMI, waist circumference, LDL/HDL ratio, type of MI, occupation status, physical activity (4 levels), participation in cardiac rehabilitation program, treatment with aspirin, treatment with any other platelet inhibitor (primarily clopidogrel),  $\beta$ -blockers, statins, and renin-angiotensin-aldosterone system inhibitors (angiotensin-converting enzyme inhibitor or angiotensin 2 receptor blocker). In the “main Model C,” which included adjustment for age, sex, past and present smoking and sun exposure,

respectively, occupation status, participation in cardiac rehabilitation program, the result was similar, though it was not statistically significant (HR: 0.57; 95% CI 0.32, 1.02). Mortality due to non-cardiovascular events was similarly decreased using the model C adjustment factors (HR 0.43; 95% CI 0.15, 1.27).

#### Quality Rating of all Studies

<b>Study</b>	<b>Endpoint(s)</b>	<b>Evidence Quality Rating</b>
Arefalk et al. 2014	Overall, and non-CVD mortality following MI event	Moderate
Hergens et al. 2007	Overall, following MI event	Moderate
Nordenvall et al. 2013	Overall, primary cancer, and non-cancer mortality following cancer diagnosis	Moderate
Wilson KM et al. 2016	Overall, and prostate cancer mortality following prostate cancer diagnosis	Moderate

#### Discussion and Conclusions

##### *Survival following a cancer diagnosis*

Though these studies (Nordenvall et al. 2013; Wilson KM et al. 2016) were well conducted, and included large populations, they present some important limitations and design considerations. Neither study allows for the assessment of the risk of developing cancer among snus users because participants had already been diagnosed when selected for inclusion in the study. Instead, these studies assessed survival following diagnosis. Although the studies suggest a potential role for snus use in disease progression, increased risks were also observed for non-cancer deaths, and overall mortality. Furthermore, tobacco use was assessed only at study entry. Tobacco habits may have changed over time, and the authors were unable to confirm whether the participants were still users around the time of diagnosis and/or death. The time between study entry and diagnosis was potentially quite long. For example, Wilson et al. (2016) reported an average of 20 years. Additionally, given the relatively modest increases in risk among snus users, minor differences in risk factors (measured or unmeasured) for mortality between snus users and never-users of tobacco could explain these increases. The evidence provided by the two cancer studies was rated as moderate, but because these studies included participants from the same population and presented other limitations discussed previously, we concluded that the studies provide *inadequate/insufficient evidence to determine whether an association exists* between snus use and survival following a cancer diagnosis.

##### *Survival following an MI diagnosis*

The study conducted by Arefalk et al. (2014) included some mixed results, depending on the adjustment model used by the study authors. Furthermore, there was a limited number of never-smoking snus users, with no analyses conducted among exclusive users), and no comparisons with never-users of tobacco were presented. Although Hergens et al. (2007) reported an increased risk of mortality following an MI diagnosis of snus users compared to never-users of tobacco, the snus user group included ever users, and not necessarily current users of tobacco following MI diagnosis. Overall, although these studies were rated as moderate in quality, each provide evidence that is

limited in different ways, and overall, present *inadequate/insufficient evidence to determine whether an association exists* between snus use and survival following an MI diagnosis.

### **2.8.22 Tongue Abnormalities**

#### Summary from 2013 ENVIRON Report

No studies on tongue abnormalities were previously included in the 2013 ENVIRON report.

#### Newly Identified Studies

A single study examined the relationship between Swedish snus use and tongue abnormalities, namely geographic tongue and fissured tongue (Dafar et al. 2015). Geographic tongue is defined by the loss of filiform papillae resulting in lesions in a map-like pattern, whereas fissured tongue is a condition where grooves or fissures develop in the dorsal and lateral surfaces of the tongue. Dafar et al. (2015) published a case-control (described as “retrospective cross-sectional”) study that enrolled a total of 6,448 dental patients in Borås, Sweden from 2004 to 2006. Patients who were not referred to oral medicine specialists (examined by a general dental practitioner) totaled 130 with geographic tongue (mean age 59.9 years) and 62 with fissured tongue (mean age 65.9 years). A second group consisted of patients referred to oral medicine specialists, with 166 geographic tongue patients and 15 fissured tongue patients, but this group was not included in the analyses of interest. 1,029 patients (mean age 55.2 years) with no oral mucosal lesions served as controls. Snus use was significantly more prevalent among those with geographic tongue vs. controls (10.1% vs. 3.8%,  $p\text{-value}<0.01$ ). No significant difference was observed in prevalence of snus use among those with fissured tongue. Multiple logistic regression analysis controlling for age and gender yielded a statistically significant 2.1 odds ratio (95% CI: 1.1, 4.35;  $p\text{-value}=0.025$ ) of using Swedish snus and having geographic tongue or fissured tongue, compared with controls.

#### Discussion and Conclusions

This study (Dafar et al. 2015) demonstrates that snus use is associated with geographic tongue and fissured tongue. However, a major limitation of the study is that smoking was not controlled for in assessing the potential relationship between snus use and tongue abnormalities. Overall, the evidence shown in this study is weak and provides *inadequate/insufficient evidence to determine whether an association exists*.

### **2.8.23 Vitamin D Levels**

#### Summary from 2013 ENVIRON Report

No studies on vitamin D levels were previously included in the 2013 ENVIRON report.

#### Newly Identified Studies

One study that investigated the association between Swedish snus use and vitamin D levels was published since the 2013 ENVIRON report (Oberg et al. 2014). This population-based cross-sectional study included 890 adolescents (475 boys and 415 girls) in Norway who attended school from September 2010 through April 2011. Vitamin D in serum was inversely associated with boys’ snus use ( $p\text{-value}=0.01$ ) but not with girls’ snus use ( $p\text{-value}=0.1$ ) reported via questionnaire. Snus use was reported in three categories: “Never”, “Sometimes”, and “Daily” use. Serum vitamin D levels were slightly lower in the “Sometimes” compared to “Daily” group, and both these groups had lower vitamin D levels than the “Never” group for boys. These linear trends in boys were statistically significant in

univariate analyses. The trend between vitamin D levels and girls' snus use was less clear, and statistically insignificant.

### Discussion and Conclusions

A major flaw of the study (Oberg et al. 2014) is that it did not account for potential confounders, such as weight, exercise, and diet. The study population was fairly small and geographically limited. Based on the limited cross-sectional nature of the study and lack of adjustment for confounding factors, it cannot be concluded whether or not snuff affects serum vitamin D levels, and whether or not an association is dependent on lifestyle or biological mechanisms. This single, weak study provides *inadequate/insufficient evidence to determine whether an association exists.*



### **3. META-ANALYSES AND STATISTICAL COMPARISONS OF HEALTH RISKS OF SNUS WITH CIGARETTES**

#### **3.1 Purpose**

After systematic identification and review of all relevant human health effects literature (described in Section 1), standard meta-analysis methods were used to quantitatively assess absolute and relative morbidity and mortality risks in snus users and smokers related to the ten smoking-related outcomes listed in Appendix VI of the 2013 ENVIRON report. These outcomes included lung, pancreatic, oral, esophageal, and stomach cancer, as well as metabolic syndrome, diabetes, cardiovascular diseases, and all-cause mortality. The summary health risks for each of these outcomes were calculated for snus users and smokers in the same study population. A within study comparative risk between snus users and smokers was calculated when mutually exclusive estimates were available. An additional wald-type test was done between snus and smoker summary estimates for all outcomes. Meta-analyses were undertaken to answer the following questions for each outcome of interest:

1. What are the absolute risks for an outcome for snus users compared to never users of tobacco (or never smokers)?
2. What are the absolute risks for an outcome for smokers from within the same study populations of Swedish snus users compared to never users of tobacco (or never snus users)?
3. Compared to smokers are snus users at a lower risk of developing the outcomes investigated?

#### **3.2 Introduction**

This section summarizes the health risks associated with Swedish snus compared to those from smoking. Quantitative results for the absolute risk of snus were used as supporting evidence for the conclusions in section 2, and statements on whether they align are provided.

The adverse health outcomes causally related to smoking were first confirmed in the 1960s, and have been well studied since that time (USDHHS 2010). These include lung and other cancers, noncancer pulmonary outcomes, such as emphysema and chronic obstructive pulmonary disease (COPD), cardiovascular diseases, and reproductive and developmental effects. The estimated disease mortality burden that smoking poses in the US has been quantified using relative risk estimates from the American Cancer Society's Cancer Prevention Study II (CPS-II), (See table 3-1) ranked by the highest number of deaths among smokers attributed to that health outcome (CDC 2008). More recently, the Food and Drug Administration revised the estimates of smoking-attributable mortality using updated relative risks based on National Health Interview Survey data (Rostron 2012). In the updated analysis, the estimated attributable fractions of smoking-related deaths were very similar to those presented in the CDC (2008) analysis (see Table 3-2). There were, however, fewer disease-specific categories; therefore, the original CDC (2008) estimates were used in the following analysis for all outcomes of interest except lung cancer, ischemic heart disease (IHD), other heart disease and stroke, for which the updated Rostron (2012) estimates were able to be used.

<b>Table 3-1: Estimated Number of Outcome-Specific Deaths and Attributable Fraction among All Smokers, 2000-2004</b>			
<b>Rank (by # of deaths)</b>	<b>Outcome</b>	<b>Smoking Deaths</b>	<b>Attributable Fraction*</b>
1	<b>Lung Cancer</b>	125,522	32.0%
2	<b>IHD</b>	80,005	20.4%
3	COPD	78,988	20.1%
4	<b>Other heart disease</b>	21,004	5.3%
5	<b>Stroke</b>	15,922	4.1%
6	Bronchitis, Emphysema	13,927	3.5%
7	Pneumonia, influenza	10,423	2.7%
8	<b>Esophageal Cancer</b>	8,592	2.2%
9	Aortic Aneurysm	8,419	2.1%
10	<b>Pancreatic Cancer</b>	6,683	1.7%
11	Urinary Bladder Cancer	4,983	1.3%
12	<b>Oral Cancer</b>	4,893	1.2%
13	Kidney Cancer	3,043	0.8%
14	Laryngeal Cancer	3,009	0.8%
15	<b>Stomach Cancer</b>	2,484	0.6%
16	Atherosclerosis	1,893	0.5%
17	Other circulatory disease	1,254	0.3%
18	AML	1,192	0.3%
19	Cervical Cancer	447	0.1%
*Among a total estimate of 392,683 smoking-related deaths (males and females combined) <b>Bolded</b> outcomes were those analyzed in this report Reference: CDC 2008 (Based on CPS-II data)			

<b>Table 3-2: Estimated Number of Outcome-Specific Deaths and Attributable Fraction (AF) among All Smokers, 2004</b>			
<b>Rank (by # of deaths)</b>	<b>Outcome</b>	<b>Smoking Deaths</b>	<b>Attributable Fraction*</b>
1	Lung Cancer	118,950	31.5%
2	COPD	91,045	24.1%
3	IHD	88,525	23.4%
4	Other heart disease	16,113	4.3%
5	Stroke	14,692	3.9%
6	Pneumonia, influenza	10,444	2.8%
*Among a total estimate of 377,521 smoking-related deaths (males and females combined) Reference: Rostron (FDA) 2012 (Based on NHIS data)			

### 3.2.1 Selection of Endpoints

The selection of outcomes for meta-analyses followed an examination of smoking-related mortality published by the CDC (2008). All endpoints identified by CDC (2008) were considered, however many were excluded from consideration from meta-analyses due to insufficient studies (See table 3-3). Additionally, diabetes and metabolic syndrome were included due to high interest in the scientific community on these endpoint's relationship with smoking. All-cause mortality was included due to general interest in overall mortality regardless of cause.

<b>Table 3-3: Endpoint Inclusion</b>			
<b>Endpoint</b>	<b>Included</b>	<b>Number of Studies</b>	<b>Reason(s)</b>
Lung Cancer	Yes	3	CDC
IHD	Yes	10	CDC
COPD	No	0	No studies
Other heart disease	Yes	2	CDC
Stroke	Yes	8	CDC
Bronchitis, Emphysema	No	1	Insufficient studies
Pneumonia, influenza	No	0	No studies
Esophageal Cancer	Yes	4	CDC
Aortic Aneurysm	No	1 animal study	Insufficient studies
Pancreatic Cancer	Yes	4	CDC
Urinary Bladder Cancer	No	1	Insufficient studies
Oral Cancer	Yes	10	CDC
Kidney Cancer	No	1	Insufficient studies
Laryngeal Cancer	No	1	Insufficient studies
Stomach Cancer	Yes	5	CDC
Atherosclerosis	No	1	Insufficient studies
Other circulatory disease	No	1	Insufficient studies
AML	No	1	Insufficient studies
Cervical Cancer	No	0	No studies
Diabetes	Yes	9	Although not confirmed as smoking-related outcomes by the US Surgeon General (USDHHS 2010), included due to the significant burden of morbidity in the population, and high interest as potentially tobacco-related outcomes within the scientific community
Metabolic syndrome	Yes	4	Although not confirmed as smoking-related outcomes by the US Surgeon General (USDHHS 2010), included due to the significant burden of morbidity in the population, and high interest as potentially tobacco-related outcomes within the scientific community

In the following analyses, the relative risks for smoking-related adverse health outcomes were compared between smokers and Swedish snus users, in the epidemiological studies that provide both of these estimates in a common study population, relative to nontobacco users in the study population. The health outcomes examined were those with the highest number of deaths attributable to smoking, as well as several additional health outcomes, as provided in the epidemiological studies. Though accounting for significantly fewer smoking-related deaths compared to some of the outcomes

presented in 3-1, other outcomes were included in this analysis for a variety of reasons. Pancreatic cancer was included in this section due to ongoing controversy within the scientific community, though it accounts for only 1.7% of smoking-related deaths in the US annually. Although not confirmed as smoking-related outcomes by the US Surgeon General (USDHHS 2010), diabetes and metabolic syndrome were also included due to the significant burden of morbidity in the population, and high interest as potentially tobacco-related outcomes within the scientific community. Oral cancer was included because it is commonly misperceived, by the general public and some within the scientific community, as an outcome related to Swedish snus, though numerous epidemiological studies and scientific reviews have now confirmed that such an association is weak, if it exists at all. In the CDC (2008) analysis, oral cancer accounted for 1.2% of smoking-related deaths annually in the US. Uncertainty about the possible relationship with snus remains for two other health outcomes presented in this section, notably esophageal cancer and stomach cancer, which account for 2.2% and 0.6% of annual smoking-related deaths, respectively. The health outcomes included in this analysis, combined with nonmalignant respiratory diseases known to be caused by smoking and unlikely to be caused by use of Swedish snus, account for nearly all, approximately 90%, of smoking-related deaths.

### **3.2.2 Differences from Previous Report**

The previous ENVIRON (2013) report focused on cause-specific mortality outcomes attributed to smoking with a qualitative synthesis of evidence paired with pictorial depictions of individual snus- and smoking-related study relative risk estimates, summary estimates from contemporary snus meta-analyses, and smoking relative risk estimates from large US cohorts. See Appendix VI of the ENVIRON (2013) report for complete details. The previous pictorial depictions of studies included relevant reported relative risk estimates, however did not include meta-analysis summary estimates or statistical tests of heterogeneity. The prior report also excluded studies with no smoking comparison group within the same study.

In response to comments from the FDA, this report used standard meta-analysis techniques to calculate summary estimates for snus users and smokers for the snus-related epidemiological studies, which allowed us to include all relevant studies for the endpoints evaluated, as well as to compare potential differences in risk among snus users and smokers quantitatively. A wald-like test was used to compare snus and smoker effect measures within studies or between summary estimates (Altman and Bland 2003). Sensitivity analyses were performed to assess changes in summary estimates due to different methodological selection of study effect measures. Data previously included in outcome summary tables has been updated and reformatted to more easily compare outcomes and study characteristics (see Appendix G). Results from newly identified meta-analyses and those in the prior report are also presented for comparison purposes. This report reflects the updated set of studies identified in Section 2.

Methodologically, this report focused on conducting meta-analyses with clear nominal or ICD-defined outcomes, independence between study populations, preference for exclusivity between smoking and snus exposure groups, preference for stratification as method of control for tobacco, preference for controlled estimates, and comparable exposure characterizations within studies of smoker and snus exposure groups.

### **3.3 Methods**

#### **3.3.1 Literature Identification and Review**

Selection of literature and associated effect measures for meta-analyses followed the process described in Section 1 with additional considerations to determine comparability of studies for meta-analysis. These considerations included explicit assessment of outcome specificity, the morbidity and mortality measurement, study design, independence of study populations, method of control for tobacco, exposure characterizations, reference group characterizations, and confounders considered.

#### **3.3.2 Procedure to Determine Suitability for Meta-Analysis**

Study selection for every outcome followed a systematic procedure to assess suitability for meta-analysis that involved exploration of the following questions: 1) Are the study outcomes sufficiently similar and the study populations independent from one another to calculate a meaningful overall summary statistic? 2) Are there exclusive reported snus and cigarette effect measures within a study to calculate a relative risk ratio within studies? And 3) How are meta-analysis statistics affected by sensitivity analyses varying included effect measures based on exposure characterization, study design, and other relevant criteria?

##### **3.3.2.1 Outcome Similarity, Independence, and Exposure Characterization**

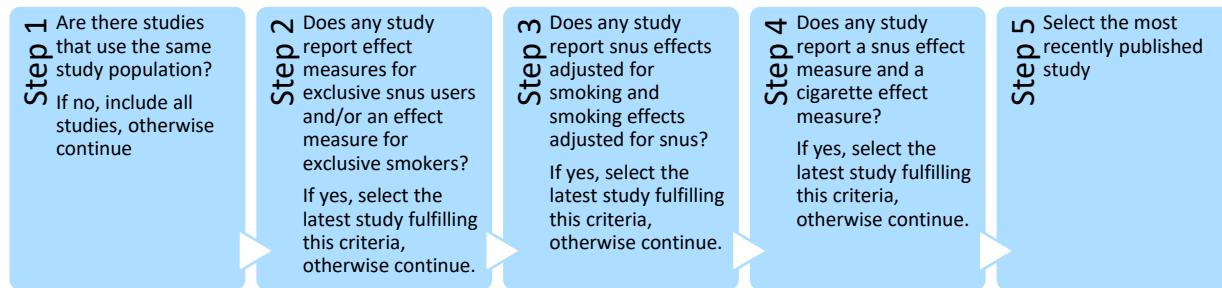
Similarity of outcomes in studies was determined by reviewing the outcome measure and definition. Studies reported on prevalence, incidence, or mortality and had an outcome defined nominally or through ICD codes. Studies were first grouped into the broad encompassing endpoint category identified in the systematic review, then divided into groups based on reported prevalence, incidence, or mortality. Lastly each of these groups were divided into subsets based on their ICD codes when possible. Nominal definitions were matched to nominal definitions of an ICD code group. When a study with a nominal definition is included, other studies with the same nominal definition will be included even if the ICD codes do not completely match with the study reporting ICD codes for the outcome. A meta-analysis summary estimate was calculated when at least two independent studies had comparable outcome measures.

Determining suitability for inclusion of a study in the main meta-analysis required establishing independence between study populations.<sup>a</sup> Estimating a summary effect measure is best when each effect measure comes from an independent sample of studies, however occasionally different studies will present results from the same cohort either as an “update” with longer follow-up or some minor inclusion and exclusion criteria differences. In order to maintain independence between studies using the same cohort, only one study was selected for inclusion in the main meta-analysis. When multiple studies used the same cohort, the newest study that reported exclusive snus and/or smoker effect measures was preferred (See Figure 3-1 for more detail). Sensitivity analyses were always performed to determine if included or excluded studies affected results.

---

<sup>a</sup> <https://training.cochrane.org/handbook>

**Figure 3-1: Determine Study to Include**



Next, effect measures from the selected studies needed to be based on exposure characterization and the method of control for tobacco. We preferred to use effect measures stratified for tobacco use. In other words, snus effect estimates obtained among never smokers and smoking effect estimates among never snus users. Stratified effect measures reduce residual confounding present in estimates adjusted for smoking or snus use. They also create exclusivity between the two exposure groups. Exclusivity between exposure groups within a study was a prerequisite to calculation of within study relative risk ratios between snus users and smokers. Occasionally, studies would define exposures to be exclusive (i.e. snus only, smoker only) or use a regression model with a dual user interaction term. In these cases, exclusivity was maintained between snus and smoker groups. Sensitivity analyses were performed to assess changes to results with preference of adjusted effect measures.

Often a study would include multiple effect measures varying in method of control, exposure characterization, and comparability of smoker and snus groups that would require selection of an effect measure. Generally, the preference for estimates was assessed in the following order: 1) preference for stratified/exclusive tobacco exposure estimates, 2) preference for multivariate-adjusted for respective tobacco use, 3) preference for comparable exposure characterizations between snus and smoker groups, 4) preference for exposure most commonly shared between studies. Exposure characterization may at times be unclear, in these cases the study estimates may still be included in the main analysis with noted limitations. Sensitivity analyses that excluded such studies were always performed. Lastly, note that either odds ratios, relative risks, or hazard ratios were included in the meta-analyses.

### **3.3.2.2 Risk Comparison Calculation**

There are two methods used to calculate risk comparisons between snus users and cigarette users: 1) A summary estimate calculated using within study relative risk ratios, and 2) A wald-like test based comparison between two summary estimates for snus users compared to cigarette users. Calculations for risk comparisons (relative risk ratios) within studies requires exclusive/independent exposure subgroups and within study relative risk ratios are not calculated for a study if this requirement is unmet. In contrast, the comparison between summary estimates will always be calculated. Inference from these latter comparisons will be limited as residual confounding will be possible. In the rest of this document, the summary estimate for the first method is labeled as "Summary Estimate of Relative Risk Ratios", while the second method is labeled as "Comparison of Summary Estimates".

### 3.3.2.3 Rationale for Sensitivity Analyses

Sensitivity analyses were performed to assess changes in summary estimates due to different inclusion criteria, exposure characterizations, study design, power considerations, and other relevant criteria. Results and graphs for sensitivity analyses for each endpoint are included in Appendix H.

Studies excluded from the main analysis were included during sensitivity analyses to assess any changes in summary estimates that result from consideration of all studies in the outcome group or to assess a different study's effect measure of the same study population. It was important to assess different study's effect measures of the same study population as frequently a cohort would only assess exposure at baseline. Studies with longer follow-up times may be subject to misclassification of exposure and those with shorter follow-up times may be subject to an inadequate latency period. The sensitivity analyses including all studies was conducted as previously identified meta-analyses combine multiple effect measures from the same study population when they determine there is limited overlap. These estimates, however will be unduly influenced from multiple observations of the same study population and its results should be interpreted as such.

Studies frequently differed in characterization of exposure, which varied between ever snus/cigarettes, current snus/cigarettes, or snus/cigarette intensity or duration of usage. When possible, effect measures that used the same exposure and reference group were used in the creation of the summary estimate, but studies were not excluded if they did not use the same exposure group. There is no distinct preference for ever or current characterizations of exposure and the main analyses will present the results for the exposure characterization present within the majority of studies for a specific endpoint. Previous meta-analyses have differed in preference for snus exposure characterization. Boffetta and Straif (2009) show preference for ever snus users, while Lee (2011) shows preference for current snus users. When possible, sensitivity analyses were performed using the alternate exposure characterization for studies that report on multiple exposure characterizations or who present enough information to obtain the alternate exposure characterization. For example, if a study included current and former snus effect estimates, these were grouped via a fixed effect meta-analysis to obtain ever snus user effect estimates.

In this meta-analysis case-control studies were combined with cohort studies, which although commonly done could lead to bias in results. Odds ratios may poorly approximate relative risk when prevalence of outcome is greater than 10%. In cases with a common outcome of interest, the odds ratio will exaggerate the magnitude of an effect compared to the relative risk. Sensitivity analyses excluding case-control studies was done to address this concern.

Preference for exclusive effect measures for smoking and snus use could limit the power of the overall study due to the frequently low number of cases with exclusive exposures. Consequently, adjusted effect measures were used in sensitivity analyses when available to gauge any differences in summary measures.

### 3.3.3 Statistical Methods

The *meta* (version 4.9.2) and *metafor* (version 2.0.0) packages in the R statistical computing environment (version 3.5.0) were used to carry out the meta-analyses and statistical heterogeneity

tests.<sup>a</sup> Meta-analysis summary estimates were performed using a random effects model with the inverse variance method and the DerSimonian-Laird estimator for  $\tau^2$ . Risk comparisons within studies and risk comparisons between summary estimates were performed by a wald-like test described by Altman and Bland (2003).

Effect estimates (RR, OR, or HR) for each systematically identified study were abstracted. If a study presented stratified risk estimates (e.g. separate results for men and women, or different age groups), the results were combined by carrying out a meta-analysis based on a fixed effect model. All estimates stratified by tobacco use were abstracted when available. If unadjusted and adjusted estimates were available, only the adjusted estimates from the study's fully adjusted model – as described by the authors – were abstracted. The main meta-analysis for an endpoint is done only for the same measure (prevalence, incidence, or mortality), a separate meta-analysis is done for each measure of an endpoint when multiple measures are available per endpoint. Operational definitions of exposures and reference groups were noted for each study. Sensitivity analyses involved conducting modified analyses to obtain summary estimates for different exposure characterizations, different inclusion criteria, preference for adjusted estimates, and no exclusion criteria.

The Quality Ratings for individual analyses of each outcome per study was also shown, however it did not factor into the calculation of the summary estimates.

## **3.4 Cancer**

### **3.4.1 Head and Neck Cancer**

#### **3.4.1.1 Overview of Evidence for Head and Neck Cancer**

Head and Neck Cancer consists of oral, pharyngeal, laryngeal, and esophageal cancer. Only one study (Lewin et al. 1998) examined overall cancer of the head and neck. Refer to section 2.3.1 for a qualitative summary of the evidence.

#### **3.4.1.2 Oral and Pharyngeal Cancer**

##### **3.4.1.2.1 Overview of Evidence for Oral and Pharyngeal Cancer**

Smoking accounts for overall 64% of all oral and pharyngeal cancer deaths in the United states and constitutes 1.2% of all deaths among smokers (CDC 2008). Our qualitative evaluation concluded that the evidence is *limited/suggestive of no association* between snus use and oral and pharyngeal cancer.

##### **3.4.1.2.2 Outcome Comparability**

In this evaluation, “oral and pharyngeal cancer” refers to the range of disease outcomes in ICD7: 140-148, ICD8, 9: 140-149, and ICD10: C00-C014. This encompasses studies of the lip, tongue, salivary gland, oral cavity, oral mesopharynx, nasopharynx, hypopharynx, and pharynx. Studies of oral and pharyngeal cancer differed in specificity of their outcome of interest. “Oral cancer” is a subset of oral

---

<sup>a</sup> Metafor package documentation: <https://cran.r-project.org/web/packages/metafor/metafor.pdf>  
Meta package documentation: <https://cran.r-project.org/web/packages/meta/meta.pdf>



and pharyngeal cancer that refers to the range of disease outcomes in ICD7: 140-144, ICD8, 9: 140-145, and ICD10: C00-C08. This encompasses studies of the lip, tongue, salivary gland, and oral cavity. These studies also differed in specificity of their outcome of interest.

Ten studies (Ahlbom 1937; Axell et al. 1978; Boffetta et al. 2005; Hirsch et al. 2012; Lewin et al. 1998; Luo et al. 2007; Roosaar et al. 2008; Rosenquist et al. 2005; Schildt et al. 1998a; and Schildt et al. 1998b) identified in our systematic search evaluated outcomes related to oral and pharyngeal cancer. Ahlbom (1937) provided only prevalence data with no effect measures. Consequently, it was excluded from further review for meta-analyses. Axell et al. (1978) did not have an English-language equivalent to review and was also excluded from further review for meta-analyses. Hirsch et al. (2012) presented only a case-series, which is not suitable for meta-analyses. The seven remaining studies were assessed for suitability for meta-analysis for overall oral-pharyngeal cancer and for oral cancer.

Three studies (Boffetta et al. 2005; Lewin et al. 1998; Roosaar et al. 2008), explicitly evaluated incidence of oral and pharyngeal cancer as defined nominally or based on ICD-code. Lewin et al. (1998) used only nominal definitions and report on pharyngeal and oral cavity cancer separately. These separate estimates were combined through fixed effect meta-analysis to create an estimate of overall oral and pharyngeal cancer. The remaining two studies (Boffetta et al. 2005; Roosaar et al. 2008) had ICD-based definitions in addition to nominal definitions, however they do not share completely comparable ICD-based outcomes. Roosaar et al. (2008) included outcomes reported as ICD7: 140-148, while Boffetta et al. (2005) excluded ICD7: 140 – lip cancer – and only include outcomes reported as ICD7: 141-148. Assessment of the impact of exclusion of ICD7: 140 was assessed with sensitivity analyses without effect measures from Boffetta et al. (2005).

Five studies (Lewin et al. 1998; Luo et al. 2007; Rosenquist et al. 2005; Schildt et al. 1998a; Schildt et al. 1998b) reported nominally on incidence of oral cancer, although these studies did not perfectly align in ICD codes for the reported outcome. Only Lewin et al. (1998) perfectly aligns with the oral cancer outcome definition of ICD7: 140-144, while the remaining studies (Luo et al. 2007; Rosenquist et al. 2005; Schildt et al. 1998a; Schildt et al. 1998b) align with each other by excluding ICD7: 142 (Salivary gland neoplasms) and including ICD7: 145 (Mesopharynx neoplasms). Consequently, the focus of meta-analyses will be the outcomes excluding salivary gland cancer (ICD7: 142) and including mesopharynx cancer (ICD7: 145). Lewin et al. (1998) will still be included in the main analyses due to its nominal definition but will be excluded in sensitivity analyses due to lack of ICD code alignment with the other four studies. These meta-analyses and sensitivity analyses will still be referred to as “oral cancer” for simplicity.

#### **3.4.1.2.3 Comparability of studies for Oral-pharyngeal cancer incidence**

The one case-control (Lewin et al. 1998) and two cohort studies (Boffetta et al. 2005; Roosaar et al. 2008) that reported on incidence of oral and pharyngeal cancer had independent study populations, variable methods of control for tobacco, comparable snus exposures, incomparable smoking exposures, comparable reference group specificity, and variation in control for risk factors.

Three studies (Boffetta et al. 2005, Lewin et al. 1998, Roosaar et al. 2008), explicitly evaluated incidence of oral and pharyngeal cancer with an analysis of the systematic sample from the 1960

Census & Relatives of U.S migrants, the Stockholm county of Sweden, and the Uppsala county of Sweden. All studies used a separate study population.

The studies differed on method of control for tobacco use. Lewin et al. (1998) reported only multivariate adjusted effect measures for snus exposures, but did not describe control of snus use for smokers. Boffetta et al. (2005) reported multivariate adjusted effect measures for snus exposures only, while not reporting any effect measures for smokers. Roosaar et al. (2008) reported multivariate adjusted and stratified estimates for snus exposures, but only multivariate adjusted effect measures for smoking exposure. No within study relative risk ratios could be calculated due to a lack of exclusive smoker and snus exposure effect measures within a study. Nevertheless, stratified estimates were preferred for the main analyses. The stratified estimates in Roosaar et al. (2008) were preferred despite no comparably snus-controlled effect measure for smokers. Sensitivity analyses that preferred multivariate adjusted estimates were conducted.

Comparable snus exposure characterization between studies was available, but not selected for the main analyses. All studies reported results for ever exposure to snus, while two studies (Boffetta et al. 2005; Lewin et al. 1998) additionally reported on current and former snus exposure. Although, the minority of studies reported on current exposure, this exposure was preferred to have comparable snus and smoker exposure groups within studies. Lewin et al. (1998) did not have exclusive or stratified estimates, but selection of current exposures allowed better comparability between smoking and snus exposures in this study. Sensitivity analyses that preferred the ever exposure characterization may present a more consistent interpretation of the effect of snus, although it may not offer any information on comparative risk.

The two studies (Lewin et al. 1998; Roosaar et al. 2008) that reported smoking exposure effect measures did not have comparable exposures. Lewin et al. (1998) reported only on current exposure and exposure of a duration  $\geq 45$  years. Meanwhile, Roosaar et al. (2008) reported only on ever daily smoking stratified by age  $< 70$  years old or age  $\geq 70$  years old. The effect measures in Roosaar et al. (2008) were combined in a fixed-effect meta-analysis to obtain an overall effect measure for ever exposure to smoking. No studies reported dose- or duration- response effects in those exposed to snus or smoking.

Reference groups were either never or occasional use of snus, never snus/smoking, or never daily snus/smoking. These reference groups were considered sufficiently comparable between studies. Notably, Boffetta et al. (2005) explicitly stated the reference group as "never or occasional" use of snus. The definition of "occasional" is unclear. This was still considered directly comparable, because many studies use a definition of current or ever *regular* smoking or snus use but do not explicitly state this in their effect estimate reporting. For example, this is equivalent to reports by Roosaar et al. (2008) of never *daily* use of snus/smoking. Interpretations of summary estimates take this into account.

All studies considered controlled for age and sex, while two studies (Lewin et al. 1998; Roosaar et al. 2005) controlled for all the same risk factors. The NCI (2009a) has identified the following as important risk factors: Heavy alcohol use, HPV infection, excessive sun exposure (lip), diet (lack of fruits and vegetables) (NCI 2009a). Comparison with confounders in the studies (see table below) showed no studies controlled for HPV, sun exposure or diet.

#### 3.4.1.2.4 Control for Confounders table

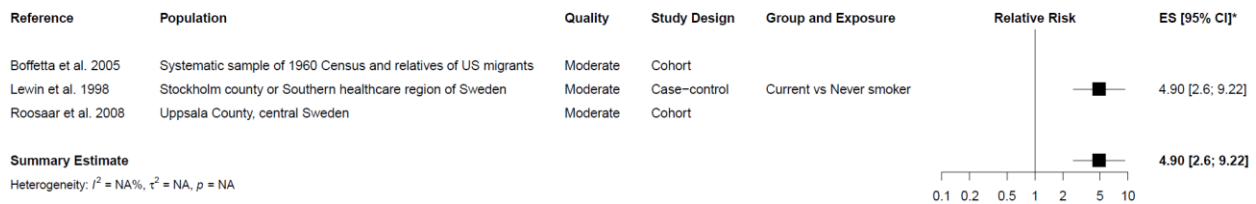
	Age	Sex	HPV	Sun exposure	Diet	Alcohol consumption	Region	Snus, Cigs
Boffetta et al. 2005	X	X						X
Lewin et al. 1998	X	X				X	X	X
Roosaar et al. 2008	X	X				X	X	X

#### 3.4.1.2.5 Incidence of Oral and Pharyngeal Cancer (ICD7: 140-148, ICD8,9: 140-149, ICD10:C00-C14)

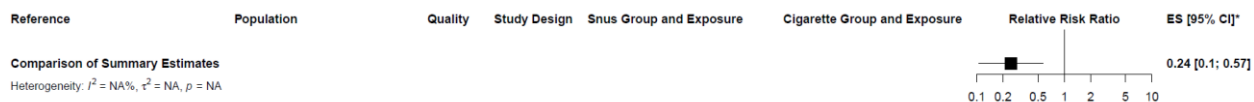
##### Oral-pharyngeal Cancer Incidence in Snus users



##### Oral-pharyngeal Cancer Incidence in Smokers



##### Oral-pharyngeal Cancer Incidence in Snus users compared to Smokers



#### 3.4.1.2.6 Sensitivity Analysis Summary Table

Five sensitivity analyses were performed to assess changes in summary estimates and risk comparisons in response to five key limitations of the main analyses: 1) Inappropriate inclusion of Boffetta et al. (2005) due to ICD outcome definition, 2) Inappropriate preference for stratified effect measures, 3) Inappropriate preference for current exposure, 4) Inappropriate inclusion of case-control studies, and 5) Inappropriate a priori decision to use random-effects meta-analysis.

No further sensitivity analyses were possible as selection of only stratified estimates would result in only one study and no studies were excluded for an outcome of oral and pharyngeal cancer. A sensitivity analyses including all studies with effect measures identified in the systematic search is presented at the end of Section 3.4.1.3.4, since this has been performed in previous meta-analyses.

	Main Analyses	1) Exclusion of Boffetta et al. (2005) due to its exclusion of ICD9: 140	2) Preference for adjusted estimates when available	3) Preference for ever use when available	4) Only cohort studies/exclude study with no control for snus in smokers	5) Fixed Effect Meta-Analysis
Summary Estimate for Snus Users (95% CI)	1.20 (0.68, 2.10)	1.30 (0.61, 2.78)	1.55 (0.69, 3.45)	1.38 (0.91, 2.11)	1.53 (0.65, 3.65)	No change
Summary Estimate for Smokers (95% CI)	4.90 <sup>a</sup> (2.6, 9.22)	No change	3.12 (1.16, 8.36)	- <sup>b</sup>	- <sup>c</sup>	No change
Summary Relative Risk Ratio (95% CI)	-	-	-	-	-	-
Comparison of Summary Estimates (95% CI)	0.24 <sup>a</sup> (0.1, 0.57)	0.27 <sup>a</sup> (0.1, 0.71)	0.50 (0.14, 1.77)	- <sup>b</sup>	- <sup>c</sup>	No change

<sup>a</sup> Only one study for smokers

<sup>b</sup> No comparable ever use estimate for smokers

<sup>c</sup> No comparable effect measures for smokers

#### 3.4.1.2.7 Conclusion criteria for Oral and Pharyngeal Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.20	-	0.24
Statistical Significance	No	-	Yes
Consistency of Direction/Magnitude of Included Studies	No  One study shows a magnitude of one, while the other two studies show a magnitude greater than one.	-	NA
Consistency of Statistical Significance of Included Studies	Yes  No study is statistically significant	-	NA

Statistically significant heterogeneity	No	-	NA
Qualitative Assessment	Three moderate studies	-	NA
Sensitivity Analysis	Supports main analyses.  All estimates above one and with no statistical significance	-	Does not support main analysis.  Preference for adjusted estimates is no longer statistically significant
Limitations	<ul style="list-style-type: none"> <li>• Possible residual confounding due to only multivariate adjustment for smoking in two studies.</li> <li>• No control for snus use for smoking effect measures in Lewin et al. (1998)</li> <li>• Lack of control for other known risk factors</li> <li>• Single cigarette effect measure used as comparison</li> </ul>		

### 3.4.1.2.8 Discussion of Oral and pharyngeal Cancer Incidence

#### **Overall Results**

The main analysis of this section summarized the effect estimates of oral and pharyngeal cancer from three moderate-quality studies to obtain a statistically non-significant summary estimate of 1.20 (95% CI: 0.68-2.10) for snus users. Smokers had a statistically significant effect measure of 4.90 (95% CI: 2.6-9.22) based on one study that did not control for snus use. Within study comparative risks could not be calculated, however a comparison of the summary estimate of snus with the relative risk of smoking had a statistically significant lower relative risk ratio of 0.24 (95% CI: 0.1-0.57).

#### **The Effect of Snus**

The main analysis shows a statistically non-significant summary estimate greater than one that is supported by all sensitivity analyses. This includes assessment of a stricter outcome definition, preference for multivariate adjustment to control for tobacco, preference for ever exposure characterization, inclusion of only cohort studies, and use of a fixed-effect meta-analysis. This suggests that methodological choices do not lead to different interpretations of the effect of snus use. However, there may be residual confounding in this estimate due to lack of stratification in two studies to control for smoking. As smoking is a known risk factor, multivariate adjusted estimates may overestimate the effect measure for snus users. The magnitude above one seems to be driven by the Roosaar et al. (2008) study, which reported a relative risk of 2.3 (95% CI: 0.7-8.3) for ever snus use in contrast to the estimates for the other two studies that were much closer to one. There may be other peculiarities of the Roosaar et al. (2008) study that explain the large magnitude of the relative risk as it is inconsistent with the other two studies. The difference in magnitude may also just be an artifact as heterogeneity between study outcomes was low and statistically non-significant. Heterogeneity remain statistically insignificant ( $I^2=61\%$ ,  $p=0.08$ ) even in meta-analyses that

preferred adjusted estimates that used the higher snus effect measure of 3.10 (95% CI: 1.5-6.6) in Roosaar et al. (2008).

Prior meta-analyses (Boffetta et al. 2008; Lee and Hamling 2009b; Lee 2011) support our interpretations of statistical non-significant risk of oral and pharyngeal cancer for snus users. Lee and Hamling (2009b) and Lee (2011) report a statistically non-significant summary estimate of 0.97 (95% CI: 0.68-1.37) for the whole population and a statistically non-significant summary estimate of 1.01 (95% CI: 0.71-1.45) for never smokers. Boffetta et al. (2008) reported a summary estimate of 1.0 (95% CI: 0.7-1.3) for snus users. Boffetta et al. (2008) also reported a statistically significant summary estimate of 2.5 (95% CI: 1.1-2.9) for smokeless tobacco users in the United States. This may support a difference in risk between smokeless tobacco products sold in the United States compared to Nordic countries. This possible difference is beyond the scope of this report. Importantly, these prior meta-analyses do not differentiate "oral and pharyngeal cancer" from "oral cancer". Sensitivity analyses that do not differentiate between these outcomes is presented in the following "oral cavity cancer" section with more discussion.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that the evidence for an effect of snus on oral and pharyngeal cancer is limited/suggestive of no association.

### ***The Effect of Smoking***

Only one study reported a comparable smoking effect estimate of 4.90 (95% CI: 2.6-9.22) but it did not control for snus use. However, a sensitivity analysis with preference for estimates adjusted for snus use included an additional study (Roosaar et al. 2008) with a smoking effect measure controlling for snus use of 1.78 (95% CI: 0.72-4.42). It is noteworthy that this additional estimate is not statistically significant, which does not align with prior knowledge on the risks of smoking. However, the resulting summary estimate remains statistically significant, albeit of lower magnitude at 3.12 (95% CI: 1.16-8.36). The statistically significant effects of smoking on oral cancer related mortality in three major U.S cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates, the mortality estimates provide some additional U.S. context to the cigarette estimate results.

### ***Comparison of the Effects of Snus with the Effects of Smoking***

Comparison of within study relative risks was not possible for this outcome due to lack of mutual exclusivity between smoking and snus exposure groups within any of the studies.

A comparison of snus summary estimates with the relative risk of smoking from one study showed a statistically significant 76% lower risk for snus users than smokers in the main analysis. However, the statistical significance of this lower risk was not supported by a sensitivity analysis preferring adjusted estimates that resulted in a summary estimate of 0.50 (95% CI: 0.14-1.77). This result could be due to the smoking effect estimate from Roosaar et al. (2008) that is much lower than Lewin et al. (1998) and statistically non-significant. As stated previously, this smoking effect measure from Roosaar et al. (2008) does not align well with accepted risks of smoking. Given this prior knowledge of smoking and the robust (i.e. not subject to methodological meta-analytic differences) summary estimate for snus users, the comparison of summary estimates in the main analyses may therefore be the best representation of risk differences.

### 3.4.1.3 Oral Cancer

#### 3.4.1.3.1 Comparability of studies for Oral Cancer incidence

The one cohort (Luo et al. 2007) and four case-control studies (Lewin et al. 1998; Rosenquist et al. 2005; Schildt et al. 1998a; Schildt et al. 1998b) that reported on oral cancer incidence had some overlap of study populations, variability in control for tobacco, modest variability of exposure characterizations, comparable reference specificity, and variation in control for risk factors.

Five studies (Lewin et al. 1998; Luo et al. 2007; Rosenquist et al. 2005; Schildt et al. 1998a; Schildt et al. 1998b) explicitly evaluated oral cancer through an analysis of a Stockholm county case-control, the Swedish construction worker cohort, a case-control of southern healthcare region of Sweden, and a case-control of the four most northern counties in Sweden. The two studies by Schildt et al. (1998a, 1998b) used the exact same study population, but varied slightly in their reported effect measures, due to emphases on different confounders in each study. Schildt et al. (1998b) was preferred for inclusion in the main analysis due to presentation of stratified estimates. Schildt et al. (1998a) was excluded from the main analysis. Sensitivity analyses that includes Schildt et al. (1998a) as opposed to Schildt et al. (1998b) was also performed.

There was variation in methods of control for tobacco use. Lewin et al. (1998) and Rosenquist et al. (2005) reported snus effect measures adjusted for smoking, however each were unclear if smoking effect measures were adjusted for snus use. Luo et al. (2007) reported multivariate adjusted estimates for snus users and exclusive snus effect measures for never-smokers. Luo et al. (2007) also presented effect measures in smokers that excluded exclusive snus users but included smokers who had current or former snus use. The effect measure for exclusive snus users was exclusive of the effect measure presented for smokers, however a sensitivity analyses without this estimate was performed to assess the effects. Schildt et al. (1998a) reported only adjusted estimates for smokers and snus users. Schildt et al. (1998b) reported adjusted and stratified estimates for smokers and snus users. Within study comparisons between smoking and snus exposure groups was also possible for Schildt et al. (1998b). Sensitivity analyses that preferred adjusted estimates over stratified estimates in Luo et al. (2007) and Schildt et al. (1998b) was performed.

Comparability of exposure characterization of snus use and smoking between studies and within studies existed for all studies except for Luo et al. (2007). Lewin et al. (1998) reported ever, current, and former snus exposure, while only current smoking exposure. Rosenquist et al. (2005) reported ever, current, and former snus exposure, but reported only dose and duration-response groups for smokers. These dose-response groups were combined through fixed-effect meta-analyses to obtain a comparable estimate of current exposure to smoking. Schildt et al. (1998a) reported adjusted effect measures for current and former snus or smoking exposure. Schildt et al. (1998b) reported adjusted effect measures for only ever exposure to snus or smoking, as well as stratified effect measures for current and former exposure to snus or smoking. Luo et al. (2007) reported adjusted effect measures for ever snus only users, while reporting stratified effect measures for ever, former, and current snus only users. They also reported ever, former, and current effect measures of a combined smokers and dual user exposure group. Current snus exposure effect measures appear in all studies when preferring stratified effect measures, similarly current exposure to smoking is the most common reported exposure, appearing in four out of five studies. All studies reported comparable current

exposures between their snus and smoking exposure groups. Sensitivity analyses that preferred ever exposure was performed.

Three studies (Luo et al. 2007; Rosenquist et al. 2005; Schildt et al. 1998b) reported dose- or duration- response effect measures in snus users, while a different set of three studies (Lewin et al. 1998; Rosenquist et al. 2005; Schildt et al. 1998b) reported these effect measures in smokers. None of these studies performed an analysis for trend, nor had comparable exposure groups between smokers and snus users within each study. Comparable exposure groups between studies did not exist either, except for the smoking lifetime consumption exposure groups between Schildt et al. (1998b) and Rosenquist et al. (2005). However, as a meta-analysis of smokers is not a primary focus of the study, no meta-analysis was performed. The dose-response results are included in Appendix G and discussion section to aid in the interpretation of the meta-analyses results.

Reference groups were either never tobacco or never snus/smoke as appropriate. These reference groups were considered sufficiently comparable between studies to obtain an interpretable summary estimate for snus users or smokers. These reference groups also allowed appropriate within group comparability between effects in snus users or smokers.

All studies considered controlled for age and sex, but no studies controlled for the same set of risk factors. The NCI (2009a) has identified the following as important risk factors: heavy alcohol use, HPV infection, excessive sun exposure (lip), and diet (lack of fruits and vegetables) (NCI 2009a). Comparison with confounders in the studies (see table below) showed no studies controlled for sun exposure or diet. Four out of five studies considered alcohol consumption as a relevant confounder.

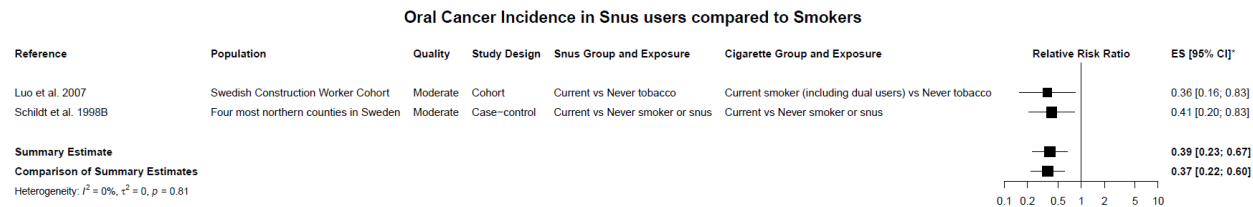
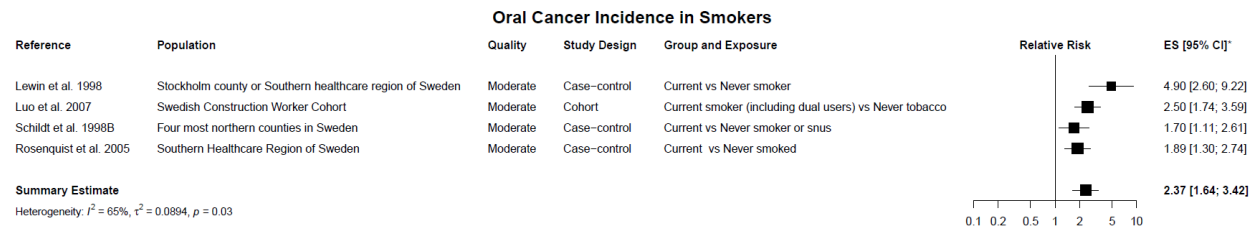
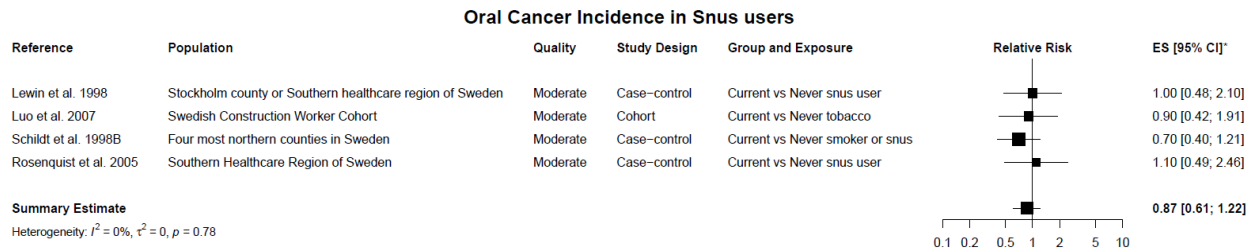
#### 3.4.1.3.2 Control for Confounders Table

	Age	Sex	Sun exposure	Diet	Alcohol consumption	HPV	BMI	Location	Oral Infection	Snus, Cigs
Lewin et al. 1998	X	X			X					X <sup>a</sup>
Luo et al. 2007	X	X					X			X
Rosenquist et al. 2005	X	X			X	X				X <sup>a</sup>
Schildt et al. 1998a	X	X			X			X	X	X
Schildt et al. 1998b	X	X			X					X

<sup>a</sup>Unclear if smoking effect measures controlled for snus use



### 3.4.1.3.3 Incidence of Oral Cancer (ICD7: 140, 141, 143-145 and ICD7: I40-144)



### 3.4.1.3.4 Sensitivity Analysis Summary Table

Eight sensitivity analyses were performed to assess changes in summary estimates and risk comparisons in response to eight key limitations of the main analyses: 1) Inappropriate inclusion of Lewin et al. (1998) due to outcome definition, 2) Inappropriate preference for Schildt et al. (1998b) instead of Schildt et al. (1998a), 3) Inappropriate use of Luo et al. (2007) smoker and dual users effect measure, 4) Inappropriate preference for stratified control of tobacco, 5) Inappropriate preference for current exposure, 6) Inappropriate exclusion of “oral cancer” studies, 7) Inappropriate preference for fixed-effect meta-analyses, and 8) Inappropriate meta-analyses differentiating “oral cancer” from “oral and pharyngeal cancer”

	Main Analysis	1) Exclusion of Lewin et al. (1998), due to outcome definition.	2) Change Schildt et al. 1998b with Schildt et al. 1998a	3) Exclusion of smoking and dual user effect estimate from Luo et al. (2007)	4) Preference for adjusted estimates when available	5) Preference for ever use when available	6) All “oral cancer” studies <sup>d</sup>	7) Fixed-effect meta-analyses	8) All studies identified in systematic search <sup>e</sup>
Summary Estimate for Snus Users (95% CI)	0.87 (0.61, 1.22)	0.83 (0.56, 1.23)	0.85 (0.59, 1.22)	No change	0.77 (0.62, 0.97)	0.96 (0.72, 1.27)	0.80 (0.59, 1.08)	No change	0.86 (0.64, 1.14)
Summary Estimate for Smokers (95% CI)	2.37 <sup>a</sup> (1.64, 3.42)	2.04 <sup>c</sup> (1.63, 2.56)	2.34 <sup>a</sup> (1.56, 3.49)	2.31 <sup>a</sup> (1.51, 3.52)	2.09 <sup>a</sup> (1.01, 4.33)	1.57 <sup>a</sup> (0.95, 2.59)	2.18 <sup>a</sup> (1.57, 3.02)	2.25 <sup>a</sup> (1.82, 2.77)	2.18 <sup>a</sup> (1.57, 3.02)
Summary Relative Risk Ratio (95% CI)	0.39 (0.23, 0.67)	No change	0.36 <sup>b</sup> (0.16, 0.83)	0.41 <sup>b</sup> (0.20, 0.83)	0.47 (0.23, 0.98)	0.58 (0.32, 1.06)	0.39 (0.23, 0.67)	No change	0.39 (0.23, 0.67)

Comparison of Summary Estimates (95% CI)	0.37 (0.22, 0.60)	0.41 (0.26, 0.64)	0.36 (0.21, 0.62)	0.37 (0.22, 0.65)	0.37 (0.17, 0.79)	0.61 (0.34, 1.08)	0.37 (0.23, 0.57)	0.38 (0.26, 0.58)	0.40 (0.29, 0.57)
--	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

<sup>a</sup> Statistically significant heterogeneity, fixed-effect meta-analyses may not be appropriate

<sup>b</sup> Only one study

<sup>c</sup> Note exclusion of Lewin et al. (1998) leads to statistically non-significant heterogeneity ( $I^2=3\%$ ,  $p=0.36$ )

<sup>d</sup> Summary estimate will overweight the population of Four most northern counties in Sweden present in Schildt et al. (1998a) and Schildt et al. (1998b)

<sup>e</sup> This has been performed by previous studies but mixes oral cancer specific outcomes with the broader outcomes of "oral and pharyngeal cancer". This prefers oral-pharyngeal effect measures when available and uses oral cancer estimates otherwise.

#### 3.4.1.3.5 Conclusion criteria for Oral Cavity Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	0.87	0.39	0.37
Statistical Significance	No	Yes	Yes
Consistency of Direction/Magnitude of Included Studies	No,  One study shows a null result, two studies show a magnitude less than one, and one study shows a magnitude above one.	Yes,  Both within study comparisons show a result of similar magnitude	NA
Consistency of Statistical Significance of Included Studies	Yes,  No study is statistically significant	Yes,  Both studies statistically significant	NA
Statistically significant heterogeneity	No	No	NA
Qualitative Assessment	Four moderate studies	Two moderate studies	NA
Sensitivity Analysis	Does not support main	Does not support main	Does not support main

	analysis.  Preferring adjusted estimates leads to a statistically significant result below one	analysis.  Preferring ever exposure results in a statistically non-significant summary estimate	analysis.  Preferring ever exposure results in a statistically non-significant summary estimate.
Limitations	<ul style="list-style-type: none"> <li>Only one cohort study used in meta-analyses</li> <li>Lewin et al. (1998) and Rosenquist et al. (2005) were unclear if smoking effect measures controlled for snus use</li> </ul>		

### 3.4.1.3.6 Discussion of Oral Cancer Incidence

#### **Overall Results**

The main analysis of this section summarized the effect estimates of oral cavity cancer from four studies to obtain a statistically non-significant summary estimate of 0.87 (95% CI: 0.61-1.22) for snus users controlling for smoking. For smokers within these studies, smokers had a statistically significant summary estimate of 2.37 (95% CI: 1.64-3.42). A statistically significant relative risk ratio of 0.39 (95% CI: 0.23-0.67) was obtained based on two studies. The comparison of summary estimates yielded a statistically significant estimate of 0.37 (95% CI: 0.22-0.60). Furthermore, an analysis of all studies with an outcome of "oral cancer" or "oral and pharyngeal cancer" studies yield statistically significant estimates in line with the main analyses for both outcomes.

These results were also in line with results from studies that reported dose- or duration response effect measures. Lewin et al. (1998) reported a statistically significant effect measure of 6.3 (95% CI: 3.2-12.4) for a smoking duration of use  $\geq 45$  years but did not providing a comparable snus effect measure. Luo et al. (2007) reported a statistically non-significant effect measure of 0.7 (95% CI: 0.2-2.8) for snus doses of 1-9 grams per day and a statistically non-significant effect measure of 0.9 (95% CI: 0.4-2.0) for snus doses  $\geq 10$  grams per day but provided no comparable smoking effect measures. Rosenquist et al. (2005) reported statistically non-significant dose-response exposure groups for snus users and statistically significant effect measures for smokers, as well as statistically non-significant duration-response groups for snus users. Schildt et al. (1998b) reported dose-response groups for high and low lifetime consumption groups, with no statistically significant exposure groups for snus users, and a statistically significant effect measure for high smoking consumption among never snuff users.

#### **The Effect of Snus**

Sensitivity analyses generally supported the main analyses interpretation of a statistically non-significant summary estimate for snus use below one, however a sensitivity analyses that preferred adjusted estimates suggested a statistically significant summary estimate below one. The statistical significance of the sensitivity analysis summary estimate is likely driven by the change in Luo et al. (2007) snus effect measure from 0.90 (95% CI: 0.48-2.10) to 0.70 (95% CI: 0.52, 0.94). The precise reason that the adjusted estimate differs considerably from other studies is unknown, however this was the sole cohort study available, as well as the only study to not adjust for alcohol use – a known risk factor for oral cancer. Furthermore, no statistically significant heterogeneity was present in any analyses for the effect of snus. The statistically significant effect below one in the sensitivity analyses

may likely just represent peculiarities of Luo et al. (2007) and the Swedish Construction Worker cohort that should be explored further. Overall, the results show evidence for no increased risk of oral cancer due to snus use.

Compared to snus summary estimate of 0.87 (95% CI: 0.61-1.22), prior meta-analyses (Boffetta et al. 2008; Lee and Hamling 2009b; Lee 2011) present slightly higher, but statistically non-significant summary estimates. Boffetta et al. (2008) report a summary estimate of 1.0 (95% CI: 0.7-1.3), while Lee and Hamling (2009b) and Lee (2011) report an overall summary estimate of 0.97 (95% CI: 0.68-1.37). These results are in line with our results as neither of these estimates are statistically significant and they are very close to the null value of one. Additional analyses by Lee and Hamling (2009b) and Lee (2011) are presented in the Appendix G. These additional results remain statistically non-significant.

### ***The Effect of Smoking***

The main analysis of smoking showed a statistically significant increased risk of oral cancer with smoking, however there is consistent statistical heterogeneity that remains in sensitivity analyses. The main analysis is in line with prior knowledge of the effects of smoking. Statistical heterogeneity of the studies appears to be driven by the inclusion of smoking effect measures in Lewin et al. (1998), which had unclear control for snus use and a much higher effect measure of 4.90 (95% CI: 2.60-9.22) for smoking compared to other studies. Preference for ever smoking exposure leads to no comparable smoking effect estimates from Lewin et al. (1998) and Rosenquist et al. (2005), which only reported ever exposure. The fewer studies available may lead to the statistical non-significance of smoker effect measures in the sensitivity analyses that preferred ever exposure.

### ***Comparison of the Effects of Snus with the Effects of Smoking***

The statistically significant lower risk of snus use compared to smokers was generally supported by sensitivity analyses except for in sensitivity analyses that preferred ever exposure. The sensitivity analysis that preferred ever exposure resulted in a statistically non-significant summary estimate of 0.58 (95% CI: 0.32-1.06). The reason for this difference was unclear, but it drives the statistical non-significance of within study relative risk ratio estimates.

The statistically significant lower risk of snus compared to smokers based on a comparison of summary estimates was generally supported by sensitivity analyses except for sensitivity analyses that preferred ever exposure. The sensitivity analysis that preferred ever exposure yields a statistically non-significant effect measure of 0.61 (95% CI: 0.34, 1.08). The reason this comparison is lower likely relate to the lower magnitude and statistical non-significance of the related smoker effect measure. Possible reasons behind this were discussed in the "The Effect of Smoking" summary above.

Overall both ways of comparing risk of oral cancer in snus users compared to smokers generally show a statistically significant lower risk of oral cancer. In sensitivity analyses, these results remain below one and become statistically non-significant only when ever-exposure to snus and smoking is preferred. Further cohort studies comparing risks in ever snus users and ever smokers could assist determining the significance of this discrepancy. Furthermore, an analysis of all studies with an outcome of "oral cancer" or "oral and pharyngeal cancer" studies yield statistically significant estimates in line with the main analyses for both outcomes.

### **3.4.1.4 Esophageal Cancer**

#### **3.4.1.4.1 Overview of Evidence for Esophageal Cancer**

Smoking accounts for overall 68% of all esophageal cancer deaths in the United states and esophageal cancer constitutes 2.2% of all deaths among smokers (CDC 2008). Qualitative evaluation found the available studies provide *balanced/mixed evidence of an association* between snus use and esophageal cancer.

#### **3.4.1.4.2 Outcome Comparability**

In this evaluation, “esophageal cancer” refers to the overall range of disease outcomes in ICD7,8,9-150 and ICD10-C15. This encompasses studies of adenocarcinoma and squamous cell carcinoma. Sufficient studies were available to perform an overall meta-analysis and two additional meta-analyses for each subtype of esophageal cancer.

Four studies (Boffetta et al. 2005, Lagergren et al. 2000, Lewin et al. 1998, and Zendehdel et al. 2008) identified in the systematic search evaluated esophageal cancer outcomes defined nominally or through ICD7,8,9-150. Only Boffetta et al. (2005) reported overall esophageal cancer incidence. Zendehdel et al. (2008) and Lagergren et al. (2000) reported effect measures for the adenocarcinoma and squamous cell carcinoma subtypes of esophageal cancer. In Zendehdel et al. (2008), identification of the outcome was defined by ICD-150 before division into esophageal subtypes based on histological code. These subtypes were combined through a fixed-effect meta-analysis to obtain an effect estimate for overall esophageal cancer. Lewin et al. (1998) reported effect measures for only squamous cell carcinoma esophageal cancer. Further consideration for meta-analyses was done for three studies (Boffetta et al. 2005; Lagergren et al. 2000; Zendehdel et al. 2008) of overall esophageal cancer, three studies (Lagergren et al. 2000; Lewin et al. 1998; Zendehdel et al. 2008) of squamous cell carcinoma esophageal cancer, and two studies (Lagergren et al. 2000; Zendehdel et al. 2008) of adenocarcinoma.

#### **3.4.1.4.3 Comparability of studies for Esophageal Cancer**

The one case-control (Lagergren et al. 2000) and two cohort studies (Boffetta et al. 2005; Lagergren et al. 2000) that reported on esophageal cancer incidence had independent study populations, variable methods of control for tobacco, variation in snus and smoking exposure characterization, comparable reference group specificity, and variation in control for risk factors.

Three studies (Boffetta et al. 2005; Lagergren et al. 2000; Zendehdel et al. 2008) evaluated incidence of esophageal cancer with an analysis of a cohort from a systematic sample of the Swedish 1960 census and relatives of U.S. migrants, a case-control a sample of the 1995-1997 Swedish population, and the Swedish Construction worker cohort. All studies used a different study population.

Method of control for tobacco varied between studies. Boffetta et al. (2005) and Lagergren et al. (2000) controlled for tobacco through adjustment only, while Zendehdel et al. (2008) reported stratified and adjusted effect measures. Stratified estimates were preferred for inclusion in the main analyses for calculation of within study relative risk ratios. Sensitivity analyses that preferred adjusted estimates was performed.

The available snus exposure characterizations varied between studies and was unclear in Zendehdel et al. (2008). Boffetta et al. (2005) report effect measures for ever, current, and former snus exposure. Lagergren et al. (2000) report only ever snus exposure. Zendehdel et al. (2008) reported “snus user” as the exposure. It is unclear if this signified current or ever snus use. As ever exposure was the most commonly available exposure it was prioritized for inclusion in the main analyses. Sensitivity analyses that assessed the impact of the unclear exposure characterization was performed. Sensitivity analyses that preferred current exposure when available was also performed.

The smoking exposure characterizations varied. Boffetta et al. (2005) reports no smoking exposure effect measures. Lagergren et al. (2000) reports previous and current smoking exposures, which are combined in a fixed-effect meta-analysis to provide an ever-smoking exposure comparable to the ever snus exposure in the same study. Zendehdel et al. (2008) reported ever and current smoking exposure effect measures. Ever snus exposures were selected to allow comparable exposures between and within studies

Only Lagergren et al. (2000) reported dose-response effect exposure groups for snus users, while two studies (Lagergren et al. 2000; Zendehdel et al. 2008) reported dose- or duration- exposure groups for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose- or duration response results were included in the discussion section to better interpret the meta-analyses results.

Reference groups were either never snus/smoker as appropriate or “never or occasional snus”. These reference groups were considered sufficiently comparable between studies. Notably, Boffetta et al. (2005) explicitly states the reference group as “never or occasional” use of snus. The definition of “occasional” is unclear. This was still considered directly comparable, because many studies use a definition of current or ever *regular* smoking or snus use but do not explicitly state this in their effect estimate reporting. For example, this is equivalent to reports by Roosaar et al. (2008) of never *daily* use of snus/smoking. Interpretations of summary estimates take this into account.

All studies controlled for age and sex, but otherwise varied in possible confounders considered. The American Cancer Society (2012) has identified the following as important risk factors for esophageal cancer: Alcohol use, a diet low in fruits and vegetables, obesity (adenocarcinoma), male (3x higher than women), age (most cases occur in those 65 and older), gastroesophageal reflux disease (GERD-adenocarcinoma), Barrett’s esophagus (adenocarcinoma), exposure to solvents used for dry cleaning, people who have had treatment to rid the stomach of *H. pylori*, and people who have had other cancers such as lung, mouth and throat cancer are at higher risk. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

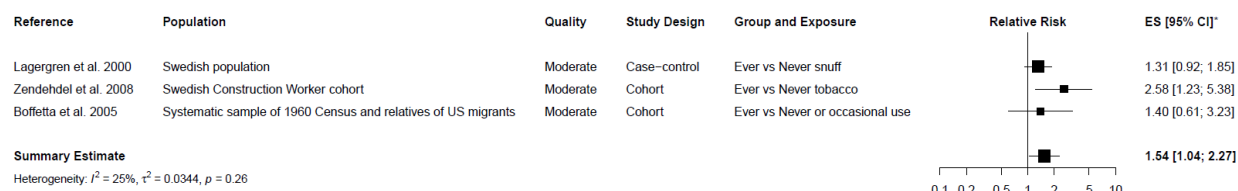
#### 3.4.1.4.4 Control for Confounders Table

	Boffetta et al. 2005	Lagergren et al. 2000	Zendehdel et al. 2008
Age	X	X	X
Sex	X	X	X
Alcohol		X	
Weight/BMI		X	X

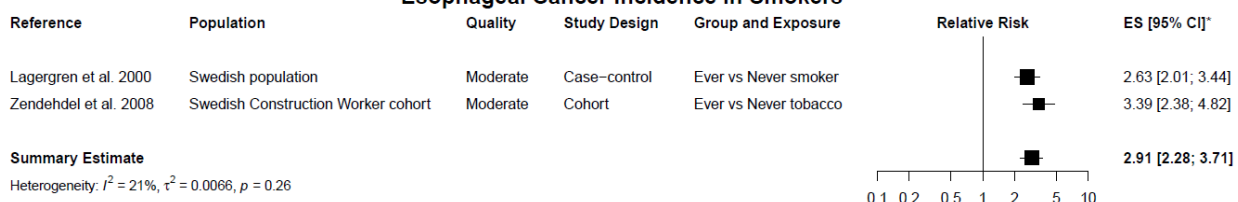
Physical Activity		X	
Diet		X	
Gastroesophageal Reflux Disease		X	
Barrett's esophagus			
H. pylori exposure			
Educational Level		X	
Prior cancers			
Snus, Cigs	X	X	X

### 3.4.1.4.5 Incidence of Esophageal Cancer (ICD8,9: 150, ICD10: C15)

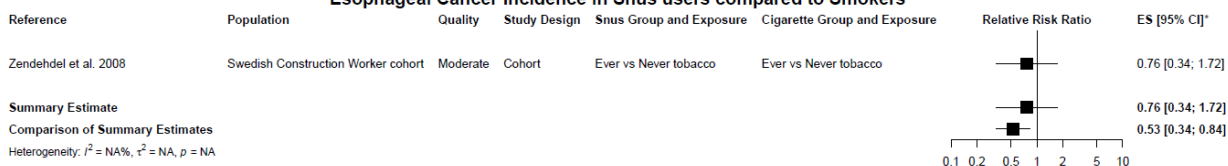
#### Esophageal Cancer Incidence in Snus users



#### Esophageal Cancer Incidence in Smokers



#### Esophageal Cancer Incidence in Snus users compared to Smokers



### 3.4.1.4.6 Sensitivity Analysis Summary Table

Five sensitivity analyses were performed to assess changes in summary estimates and risk comparisons in response to five key limitations of the main analyses: 1) Inappropriate preference for stratified effect measures, 2) Inappropriate inclusion of an unclear exposure, 3) Inappropriate preference for ever exposure, 4) Inappropriate inclusion of case-control studies, 5) Inappropriate a priori decision to use random-effects meta-analysis, 6) Inappropriate exclusion of studies identified in systematic search

	Main Analysis	1) Preference for adjusted estimates	2) Exclusion of study with unclear snus exposure	3) Preference for current use when	4) Cohort studies only	5) Fixed-effects meta-analysis	6) Inclusion of all studies identified in systematic
--	---------------	--------------------------------------	--	------------------------------------	------------------------	--------------------------------	--

		when available	(Zendehdel et al. 2008)	available			search <sup>d</sup>
Summary Estimate for Snus Users (95% CI)	1.54 (1.04, 2.27)	1.11 (0.91, 1.35)	1.32 (0.96, 1.82)	1.52 (0.97, 2.40)	1.96 (1.08, 3.56)	1.47 (1.09, 1.98)	1.43 (1.07, 1.91)
Summary Estimate for Smokers (95% CI)	2.91 (2.28, 3.71)	2.63 <sup>a</sup> (2.01, 3.44)	2.63 <sup>a</sup> (2.01, 3.44)	No change	3.39 <sup>a</sup> (2.38, 4.82)	2.89 (2.33, 3.58)	3.23 (2.36, 4.41)
Summary Relative Risk Ratio (95% CI)	0.76 <sup>a</sup> (0.34, 1.72)	- <sup>b</sup>	- <sup>b</sup>	No change	No Change	0.76 (0.34, 1.72)	No change
Comparison of Summary Estimates (95% CI)	0.53 (0.34, 0.84)	0.42 <sup>c</sup> (0.30, 0.59)	0.50 <sup>c</sup> (0.30, 0.76)	0.52 (0.31, 0.88)	0.58 (0.29, 1.16)	0.51 (0.35, 0.73)	0.44 (0.29, 0.68)

<sup>a</sup> Estimate from only one study

<sup>b</sup> No studies with exclusive estimates

<sup>c</sup> Comparison with an effect measure from only one study

<sup>d</sup> Effect measure represents a mixture of outcomes between Squamous Cell Carcinoma Esophageal cancer reported in Lewin et al. (1998) with Esophageal cancer outcome reported in other studies

#### 3.4.1.4.7 Conclusion criteria for Esophageal Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.54	0.76	0.53
Statistical Significance	Yes	No	Yes
Consistency of Direction/Magnitude of Included Studies	Yes,  All three studies above one.	Only one study	NA
Consistency of Statistical Significance of Included Studies	No,  One study is statistically significant, while the other two are not.	Only one study	NA
Statistically significant heterogeneity	No	-	NA
Qualitative Assessment	Three moderate	One moderate study	NA



	studies		
Sensitivity Analysis	Does not support main analysis.  Statistically non-significant results for three sensitivity analyses	Supports main analyses when estimates available, however no estimate in two sensitivity analyses	Does not support main analysis.  Statistically non-significant when only cohort studies are used.
Limitations	<ul style="list-style-type: none"> <li>• Within study relative risk ratios only possible for one study.</li> <li>• Fixed-effects meta-analyses was performed to obtain ever exposures for one study</li> </ul>		

#### **3.4.1.4.8 Discussion of Esophageal Cancer Incidence**

##### ***Overall results***

The main analysis of this section summarized the effect estimates of esophageal cancer from three studies to obtain a statistically significant summary estimate of 1.54 (95% CI: 1.04-2.27) for snus users. Smokers within these studies had a statistically significant summary estimate of 2.91 (95% CI: 2.28-3.71) based on two studies. A statistically non-significant relative risk ratio of 0.76 (95% CI: 0.34-1.72) was obtained for within study comparisons of risks based on one study. The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.53 (95% CI: 0.34-0.84).

These results were also generally in line with the statistical significance of dose- or duration-response trends reported in the two studies assessing this in smokers and one study assessing this in snus users. Only Lagergren et al. (2000) reported dose-response effect exposure groups for snus users, and found statistically non-significant effects in trends for years of duration of use and for intensity of use. The smoking dose- and duration- exposure groups reported in Lagergren et al. (2000) did not assess trend, but the effect measures of dose- and duration- response groups were either elevated or statistically significant for each smoking exposure group. Zendehdel et al. (2008) reported statistically significant smoker effect estimates for each dose-response group and a statistically significant trend.

##### ***The Effect of Snus***

Although our main analysis shows a statistically significant summary estimate for snus use above one, sensitivity analyses suggests inconsistency in statistical significance based on methodological choices. Preference for adjusted estimates, the exclusion of the unclear snus exposure, and preference for current exposure all resulted in a lack of statistical significance. Preference for adjusted estimates and exclusion of unclear snus exposure result in statistical non-significance due to alternate effect measure selection from Zendehdel et al. (2008). The selected effect measure of 2.58 (95% CI: 1.23-5.38) from Zendehdel et al. (2008) appears to be a driver of the statistical significance when compared to the lower effect measures of 1.40 (95% CI: 1.04-2.27) and 1.31 (95% CI: 0.92-1.85) in the other two studies. Additionally, the selected stratified effect measure from Zendehdel et al. (2008) is much larger compared to the adjusted effect measure of 1.00 (95% CI: 0.78-1.28) from Zendehdel et al. (2008). The change in statistical significance due to preference for current snus exposure results from

changes in selected effect measure from Boffetta et al. (2005) from 1.40 (95% CI: 0.61-3.23) to 1.06 (95% CI: 0.35-3.22). Lastly, the results for each subtype in the two following sections need to be considered, as adenocarcinoma and squamous cell carcinoma appear to differ in direction of effect measure. Snus users had a summary estimate of 1.71 (95% CI: 0.92-3.15) for squamous cell carcinoma, while they had a summary estimate of 0.69 (95% CI: 0.14-3.50) for adenocarcinoma.

The inconsistency of our results is in line with inconsistent results from two prior meta-analyses. Lee and Hamling (2009b) and Lee (2011) reported statistically non-significant summary measures of 1.10 (95% CI: 0.92-1.33), while Boffetta et al. (2008) reported statistically significant summary measure of 1.6 (95% CI: 1.1-2.2). These results differ from what is presented here due to their respective methodological choices and the greater care with regards to outcome specificity used for the main analysis in this study. However, an additional sensitivity analyses incorporating all studies identified in the systematic search regardless of outcome comparability resulted in a summary estimate of 1.43 (95% CI: 1.07-1.91) in agreement with the main analyses.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that the evidence for an effect of snus on esophageal cancer incidence is balanced/mixed.

### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases in the risk of esophageal cancer in smokers compared to never smoker/tobacco users. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on esophageal cancer related mortality in four major U.S. cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates, the mortality estimates provide some additional U.S. context.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for only one study (Zendehdel et al. 2008) with an unclear snus exposure that resulted in a statistically non-significant relative risk ratio of 0.76 (95% CI: 0.34-3.71) that was consistent in all sensitivity analyses in which this estimate was selected.

On the other hand, the comparison of summary estimates suggests a statistically significant lower risk of esophageal cancer in snus users compared to smokers/cigarette users. The value for comparisons of summary estimates is statistically significant in all sensitivity analyses except for the sensitivity analysis of only cohort studies.

Although both methods of comparing risk of esophageal cancer in snus users compared to smokers consistently show a lower magnitude of risk for snus users, the statistical significance of this risk is unclear. Further cohort studies comparing risks in snus users and smokers will be necessary to determine if the observed lower risk in snus users is statistically significant.

### **3.4.1.5 Incidence of Esophageal Squamous Cell Carcinoma**

#### **3.4.1.5.1 Comparability of studies for Esophageal Squamous Cell Carcinoma**

The one cohort (Zendehdel et al. 2008) and two case control studies (Lewin et al. 1998; Lagergren et al. 2000) that reported on esophageal squamous cell carcinoma incidence had independent study

populations, variation in methods of control for tobacco, variation in snus and smoking exposure characterization, comparable reference group specificity, and variation in control for risk factors.

Three studies (Lagergren et al. 2000; Lewin et al. 1998; Zendehdel et al. 2008) evaluated incidence of esophageal squamous cell carcinoma with analysis of the 1995-1997 Swedish population, Stockholm county or Southern healthcare region of Sweden, and the Swedish Construction Worker cohort. No overlap of study populations was suspected.

The method of control for tobacco varied between studies. Zendehdel et al. (2008) reported adjusted and stratified effect measures, while Lagergren et al. (2000) and Lewin et al. (2000) controlled for tobacco through adjustment only. Stratified estimates were preferred for inclusion in the main analyses for calculation of within study relative risk ratios and minimal residual confounding. Sensitivity analyses that preferred adjusted estimates were performed.

The snus and smoking exposure characterizations varied between and within studies. Lagergren et al. (2000) reported effect measures for only ever snus exposure, while it reported smoking effect measures for previous and current smoking exposure. The smoking effect measures from Lagergren et al. (2000) were combined in a fixed-effect meta-analysis to provide an ever-smoking exposure comparable to the ever snus exposure in the same study. Lewin et al. (1998) reported adjusted effect measures for ever, current, and former snus exposure, but reported adjusted effect measures for only current smoking exposure. Zendehdel et al. (2008) reported "snus user" as the exposure. It is unclear if this signified current or ever snus use. Although ever exposure is the most common exposure characterization, comparability between snus and smoking exposures is preferred when no exclusive or stratified effect measures are available in a study. Thus, the current exposure effect measures were used from Lewin et al. (1999). Sensitivity analyses that excluded the study with unclear exposure characterization was performed. Sensitivity analyses that preferred ever exposure in Lewin et al. (2000) was also performed.

Only Lagergren et al. (2000) reported dose-response effect exposure groups for snus users, while two studies (Lagergren et al. 2000; Zendehdel et al. 2008) reported dose- or duration- exposure groups for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose- or duration response results were included in the discussion section to better interpret meta-analyses results.

Reference groups were either never snus/smoker as appropriate or never tobacco. These reference groups were considered sufficiently comparable between studies.

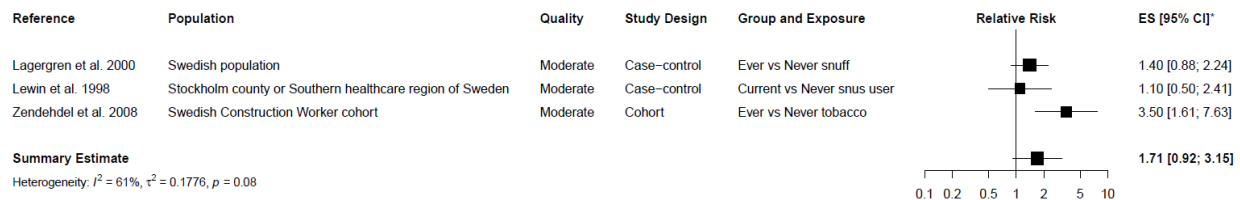
All studies controlled for age and sex, but otherwise varied in possible confounders considered. The American Cancer Society (2012) has identified the following as important risk factors for esophageal cancer: Alcohol use, a diet low in fruits and vegetables, obesity (adenocarcinoma), male (3x higher than women), age (most cases occur in those 65 and older), gastroesophageal reflux disease (GERD-adenocarcinoma), Barrett's esophagus (adenocarcinoma), exposure to solvents used for dry cleaning, people who have had treatment to rid the stomach of *H. pylori*, and people who have had other cancers such as lung, mouth and throat cancer are at higher risk. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

### 3.4.1.5.2 Control for Confounders Table

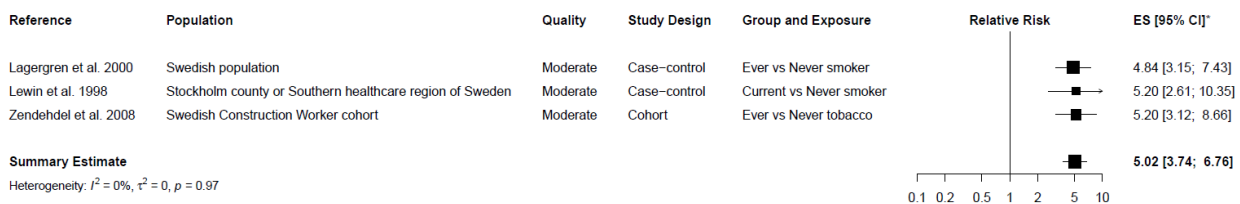
	Lagergren et al. 2000	Lewin et al. 1998	Zendejdel et al. 2008
Age	X	X	X
Sex	X	X	X
Alcohol	X	X	
Weight/BMI	X		X
Physical Activity	X		
Diet	X		
Gastroesophageal Reflux Disease	X		
Barrett's esophagus			
Dry-cleaning solvents			
H. pylori exposure			
Educational Level	X		
Prior cancers			
Region		X	
Snus, Cigs	X	X	X

### 3.4.1.5.3 Incidence of Esophageal Squamous Cell Carcinoma

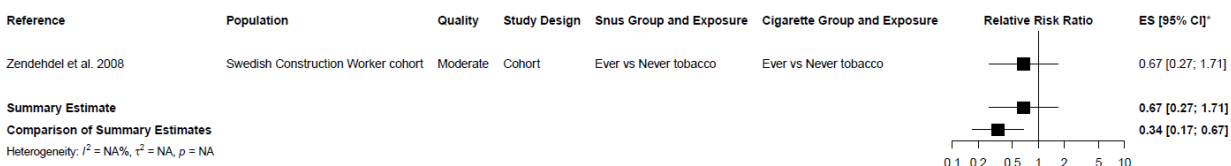
#### Esophageal Cancer Incidence in Snus users



#### Esophageal Cancer Incidence in Smokers



### Esophageal Cancer Incidence in Snus users compared to Smokers



#### 3.4.1.5.4 Sensitivity Analysis Summary Table

Five sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to five key limitations of the main analyses: 1) Inappropriate preference for stratified effect measures, 2) Inappropriate inclusion of an unclear exposure, 3) Inappropriate preference for current exposure in Lewin et al. (1998), 4) Inappropriate a priori decision to use random-effects meta-analysis

Sensitivity analyses for only cohort studies was not possible, as only one cohort study existed.

	Main Analysis	1) Preference for adjusted estimates when available	2) Exclusion of study with unclear snus exposure	3) Preference for ever use when available	4) Fixed-effects meta-analysis
Summary Estimate for Snus Users (95% CI)	1.71 (0.92, 3.15)	1.09 (0.87, 1.38)	1.31 (0.88, 1.97)	1.69 (0.97, 2.93)	1.62 (1.13, 2.31)
Summary Estimate for Smokers (95% CI)	5.02 (3.74, 6.76)	4.94 (3.43, 7.10)	4.94 (3.43, 7.10)	4.99 (3.59, 6.92)	No change
Summary Relative Risk Ratio (95% CI)	0.67 <sup>a</sup> (0.27, 1.71)	— <sup>b</sup>	— <sup>b</sup>	No change	No change
Comparison of Summary Estimates (95% CI)	0.34 (0.17, 0.67)	0.22 (0.14, 0.34)	0.27 (0.15, 0.46)	0.34 (0.18, 0.64)	0.32 (0.20, 0.51)

<sup>a</sup> Only one study

<sup>b</sup> No studies with exclusive smoking and snus effect measures

#### 3.4.1.5.5 Conclusion criteria for Esophageal Squamous Cell Carcinoma Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.71	0.67	0.34
Statistical Significance	No	No	Yes

Consistency of Direction/Magnitude of Included Studies	Yes.  All three studies above one.	Only one study	NA
Consistency of Statistical Significance of Included Studies	No  One study is statistically significant, while the other two are not.	Only one study	NA
Statistically significant heterogeneity	No	-	NA
Qualitative Assessment	Three moderate studies	One moderate study	NA
Sensitivity Analysis	Does not support main analysis.  Statistically significant results in fixed-effect meta-analysis	Supports the main analyses when estimate available.  No estimate in two sensitivity analyses	Supports the main analyses
Limitations	<ul style="list-style-type: none"> <li>• Within study relative risk ratios only possible for one study.</li> <li>• Fixed effects meta-analysis was required to obtain ever exposure in Lagergren et al. (2000)</li> </ul>		

#### **3.4.1.5.6 Discussion of Esophageal Cancer Squamous cell carcinoma**

##### **Overall results**

The main analysis of this section summarized the effect estimates of esophageal squamous cell carcinoma from three studies to obtain a statistically non-significant summary estimate of 1.71 (95% CI: 0.92-3.15) for snus users. Smokers within these studies had a statistically significant summary estimate of 5.02 (95% CI: 3.74-6.75) based on three studies. A statistically non-significant relative risk ratio of 0.67 (95% CI: 0.27-1.71) was obtained for within study comparisons of risks based on one study. The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.34 (95% CI: 0.17-0.67).

These results were also generally in line with the statistical significance of dose- or duration-response trends reported in the two studies (Lagergren et al. 2000; Zendehdel et al. 2008) that assessed smokers and one study (Lagergren et al. 2000) that assessed snus users. Only Lagergren et al. (2000) reported dose-response effect exposure groups for snus users, finding statistically non-significant effects in trends for years of duration of use and for intensity of use. The smoking dose-

and duration- exposure groups reported in Lagergren et al. (2000) did not assess trend, but the effect measures of dose- and duration- response groups were either elevated or statistically significant for each smoking exposure group. Zendehdel et al. (2008) reported statistically significant smoker effect estimates for each dose-response group and a statistically significant trend.

### ***The Effect of Snus***

Although our main analysis shows a statistically non-significant summary estimate for snus use, sensitivity analyses showed a fixed-effect meta-analysis results in statistically significant increased risk. However, the high statistical heterogeneity at 61% ( $p = 0.08$ ) suggest that a fixed-effects meta-analysis may be inappropriate.

Prior meta-analyses did not present an effect estimate for esophageal squamous cell carcinoma.

Overall, the quantitative evaluation presents a non-significantly elevated risk, and some mixed results in sensitivity analyses. It therefore supports the qualitative conclusion of balanced/mixed evidence of an association between squamous cell carcinoma and snus use.

### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases in the risk of esophageal cancer in smokers compared to never smoker/tobacco users. Furthermore, the magnitude of the effect measure is consistently near five.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for only one study (Zendehdel et al. 2008) with an unclear snus exposure that resulted in a statistically non-significant relative risk ratio of 0.67 (95% CI: 0.27-1.71) that was consistent in all sensitivity analyses.

On the other hand, the comparison of summary estimates suggests a statistically significant 0.34 (95% CI: 0.17-0.67) lower risk of esophageal squamous cell carcinoma in snus users compared to smokers/cigarette users. The value for comparisons of summary estimates is statistically significant in all sensitivity analyses.

Although both methods of comparing risk of esophageal cancer in snus users compared to smokers consistently show a lower magnitude of risk for snus users, the statistical significance of this risk is unclear. Further cohort studies allowing within study comparison of risks in snus users and smokers will help determine if the observed lower risk in snus users is statistically significant. The consistently high magnitude of the effect in smokers compared to the snus effect measures consistently below a magnitude of two suggest further study will bolster these results.

#### **3.4.1.6 Incidence of Esophageal Adenocarcinoma**

##### **3.4.1.6.1 Comparability of esophageal adenocarcinoma studies**

The one cohort (Zendehdel et al. 2008) and one case-control (Lagergren et al. 2000) study that reported on esophageal adenocarcinoma had independent study populations, variation in methods of control for tobacco, variation in exposure characterization, variation in snus and smoking exposure characterization, comparable reference group specificity, and variation in control for risk factors.

Two studies (Lagergren et al. 2000; Zendejdel et al. 2008) evaluated incidence of esophageal adenocarcinoma with an analysis of the Swedish population in 1995-1997 and the Swedish Construction Worker Cohort from 1971-2004. No overlap of study populations was suspected.

The method of control for tobacco varied between studies. Zendejdel et al. (2008) reported adjusted and stratified effect measures, while Lagergren et al. (2000) controlled for tobacco through adjustment only. Stratified estimates were preferred for inclusion in the main analyses for calculation of within study relative risk ratios and minimal residual confounding. Sensitivity analyses that preferred adjusted estimates was performed.

The snus and smoking exposure characterizations varied between and within studies. Lagergren et al. (2000) reported snus effect measures for only ever snus exposure, while it reported smoking effect measures for previous and current smoking exposure. The smoking effect measures from Lagergren et al. (2000) were combined in a fixed-effect meta-analysis to provide an ever-smoking exposure comparable to the ever snus exposure in the same study. Zendejdel et al. (2008) reported "snus user" as the exposure. It is unclear if this signified current or ever snus use. Sensitivity analyses of the unclear exposure characterization could not be performed as only one study would remain. Sensitivity analyses of exposure characterizations was also not possible as neither study reported an alternative characterization for snus users.

Only Lagergren et al. (2000) reported dose-response effect exposure groups for snus users, while both studies (Lagergren et al. 2000; Zendejdel et al. 2008) reported dose- or duration- response exposure groups for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose- or duration response results were included in the discussion section to better interpret meta-analyses results.

Reference groups were either never snus/smoker as appropriate or never tobacco. These reference groups were considered sufficiently comparable between studies.

All studies controlled for age, sex, and weight but otherwise varied in possible confounders considered. The American Cancer Society (2012) has identified the following as important risk factors for esophageal cancer: Alcohol use, a diet low in fruits and vegetables, obesity (adenocarcinoma), male (3x higher than women), age (most cases occur in those 65 and older), gastroesophageal reflux disease (GERD- adenocarcinoma), Barrett's esophagus (adenocarcinoma), exposure to solvents used for dry cleaning, people who have had treatment to rid the stomach of H. pylori, and people who have had other cancers such as lung, mouth and throat cancer are at higher risk. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

#### 3.4.1.6.2 Control for Confounders Table

	Lagergren et al. 2000	Zendejdel et al. 2008
Age	X	X
Sex	X	X
Alcohol	X	
Weight/BMI	X	X

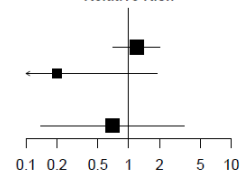


Physical Activity	X	
Diet	X	
Gastroesophageal Reflux Disease	X	
Barrett's esophagus		
Dry-cleaning solvents		
H. pylori exposure		
Educational Level	X	
Prior cancers		
Region		
Snus, Cigs	X	X

### 3.4.1.6.3 Incidence of Esophageal Adenocarcinoma

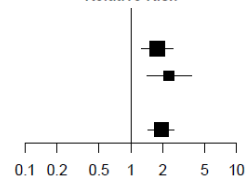
#### Esophageal Cancer Incidence in Snus users

Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Lagergren et al. 2000	Swedish population	Moderate	Case-control	Ever vs Never snuff		1.20 [0.71; 2.03]
Zendehdel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	Snus user vs Never tobacco		0.20 [0.02; 1.90]
<b>Summary Estimate</b>						0.69 [0.14; 3.60]
Heterogeneity: $I^2 = 57\%$ , $\tau^2 = 0.9089$ , $p = 0.13$						



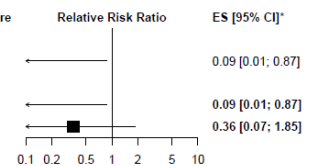
#### Esophageal Cancer Incidence in Smokers

Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Lagergren et al. 2000	Swedish population	Moderate	Case-control	Ever vs Never smoker		1.78 [1.26; 2.51]
Zendehdel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	Ever vs Never tobacco		2.30 [1.41; 3.74]
<b>Summary Estimate</b>						1.94 [1.46; 2.56]
Heterogeneity: $I^2 = 0\%$ , $\tau^2 = 0$ , $p = 0.39$						



#### Esophageal Cancer Incidence in Snus users compared to Smokers

Reference	Population	Quality	Study Design	Snus Group and Exposure	Cigarette Group and Exposure	Relative Risk Ratio	ES [95% CI]*
Zendehdel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	Snus user vs Never tobacco	Ever vs Never tobacco		0.09 [0.01; 0.87]
<b>Summary Estimate</b>							0.09 [0.01; 0.87]
<b>Comparison of Summary Estimates</b>							0.36 [0.07; 1.85]
Heterogeneity: $I^2 = \text{NA}\%$ , $\tau^2 = \text{NA}$ , $p = \text{NA}$							



#### 3.4.1.6.4 Sensitivity Analysis Summary Table

Two sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to five key limitations of the main analyses: 1) Inappropriate preference for stratified effect measures, 2) Inappropriate a priori decision to use random-effects meta-analysis

Sensitivity analyses for only cohort studies was not possible as only one cohort study existed. Sensitivity analyses for alternate exposure preferences or the unclear snus exposure in Zendejdel et al. (2008) was not possible due to insufficient studies.

	Main Analysis	1) Preference for adjusted estimates when available	2) Fixed-effects meta-analysis
Summary Estimate for Snus Users (95% CI)	0.69 (0.14, 3.50)	1.08 (0.77, 1.53)	1.09 (0.66, 1.82)
Summary Estimate for Smokers (95% CI)	1.94 (1.46, 2.56)	1.78 (1.26, 2.51)	No change
Summary Relative Risk Ratio (95% CI)	0.09 <sup>a</sup> (0.01, 0.87)	— <sup>b</sup>	No change
Comparison of Summary Estimates (95% CI)	0.36 (0.07, 1.85)	0.61 (0.37, 0.99)	0.57 (0.32, 1.01)

<sup>a</sup> Only one study

<sup>b</sup> No studies with exclusive smoking and snus effect measures

#### 3.4.1.6.5 Conclusion criteria for Esophageal Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	0.69	0.09	0.36
Statistical Significance	No	Yes	No
Consistency of Direction/Magnitude of Included Studies	No,  One study above one and one below one	Only one study	NA
Consistency of Statistical Significance of Included Studies	Yes,  Both studies are statistically non-	Only one study	NA

	significant		
Statistically significant heterogeneity	No	-	NA
Qualitative Assessment	Two moderate studies	One moderate study	NA
Sensitivity Analysis	Supports the main analysis  Statistically non-significant results for two sensitivity analyses	Supports the main analysis when estimates available, but no estimate in one sensitivity analyses	Does not support main analysis.  Statistically significant when adjusted estimates are used.
Limitations	<ul style="list-style-type: none"> <li>• Within study relative risk ratios only possible for one study.</li> <li>• Only two studies, one with low number of cases resulting in a very wide confidence interval.</li> </ul>		

### 3.4.1.6.6 Discussion of Esophageal Adenocarcinoma

#### **Overall results**

The main analysis of this section summarized the effect estimates of esophageal adenocarcinoma from two studies to obtain a statistically non-significant summary estimate of 0.69 (95% CI: 0.14-3.50) for snus users. Smokers within these studies had a statistically significant summary estimate of 1.94 (95% CI: 1.46-2.56) based on two studies. A statistically significant relative risk ratio of 0.09 (95% CI: 0.01-0.87) was obtained for within study comparisons of risks based on one study. The comparison of summary estimates yielded a statistically non-significant relative risk ratio of 0.36 (95% CI: 0.07-1.85).

These results are also generally in line with the statistical significance of dose- or duration-response trends reported in the two studies (Lagergren et al. 2000; Zendehdel et al. 2008) that assessed smokers and one study (Lagergren et al. 2000) that assessed snus users. Only Lagergren et al. (2000) reported dose-response effect exposure groups for snus users, finding statistically non-significant effects in trends for years of duration of use and for intensity of use. The risk was elevated for snus users consuming 15-35 quids per week, however there was no evident dose-response trend. The smoking duration- exposure groups reported in Lagergren et al. (2000) did not assess trend, but the effects were statistically significant for 1-20 years of smoking and >35 years of smoking, while statistically non-significantly elevated for 21-35 years of smoking. No dose-exposure groups had statistically significant effects. Zendehdel et al. (2008) reported statistically significant smoker effect estimates for two of three dose-response group and had a statistically significant trend.

#### **The Effect of Snus**

Our main analysis shows a statistically non-significant summary estimate for snus use that remains consistent despite methodological choices. The direction of the effect, however does change when adjusted estimates were preferred in analysis or when a fixed-effects meta-analysis was performed.

Prior meta-analyses did not present an effect estimate for esophageal adenocarcinoma.

Overall, the quantitative evaluation supports our qualitative conclusion that there is limited/suggestive evidence of no association snus use and adenocarcinoma.

### ***The Effect of Smoking***

The analyses show consistent statistically significant increases in the risk of adenocarcinoma in smokers compared to never smoker/tobacco users. This is in line with previous knowledge of the adverse effects of smoking.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for only one study (Zendehdel et al. 2008) with an unclear snus exposure that resulted in a statistically significant relative risk ratio of 0.76 (95% CI: 0.34-3.71) that was consistent in the one sensitivity analysis that included this estimate.

On the other hand, the comparison of summary estimates suggests a statistically non-significant 0.36 (95% CI: 0.07-1.85) lower risk of esophageal cancer in snus users compared to smokers/cigarette users. The value for comparisons of summary estimates is statistically significant when adjusted estimates are preferred, but not in a fixed-effects meta-analysis.

Although both methods of comparing risk of esophageal cancer in snus users compared to smokers consistently show a lower magnitude of risk for snus users, the statistical significance of this risk is unclear. Further cohort studies comparing risks in snus users and smokers will be necessary to determine if the observed lower risk in snus users is statistically significant

#### **3.4.1.7 Cancer at Other Sites in the Head and Neck**

Only Lewin et al. (1998) present effect estimates for pharynx and larynx cancer. No meta-analyses were possible.

### **3.4.2 Pancreatic Cancer**

#### **3.4.2.1 Overview of Evidence for Pancreatic Cancer**

Smoking accounts for overall 22% of all pancreatic cancer deaths in the United states and constitutes 1.7% of all deaths among smokers (CDC 2008). Qualitative evaluation found that the available studies provide limited/suggestive evidence of no association between snus use and pancreatic cancer.

#### **3.4.2.2 Outcome Comparability**

In this evaluation, "pancreatic cancer" refers to the disease outcomes represented by ICD7,8,9: 157 and ICD10: C25.

Four studies (Boffetta et al. 2005; Luo et al. 2007; Heuch et al. 1983; Araghi et al. 2017) identified in the systematic search evaluated pancreatic cancer defined nominally or by ICD7-157. Only Heuch et al. (1983) reported pancreatic cancer nominally. Every study assessed pancreatic cancer incidence.

### 3.4.2.3 Comparability of pancreatic cancer studies

The one case-control (Heuch et al. 1983), two cohort (Luo et al. 2007; Boffetta et al. 2005), and one pooled cohort study (Araghi et al. 2017) that reported on pancreatic cancer incidence had non-independent study populations, variation in methods of control for tobacco, variation in snus and smoking exposure characterization, comparable reference group specificity, and variation in control for risk factors.

The four studies (Boffetta et al. 2005; Luo et al. 2007; Heuch et al. 1983; and Araghi et al. 2017) had overlap in study populations. Two studies (Boffetta et al. 2005; Heuch et al. 1983) utilized the systematic sample from the 1960 Census & Relatives of U.S migrants. Heuch et al. 1983 was excluded from the main analysis due to this overlap and due to a failure to report confidence intervals, which prevents calculation of a meta-analysis summary estimate. Luo et al. (2007) assessed the Swedish construction worker cohort, while Araghi et al. (2017) assessed a pooled cohort of the Swedish Construction Worker Cohort, the Malmo Diet and Cancer Study, MONICA, National March Cohort, the Screening Across the Lifespan Twin Study, the Stockholm Public Health Cohort, the Vasterbotten Intervention Programme, and the Work, Lipids, and Fibrinogen Study. Thus, independence did not exist between Araghi et al. (2017) and Luo et al. (2007) due to the presence of the Swedish Construction Worker cohort in the pooled cohort. Araghi et al. (2017) reported an effect estimate excluding the Swedish construction worker cohort that was used in the main analysis to avoid overlapping study populations. A sensitivity analysis that excludes Luo et al. (2007) in favor of the Araghi et al. (2017) including the Swedish construction worker cohort was performed. Note that it was preferable to keep Luo et al. (2007) as it was the only study that allows within study smoker comparison.

Method of control for tobacco varied between studies. Two studies (Araghi et al. 2017; Heuch et al. 1983) controlled for tobacco through adjustment only, while the other two studies (Boffetta et al. 2005; Luo et al. 2007) reported stratified and adjusted effect measures. Stratified estimates were preferred for inclusion in the main analyses for calculation of within study relative risk ratios. Sensitivity analysis that preferred adjusted estimates was performed.

The available snus exposure characterizations varied between studies. Boffetta et al. (2005) reported adjusted effect measures for ever, current, and former snus exposure, however reported stratified effect measures for only ever snus users. Luo et al. (2007) reported adjusted estimates for ever-users, and stratified exclusive estimates for ever, former, and current snus use. Heuch et al. (1983) report results for regular users. Araghi et al. (2017) reported adjusted results for ever, current, and former users. Ever use was prioritized as it was the only stratified exposure characterization in Boffetta et al. (2005). Sensitivity analyses that preferred current use when available was also performed.

The available smoking exposures varied between studies. Araghi et al. (2017) did not report any smoking effect estimates. Boffetta et al. (2005) only reported smoking effect measures among ever users of snus that could not be compared to snus effect estimates. Heuch et al. (1983) reported exposures for greater than or equal to 10 cigarettes per day. Lastly, Luo et al. (2007) reported ever, former, and current exposure to smoking. However, the authors note that "combined use of snus and smoking tobacco was allowed in these analyses" although the smoking exposure group did exclude exclusive snus users. The smoking estimates from Luo et al. (2007) therefore represents the mixed effect between exclusive smokers and dual users. Since this group excludes snus users, these two

exposure groups can be compared, however the results need to be interpreted accordingly. The ever exposure effect estimate was selected for comparability with ever snus exposures.

Luo et al. (2007) and Araghi et al. (2017) reported dose-response effect exposure groups for snus users, while no studies reported dose-response exposure groups for smokers. The dose-exposure groups in Luo et al. (2007) assessed grams per day, while Araghi et al. (2017) reported cans/week. Additionally, Araghi et al. (2017) reported duration-exposure groups. There were consequently insufficient comparable studies to further assess meta-analyses based on snus dose- or duration exposure groups. Dose- or duration response results were included in the discussion section to better interpret meta-analyses results.

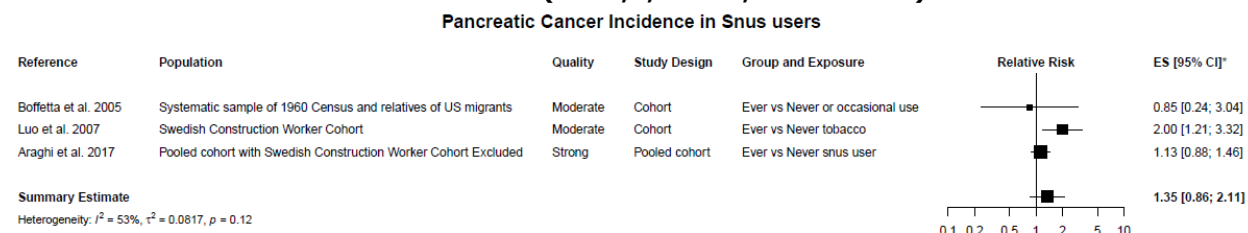
Reference groups were either never snus, never tobacco, or “never or occasional snus”. These reference groups were considered sufficiently comparable between studies. Notably, Boffetta et al. (2005) explicitly states the reference group as “never or occasional” use of snus. The definition of “occasional” is unclear. This was still considered directly comparable, because many studies use a definition of current or ever *regular* smoking or snus use but do not explicitly state this in their effect estimate reporting. For example, this is equivalent to reports by Roosaar et al. (2008) of never *daily* use of snus/smoking. Interpretations of summary estimates take this into account.

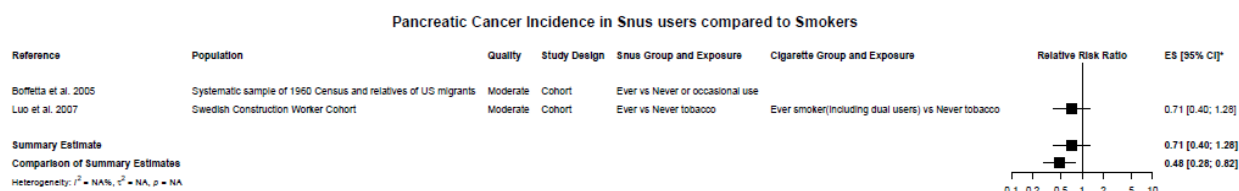
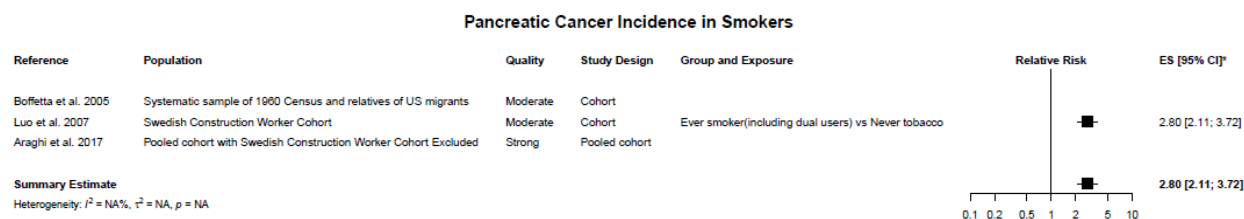
All studies controlled for age and sex, but otherwise varied in possible confounders considered. The National Cancer Institute (2010) has identified the following as important risk factors for pancreatic cancer: age (60 and older), diabetes, male gender, African American ethnicity, family history, chronic pancreatitis. Additionally, the US Surgeon General (USDHHS 2004) identified alcohol use as an important risk factor. Comparison with confounders in the studies (see table below) show no study controlled for all these possible risk factors and that only two studies (Luo et al. 2007; Araghi et al. 2017) study control for the same set of confounders.

#### 3.4.2.4 Control for Confounders Table

	Age	Sex	Alcohol	BMI	Race	Diabetes	Family History	Chronic Pancreatitis	Snus, Cigs
Heuch et al. 1983	X	X	X						X
Boffetta et al. 2005	X	X							X
Luo et al. 2007	X	X		X					X
Araghi et al. 2017	X	X		X					X

#### 3.4.2.5 Incidence of Pancreatic Cancer (ICD7,8,9: 157; ICD10: C25)





### 3.4.2.6 Sensitivity Analysis Summary Table

Five sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to five key limitations of the main analyses: 1) Inappropriate preference for ever exposure, 2) Inappropriate preference for stratified effect estimates, 3) Inappropriate exclusion of updated Swedish construction worker cohort estimate, 4) Inappropriate a priori decision to use random-effects meta-analysis

	Main Analysis	1) Preference for current exposure when available	2) Preference for adjusted estimates when available	3) Exclude Luo et al. (2007) and use the Araghi et al. (2017) estimate with the CWC	4) Fixed Effects meta-analysis
Summary Estimate for Snus Users (95% CI)	1.35 (0.86, 2.11)	1.47 (1.01, 2.12)	1.29 (0.93, 1.79)	0.93 (0.82, 1.06)	1.25 (1.00, 1.57)
Summary Estimate for Smokers (95% CI)	2.80 <sup>a,b</sup> (2.11, 3.72)	3.50 <sup>a,b</sup> (2.63, 4.66)	No Change	- <sup>d</sup>	No change
Summary Relative Risk Ratio (95% CI)	0.71 <sup>a,c</sup> (0.40, 1.28)	0.60 <sup>a,c</sup> (0.32, 1.11)	No Change	- <sup>d</sup>	No Change
Comparison of Summary Estimates (95% CI)	0.48 <sup>c</sup> (0.28, 0.82)	0.42 <sup>c</sup> (0.26, 0.67)	0.46 <sup>c</sup> (0.3, 0.71)	- <sup>d</sup>	0.45 (0.31, 0.64)

<sup>a</sup> Only one study

<sup>b</sup> This is a combined dual user and cigarette effect estimate

<sup>c</sup> This is probably best described as the relative risk of snus compared to the relative risk of dual users or exclusive cigarette smokers.

<sup>d</sup> No cigarette effect measures available

### 3.4.2.7 Conclusion Criteria for Pancreatic cancer

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.35	0.71	0.48
Statistical Significance	No	No	Yes
Consistency of Direction/Magnitude of Included Studies	No,  One study has a magnitude below one, while the other two are above one	Only one study	NA
Consistency of Statistical Significance of Included Studies	No,  One study has a statistically significant effect above one	Only one study	NA
Statistically significant heterogeneity	No	-	-
Qualitative Assessment	Two moderate studies, and one strong study	One moderate study	-
Sensitivity Analysis	Does not support main analysis  Sensitivity analyses that preferred current exposure was statistically significant	Supports main analysis	Supports main analyses
Other Limitations	<ul style="list-style-type: none"> <li>• Within study relative risk ratios only possible for one study.</li> <li>• Unique smoking exposure group in Luo et al. (2007)</li> </ul>		

### 3.4.2.8 Discussion of Pancreatic Cancer Incidence

#### **Overall results**

The main analysis of this section summarized the effect estimates of pancreatic cancer from three studies to obtain a statistically non-significant summary estimate of 1.35 (95% CI: 0.86-2.11) for



snus users controlled for smoking. Smokers within one of these studies had a statistically significant relative risk of 2.80 (95% CI: 2.11-3.72). A statistically non-significant relative risk ratio of 0.71 (95% CI: 0.40-1.28) was obtained for within study comparisons of risks based on one study. The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.48 (95% CI: 0.28-0.82). However, these last two estimates described the relative risk of snus compared to the combined group of dual users and exclusive cigarette smokers. This is due to the limitations with the single smoking estimate available discussed in the study comparability section for this endpoint.

### ***The Effect of Snus***

Although our main analysis shows a statistically non-significant summary estimate for snus use, sensitivity analysis that preferred current exposure characterization suggests inconsistency in statistical significance. Preference for current exposure resulted in a statistically significant effect measure of 1.47 (95% CI: 1.01-2.12). This change results from a substantial change in selected effect measures from Boffetta et al. (2005) from 0.85 (95% CI: 0.24-3.04) to 1.60 (95% CI: 1.00-2.55). As well as a smaller change in the selected estimate from Luo et al. (2007) from 2.00 (95% CI: 1.21-3.32) to 2.10 (95% CI: 1.21-3.64).

Luo et al. (2007) and Araghi et al. (2017) present dose-exposure groups for current snus users. Luo et al. (2007) reported current snus use of 1-9 g/day had a statistically non-significant relative risk of 1.9 (95% CI: 0.8-4.3), while snus use of  $\geq 10$  g/day had a statistically significant relative risk of 2.1 (95% CI: 1.1-3.8). There was a statistically significant p-value for trend of 0.01. In contrast, the estimates from Araghi et al. (2017) show no statistically significant results and comparable low magnitude for exposures groups of < 4 cans/week, 4-6 cans/week, and  $\geq 7$  cans/week. Similarly, duration exposure groups in Araghi et al. (2017) showed no statistically significant results.

Araghi et al. (2017) also presented updated results of the Swedish construction worker cohort, which was used in Luo et al. (2007). Araghi et al. (2017) report current users in the Swedish construction worker cohort had a statistically non-significant 0.86 (95% CI: 0.72-1.02) relative risk. This was in stark contrast to the reported 2.10 (95% CI: 1.21-3.64) relative risk in Luo et al. (2007).

The inconsistency of our results are in line with inconsistent results from prior meta-analyses (Boffetta et al. 2008; Lee and Hamling 2009b; Lee 2011; Sponsiello-Wang et al. 2008). Lee and Hamling (2009b) and Lee (2011) reported a statistically non-significant summary measure of 1.2 (95% CI: 0.66-2.20) for the overall data, while Boffetta et al. (2008) reported a statistically significant summary measure of 1.8 (95% CI: 1.32-2.5). Sponsiello-Wang et al. (2008) present fixed-effects and random-effects meta-analyses for the overall cohort and restricted to never smokers (when available). They reported a statistically significant summary estimate of 1.78 (95% CI: 1.11-2.85) for only the fixed-effects meta-analysis among never-smokers. These results differ from what is presented here due to their respective methodological choices.

The previous 2013 ENVIRON report also discussed results from Bertuccio et al. (2011). Bertuccio et al. (2011) is a pooled analysis of 11 international case-control studies and of cigarette and western population smokeless tobacco users. In this study, exclusive smokeless tobacco users did not face a significantly increased risk of pancreatic cancer, whereas the risk of pancreatic cancer was significantly increased among smokers. Given that the smokeless tobacco used by participants in these studies likely contained higher levels of TSNA compared to Swedish snus, the principal component of tobacco

thought to be associated with the development of pancreatic cancer (Boffetta et al. 2008), it is unlikely that Swedish snus poses a risk for pancreatic cancer. However, this study does not meet our criteria for Swedish snus use.

Overall, results of the main meta-analyses provide support for the qualitative evaluation that the available evidence is *limited/suggestive of no association* between snus and pancreatic cancer incidence.

### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases in the risk of pancreatic cancer in smokers compared to never-smoker/tobacco users. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on pancreatic cancer-related mortality in six major U.S. cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates, the mortality estimates provide some additional U.S. context.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for only one study (Luo et al. 2007) that resulted in a statistically non-significant relative risk ratio of 0.76 (95% CI: 0.34-3.71) that was consistent in all sensitivity analyses.

On the other hand, the comparison of summary estimates suggests a statistically significant 0.48 (95% CI: 0.28, 0.82) lower risk of pancreatic cancer in snus users compared to smokers/cigarette users. The comparison of summary estimates remained consistently statistically significant in sensitivity analyses.

Both methods of comparing risk of pancreatic cancer in snus users compared to smokers consistently show a lower statistically significant risk for snus users.

## **3.4.3 Stomach Cancer**

### **3.4.3.1 Overview of Evidence for Stomach Cancer**

Smoking accounts for 21% of all stomach cancer deaths in the United states and stomach cancer constitutes 0.6% of all deaths among smokers (CDC 2008). Qualitative evaluation found that the available studies provide limited/suggestive of no association between snus use and overall stomach cancer. The available studies provide limited/suggestive evidence of no association between use of snus and cardia stomach cancer. Overall, the available studies provided inadequate/insufficient evidence to determine whether an association exists between snus use and non-cardia stomach cancer.

### **3.4.3.2 Outcome Comparability**

In this evaluation, "stomach cancer" refers to the overall range of disease outcomes represented by ICD7,8,9: 151 and ICD10: C16. This encompasses studies of cardia and non-cardia stomach cancer. Studies variably reported on specific subtypes of stomach cancer and overall stomach cancer. Enough studies were available to perform a meta-analysis of stomach cancer and cardia stomach cancer, however there were not sufficient studies for meta-analyses of non-cardia stomach cancer.

Five studies (Boffetta et al. 2005; Hansson et al. 1994; Lagergren et al. 2000; Ye et al. 1999; Zendehdel et al. 2008) identified in our systematic review evaluated outcomes related to stomach cancer. Three of the studies (Boffetta et al. 2005; Hansson et al. 1994; Ye et al. 1999) reported directly comparable outcomes of overall stomach cancer incidence, while the other two reported incidence of stomach cancer subtypes. Lagergren et al. (2000) reported on only the cardia subtype of stomach cancer, while Zendehdel et al. (2008) reported on mutually exclusive cardia and non-cardia subtypes without giving an overall risk estimate of total stomach cancer. Zendehdel et al. (2008) categorized cases based on the ICD7-151 definition of stomach cancer before dividing it into the mutually exclusive, but collectively exhaustive subtypes of cardia (ICD7-151.1) and non-cardia (all other ICD7-151) stomach cancer. These outcomes were combined through a fixed effects meta-analysis to estimate an overall stomach cancer effect measure for the Zendehdel et al. (2008) study population. This estimate was further considered for inclusion in the main meta-analysis of stomach cancer, while the Lagergren et al. (2000) estimate could not be reasonably included in the meta-analysis of overall stomach cancer.

Additional meta-analyses for each cardia subtype and noncardia subtypes were considered due to assessment by multiple studies. Three studies (Lagergren et al. 2000, Ye et al. 1999, and Zendehdel et al. 2008) reported effect measures of the cardia subtype of stomach cancer that were further evaluated for a meta-analysis. Two studies (Zendehdel et al. 2008; Ye et al. 1999) discuss non-cardia stomach cancer, however a meta-analysis for this subtype could not be performed as Ye et al. (1999) reports on only selected sub-categories of non-cardia stomach cancer. Ye et al. (1999) described non-cardia stomach cancer as either distal diffuse, distal intestinal, mixed, or indeterminate. Although these four categories could be reasonably combined through a fixed effect meta-analysis to represent overall non-cardia stomach cancer, Ye et al. (1999) did not report effect measures for mixed and indeterminate type cancers. Consequently, only Zendehdel et al. (2008) reported an estimate for overall non-cardia stomach cancer.

### **3.4.3.3 Overall Stomach Cancer**

#### **3.4.3.3.1 Comparability of studies for stomach cancer studies**

The four studies considered did not all have independent study populations and differed in selected methods of control for tobacco, available exposure characterizations, reference group specification, and control of confounders.

Four studies (Boffetta et al. 2005; Hansson et al. 1994; Ye et al. 1999; Zendehdel et al. 2008) explicitly evaluated incidence of any stomach cancer with an analysis of a 1966 Swedish population and relatives of U.S. migrants' cohort, the Swedish Construction Worker cohort, and a case-control of 5 counties in northern and central Sweden. Exclusivity between studies was not maintained for two studies (Hansson et al. 1994; Ye et al. 1999) that assessed a case-control from the same five Swedish counties albeit with different relevant time periods. Hansson et al. (1994) looked at the period from 1989 to 1992, while Ye et al. (1999) focused on the wider period from 1989 to 1995. Only one of these studies was included in the main analysis due to use of the same source population and considerable overlap of time periods. Sensitivity analyses were conducted to assess impact of study exclusion.

The method of control for tobacco use varied. Only multivariate adjusted estimates were reported by Boffetta et al. (2005) and Hansson et al. (1994), while only stratified estimates were reported by Ye et al. (1999). Multivariate adjusted and stratified estimates were reported by Zendejdel et al. (2008). Stratified estimates are prioritized for inclusion in the main meta-analysis as only these studies are used for within study relative risk ratios of their stratified estimates. Sensitivity analyses that preferred multivariate adjusted estimates was performed.

The snus exposure characterization varied and was unclear for two studies. Boffetta et al. (2005) presented multivariate adjusted estimates for ever and current exposure to snus. Ye et al. (1999) reported only ever exposure stratified effect measures. The remaining two studies (Hansson et al. 1994; Zendejdel et al. 2008) respectively reported "snuff dipping" or "user of snus". It is unclear if these latter characterizations signify current or ever snus use. Ever exposure characterization was prioritized for inclusion in the main analysis as it was available in two out of four studies, whereas other exposure characterizations were available in only a single study. Sensitivity analyses excluding unclear characterizations was performed.

Exposure characterization for smokers was also varied. Zendejdel et al. (2008) reported ever and current smoking exposure, Ye et al. (1999) reported current and former smoking exposure, Boffetta et al. (2005) did not report a smoking comparison, and Hansson et al. (1994) reported only current and former *cigarette* exposure. As the most common snus exposure was ever exposure, the same exposure characterization for smokers was preferred. This required a fixed-effect meta-analysis in Ye et al. (1999) and Hansson et al. (1994) to combine current and former cigarette/smoking exposure strata. Zendejdel et al. (2008) and Ye et al. (1999) had directly comparable exclusive ever smoking/cigarette and ever snus groups to include in the main analysis.

All except for Boffetta et al. (2005) assessed smoker or cigarette dose-response effects, but only Ye et al. (1999) assessed dose-response effects in snus users. Therefore, a possible meta-analysis of dose-response exposures was not considered any further. The dose-response results are included in the discussion section to better interpret meta-analyses results.

Reference groups for studies were either never snus, never smoker, or never tobacco with some exceptions. Two of the four studies use common reference groups (never-users of any tobacco) for snus and smoking risk estimates (Zendejdel et al. 2008; Ye et al. 1999). The reference group among snuff users in the Hansson et al. (1994) study is unspecified, however, it's likely that it was "non-users of tobacco" as was used for the smoking reference group. Boffetta et al. (2005) explicitly state the reference group as "never or occasional" use of snus. The definition of "occasional" is unclear. This was still considered directly comparable, because many studies use a definition of current or ever *regular* smoking or snus use but do not explicitly state this in their effect estimate reporting. For example, in Ye et al. (1999) "Cigarette smokers were defined as those smoking one cigarette or more per day for at least half a year...Users of smokeless tobacco, including chewing tobacco and snuff, were defined as those practicing the habit at least once a week for 6 months or more."

All studies controlled for age and gender, but otherwise varied in confounders considered. The National Cancer Institute (2009b) and the American Cancer Society (2013b) have identified the following as risk factors: *H. pylori* infection, long term inflammation of the stomach, smoking, family history, poor diet (high in foods that are smoked, salted, or pickled), lack of physical activity, obesity, gender (more common in men), ethnicity (in the US: more common in Hispanic and African

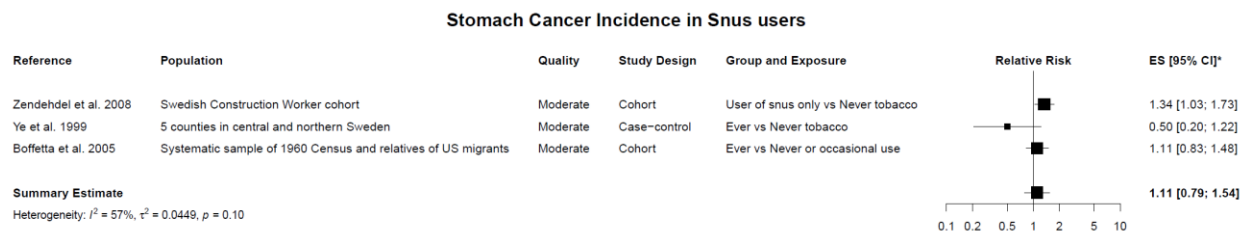
Americans, and most common in Asian/Pacific Islanders) and geography (most common in Japan, China, southern and Eastern Europe, and South and Central America). Comparison with confounders controlled for in the studies (see table below) show that not all the above risk factors were considered and that some additional factors were identified as potential confounders.

Hansson et al. (1994) was excluded from the main meta-analysis due to overlap of its study population with Ye et al. (1999), limitation in its exposure characterization of “snuff dipping”, and an unspecified reference group. Further consideration of this study in sensitivity analyses may reflect the above characteristics or its decision to control for confounding by diet – a variable not present in any of the remaining studies.

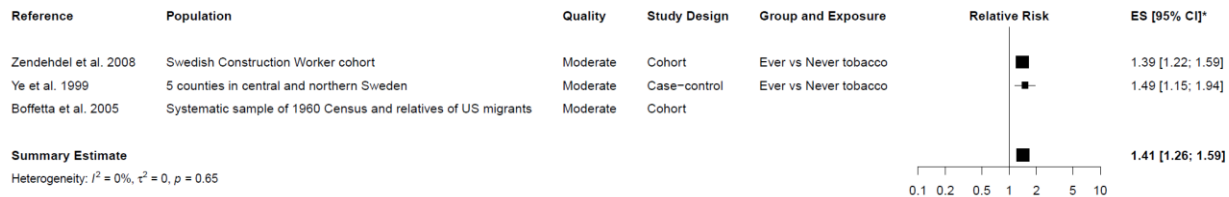
#### 3.4.3.3.2 Control for Confounders Table

	Boffetta et al. 2005	Hansson et al. 1994	Ye et al. 1999	Zendeheel et al. 2008
Age	X	X	X	X
Sex	X	X	X	X
Alcohol			X	
BMI			X	X
Physical Activity				
Diet		X		
Ethnicity				
Geography				
H. pylori exposure				
Long-term inflammation				
Gastro-esophageal reflux disease				
SES		X	X	
Snus, Cigs	X	X	X	X

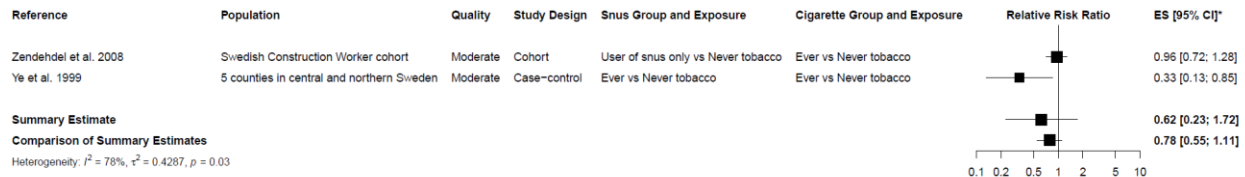
#### 3.4.3.3.3 Incidence of Stomach Cancer (ICD7,8,9: 151, ICD10: C16)



### Stomach Cancer Incidence in Smokers



### Stomach Cancer Incidence in Snus users compared to Smokers



Note: The effect measure from Zendehele et al. (2008) results from a fixed-effect meta-analysis of cardia and non-cardia stomach cancer effect measures in the study

#### 3.4.3.3.4 Sensitivity Analysis Summary Table

Eight sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to eight key limitations of the main analyses: 1) Inappropriate exclusion of study with similar population, 2) Inappropriate preference for stratified effect estimates, 3) Inappropriate inclusion of unclear exposure characterization, 4) Inappropriate preference for ever use, 5) Inappropriate use of case-control studies, 6) Inappropriate mixing of multivariate adjusted and stratified estimates, 7) Inappropriate a priori decision to use random-effects meta-analysis, and 8) Inappropriate exclusion of studies identified in systematic review regardless of stomach cancer outcome specification.

	Main Analysis	1) Inclusion of Hansson et al. (1994) <sup>a</sup>	2) Preference for adjusted estimates when available	3) Exclusion of unclear exposure (Zendehele et al. 2008)	4) Preference for current use when available	5) Only cohort studies	6) Only stratified studies	7) Fixed-effects meta-analysis	8) All studies identified in systematic review <sup>d</sup>
Summary Estimate for Snus Users (95% CI)	1.11 (0.79, 1.54)	0.96 (0.68, 1.36)	1.06 (0.88, 1.27)	0.84 (0.40, 1.77)	1.16 (0.80, 1.67)	1.23 (1.02, 1.49)	0.90 (0.35, 2.32)	1.25 (1.02, 1.55)	1.02 (0.78, 1.34)
Summary Estimate for Smokers (95% CI)	1.41 (1.26, 1.59)	1.44 (1.28, 1.61)	1.49 <sup>b</sup> (1.15, 1.94)	1.49 <sup>b</sup> (1.15, 1.94)	No changes	1.39 <sup>b</sup> (1.22, 1.59)	No changes	No changes	1.91 <sup>c</sup> (1.23, 2.97)
Summary Relative Risk Ratio (95% CI)	0.62 (0.23, 1.72)	No changes	0.33 <sup>b</sup> (0.13, 0.85)	0.33 <sup>b</sup> (0.13, 0.85)	No changes	0.96 <sup>b</sup> (0.72, 1.28)	No changes	0.87 (0.66, 1.15)	No changes
Comparison of Summary Estimates (95% CI)	0.78 (0.55, 1.11)	0.67 (0.46, 0.96)	0.71 (0.51, 0.98)	0.56 (0.25, 1.24)	0.82 (0.56, 1.20)	0.88 (0.70, 1.12)	0.64 (0.25, 1.65)	0.89 <sup>c</sup> (0.70, 1.13)	0.53 (0.32, 0.89)

<sup>a</sup> These estimates are unduly weighted by the case-control of five Swedish counties in northern and central Sweden.

<sup>b</sup> Only one study

<sup>c</sup> Statistically significant heterogeneity, fixed effects analysis not methodologically appropriate.

<sup>d</sup> These estimates combine overall stomach cancer and cardia stomach cancers, as well as overemphasize the weight of the case-control of five Swedish counties present in two studies.

### 3.4.3.3.5 Conclusion criteria for Stomach Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.11	0.62	0.78
Statistical Significance	No	No	No
Consistency of Direction/Magnitude of Included Studies	No, one of the three studies is less than one, while the other two are greater than one	No, Both included studies are less than one, but the magnitude of effect in the case-control study is almost a third lower than the other study.	NA
Consistency of Statistical Significance of Included Studies	No, Only one study is statistically significant	No, Only the case-control study is statistically significant	NA
Statistically significant heterogeneity	No, but 57% of variance is due to between study variation.	Yes, 78% of variance due to between study variation	-
Qualitative Assessment	Three moderate quality studies	Two moderate quality studies	-
Sensitivity Analysis	Does not support main analysis as inclusion of only cohort studies results in statistically significant effect above one. The use of fixed-effect analysis results in statistically significant effect above one.	Does not support meta-analyses.  All studies below one, but three statistically significant	
Other Limitations	<ul style="list-style-type: none"> <li>• Zendejdel et al. (2008) required combination of effect estimates, the resulting estimate may be driven largely by the non-cardia estimate.</li> <li>• Studies (Hansson et al. 1994; Ye et al. 1999) that used the five counties in Sweden were selected purposefully. The two northern counties (Västerbotten and Norrbotten) have the highest incidence of gastric cancer, while the 3 counties in central Sweden (Uppsala, Västmanland, and Södermanland) have incidence below the national average.</li> <li>• Hansson et al. (1994) and Zendejdel et al. (2008) respectively reported</li> </ul>		

	"snuff dipping" or "user of snus". It is unclear if these latter characterizations signify current or ever snus us.
--	---

### 3.4.3.3.6 Discussion of Stomach Cancer Incidence

#### **Overall results**

The main analysis of this section summarized the effect estimates of stomach cancer from three studies to obtain a summary estimate of 1.11(95% CI: 0.79-1.54) for snus users that have never smoked or adjusted for smoking. For smokers within these studies a statistically significant summary estimate of 1.41 (95% CI: 1.26-1.59) was obtained. Due to lack of stratification there may be residual confounding in these estimates. A statistically non-significant summary relative risk ratio of 0.62 (95% CI: 0.23-1.72) was obtained for within study comparisons of risk. The comparison of summary estimates yielded a statistically non-significant estimate of 0.78 (95% CI: 0.55-1.11).

These results are also in line with the statistical significance of dose- or duration-response trends reported in the three studies assessing this in smokers and one study assessing this in snus users. Ye et al. (1999) observed statistically significant smoking dose and duration response trends, but no statistically significant dose or duration response trends for snus users. Hansson et al. (1994) reported a statistically significant trend effects for duration of cigarette smoking but did not find a statistically significant effect for cigarettes per day. Zendehdel et al. (2008) observed no statistically significant dose-response for smokers in their respective stomach cancer subtypes, however an increasing effect estimate for cardia stomach cancer was observed for each group with an increasing dose.

#### **The Effect of Snus**

Although our main analysis shows a summary estimate for snus use that is above one and not statistically significant, the sensitivity analysis suggests inconsistency in direction, magnitude, and statistical significance based on methodological choices. The use of a fixed effect meta-analysis, use of only cohort studies, or result in a different interpretation compared to the main analysis. The statistically significant effect above one based on a fixed-effect meta-analysis, may be due to not accounting for the large but not statistically significant heterogeneity of 57% variation resulting from between study differences. Inconsistencies may also be driven by the identified case-control study as its effect measure of 0.50 (95% CI: 0.20, 1.20) differs considerably from the effect measures in the two cohort studies of 1.29 (95% CI: 0.87, 1.91) and 1.34 (95% CI: 1.03, 1.73). Consequently, a sensitivity analysis of only cohort studies has a statistically significant increased risk of stomach cancer for snus users. This case-control study and/or study population may contribute to the observed statistical heterogeneity as the addition of the excluded case-control that utilizes the same study population with a shorter time-period leads to statistically significant heterogeneity. The case-control studies may be driving heterogeneity, a lower magnitude of effect, and statistical non-significance. Further results from cohort studies may clarify inconsistencies based on methodological choices.

Another source of heterogeneity may be differences in subtypes constituting overall stomach cancer estimates in each study. For example, Zendehdel et al. (2008) show a statistically non-significant relative risk of 0.9 (95% CI: 0.4-2.0) for the cardia subtype, but a statistically significant relative risk of 1.4 (95% CI: 1.1-1.9) for the non-cardia subtype. The composition of subtypes included in a study



could result in varying summary estimates seen in the sensitivity analysis. The cardia subtype of stomach cancer is explored further, but exploration of non-cardia subtypes was not possible.

Compared to the snus summary estimate of 1.11 (95% CI: 0.79-1.54), prior meta-analyses (Lee and Hamling 2009b; Lee 2011) of stomach cancer present lower, but statistically non-significant smoking-adjusted summary estimate of 0.98 (95% CI: 0.82-1.17) and a summary estimate for never-smokers of 0.90 (95% CI: 0.35-2.30). The differences in the magnitude are due to the use of the multivariate adjusted estimates from all five studies identified in the systematic review and use of only the two studies reporting stratified results to obtain the latter estimate – equivalent to results of a sensitivity analysis. This differs from our main approach focused on concordance of defined outcomes for each study in the meta-analysis and to include estimates from all studies regardless of method of tobacco control. Thus, our snus main analysis excludes the cardia stomach cancer estimates from Lagergren et al. (2000) and presents a mix of three multivariate adjusted estimates and two stratified estimates. Despite differences in approach and direction of effect, both of these prior estimates include one in the confidence interval suggesting no evidence for an effect.

Overall, results of the main meta-analyses provide support for the qualitative evaluation that the available evidence is *limited/suggestive of no association* between snus and stomach cancer incidence.

### ***The Effect of Smoking/Cigarettes:***

Our main analysis shows consistent statistically significant increases in the risk of stomach cancer in smokers/cigarette users compared to never tobacco/cigarette users. This is in line with previous knowledge of adverse effects of smoking. The effects of smoking on stomach cancer related mortality in three major U.S cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates, the mortality estimates provide some additional U.S. context to the cigarette estimate results.

### ***Comparison of Effects of Snus with Effects of Smoking/Cigarettes***

Comparison of within study relative risks shows that the overall current evidence consisting of two studies suggests a lower statistically nonsignificant risk of stomach cancer in snus users compared to cigarette/smokers, however considerable statistically significant heterogeneity is present with 78% of the variation due to between study variation. These estimates also consist of only two studies. The estimate in the one cohort study that reported exclusive snus and smoking exposure groups reports a relative risk ratio of 0.96 (95% CI: 0.72-1.28). This would suggest a more modest difference between smoking and snus use.

The comparison of summary estimates is higher than the comparison of within study relative risks, but also suggests a statistically nonsignificant risk of stomach cancer below one in snus users compared to smokers/cigarette users. Comparisons of summary estimates is generally higher than the summary relative risk ratios in sensitivity analyses except for the sensitivity analysis of only cohort studies, which presents a relative risk ratio of 0.88 (95% CI: 0.70-1.12).

Overall both ways of comparing risk of stomach cancer in snus users compared to smokers show a decreased statistically non-significant risk of stomach cancer. In sensitivity analyses, these results remain below one and become statistically significant only when an additional case-control is added. Further cohort studies comparing risks in snus users and smokers will be necessary to determine if the

observed lower risk in snus users is statistically significant. Further evidence may likely suggest a statistically significant decreased risk of stomach cancer in snus users as the risk of stomach cancer in smokers is consistently increased in all studies, the main meta-analysis, and sensitivity analyses.

#### **3.4.3.4 Cardia Stomach Cancer**

##### **3.4.3.4.1 Comparability of studies for cardia stomach cancer meta-analysis**

Three studies (Lagergren et al. 2000, Ye et al. 1999, and Zendejdel et al. 2008) explicitly evaluated incidence of cardia stomach cancer with an analysis of the Swedish Construction Worker cohort, a case control of a sample of the Swedish population in 1995-1997, and a case-control of five counties in Northern and Central Sweden. All studies used a different source population and no studies were excluded.

The method of control for tobacco use varied. Only multivariate adjusted estimates were reported by Lagergren et al. (2000) and Ye et al. (2008), while multivariate adjusted and stratified estimates were reported by Zendejdel et al. (2008). Stratified estimates are prioritized for inclusion in the main meta-analysis as only these studies are used for within study relative risk ratios of their stratified estimates. Sensitivity analyses preferring multivariate adjusted estimates of Zendejdel et al. (2008) will be performed.

The snus exposure characterization varied and was unclear for one study. Lagergren et al. (2000) reported multivariate adjusted effects for cardia cancer in only ever snus users. Ye et al. (1999) reported multivariate adjusted effects for cardia cancer in current and ever snus users. Zendejdel et al. (2008) reported an unclear exposure characterization of "user of snus". Ever exposure characterization was prioritized for inclusion in the main analysis as it was available in two out of three studies, whereas other exposure characterizations were available in only a single study. Sensitivity analyses excluding the unclear characterization was performed.

Exposure characterization for smokers was also varied. Zendejdel et al. (2008) reported ever and current smoking exposure, while Ye et al. (1999) and Lagergren et al. (2000) reported current and former smoking exposure. Current smoking was the most reported, however this would not be comparable with the ever exposure selected for snus users. Therefore, a fixed-effect meta-analysis was performed in Ye et al. (1999) and Lagergren et al. (2000) to combine current and former smoking exposure strata.

All studies assessed dose response trends in smokers and two studies (Ye et al. 1999; Lagergren et al. 2000) did so for snus users, but poor comparability between snus and cigarette exposure groups between and within studies precluded further consideration of meta-analyses. Lagergren et al. (2000) and Ye et al. (1999) each report on intensity and duration for snus users and cigarette/smokers. Lagergren et al. (2000) chooses different intensity metrics for snus use ( $\leq 5$  or  $> 5$  times per day) compared to cigarette use (1-10, 11-15, or  $\geq 16$  cigarettes per day). It is unclear how these could be compared to each other due to different groups and uncertainty on the amount of carcinogenic substance in each cigarette compared to that in each snus quid. The same problem arises in Lagergren et al. (2000) with an added difference in the time period considered. Lagergren et al. (2000) compares snus uses exposures of 1-14, 15-35, and  $> 35$  quids per *week* to cigarette exposures of 1-9, 10-19, and  $> 19$  cigarettes per *day*. The reported duration-response exposure groups share years as the unit of analysis but select different years of exposure groups from each other. Lagergren

et al. (2000) assess different snus exposure durations (1-10, 11-25, and >25 years) compared to smoking exposure durations (1-20, 21-35, and >35 years). Ye et al. (1999) have potentially comparable duration exposures between snus (1-10, 11-30, and  $\geq 31$  years) and cigarettes (1-30 and  $\geq 31$  years), however these cannot be combined with the duration exposures in Lagergren et al. (2000). The results from these dose-response evaluations are considered further in the discussion section to better interpret meta-analysis results.

Reference groups for studies were either never snus, never smoker, or never tobacco. The reference group was never snus use or never smoker in each respective exposure group for Ye et al. (1999) and Lagergren et al. (2000). The reference group for each exposure group in Zendehdel et al. (2008) was never tobacco.

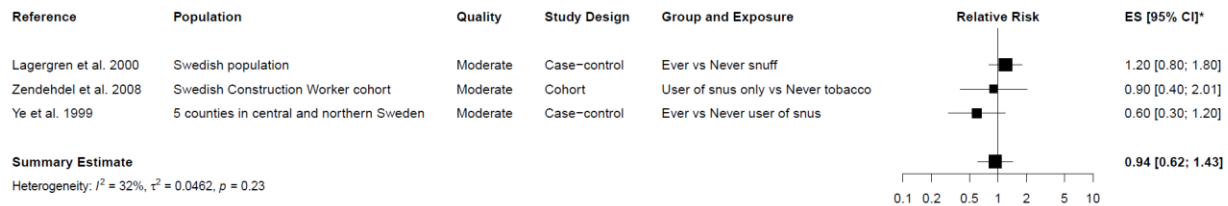
All studies controlled for age, gender, and BMI, but otherwise varied in confounders considered. The National Cancer Institute (2009b) and the American Cancer Society (2013b) have identified the following as risk factors: *H. pylori* infection, long term inflammation of the stomach, smoking, family history, poor diet (high in foods that are smoked, salted, or pickled), lack of physical activity, obesity, gender (more common in men), ethnicity (in the US: more common in Hispanic and African Americans, and most common in Asian/Pacific Islanders) and geography (most common in Japan, China, southern and Eastern Europe, and South and Central America). Comparison with confounders controlled for in the studies (See table below) show that not all the above risk factors were considered and that some additional factors were identified as potential confounders. It seems that in general more confounders were considered in the selected studies evaluating cardia stomach cancer than those evaluating overall stomach cancer.

#### 3.4.3.4.2 Control for Confounders Table

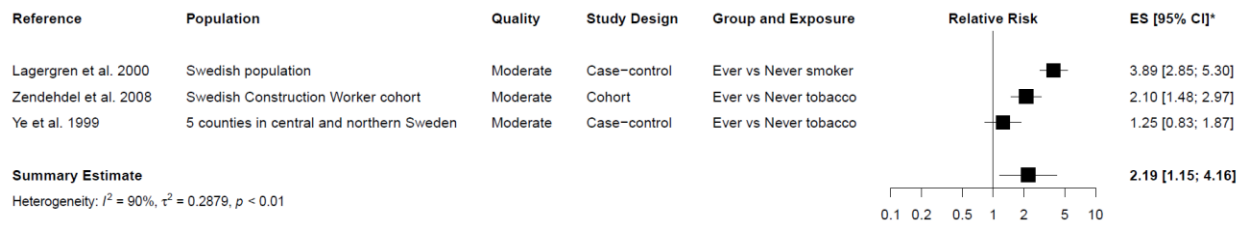
	Lagergren et al. 2000	Ye et al. 1999	Zendehdel et al. 2008
Age	X	X	X
Sex	X	X	X
Alcohol	X	X	
BMI	X	X	X
Physical Activity	X		
Diet	X		
Ethnicity			
Geography			
H. pylori exposure			
Long-term inflammation			
Gastro-esophageal reflux disease	X		
SES	X	X	
Snus, Cigs	X	X	X

### 3.4.3.4.3 Incidence of Cardia Subtype of Stomach Cancer

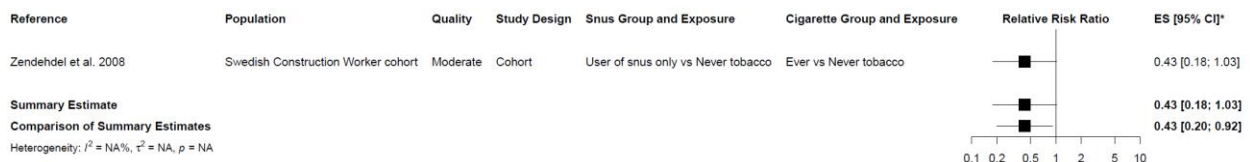
#### Stomach Cancer Incidence in Snus users



#### Stomach Cancer Incidence in Smokers



#### Stomach Cancer Incidence in Snus users compared to Smokers



### 3.4.3.4.4 Sensitivity Analysis Summary Table

Four sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to four key limitations of the main analyses: 1) Inappropriate preference for stratified estimates, 2) Inappropriate inclusion of unclear snus exposure characterization, 3) Inappropriate preference for ever use, and 4) Inappropriate use of a random effects meta-analysis.

	Cardia-subtypes meta-analysis	1) Preference for adjusted estimates when available	2) Exclusion of unclear snus exposure in Zendeheide et al (2008)	3) Preference for current use when available	4) Fixed Effects Meta-Analysis
Summary Estimate for Snus Users (95% CI)	0.94 (0.62, 1.43)	0.99 (0.74, 1.31)	0.90 (0.46, 1.76)	0.91 (0.55, 1.49)	0.99 (0.72, 1.36)
Summary Estimate for Smokers (95% CI)	2.19 <sup>b</sup> (1.15, 4.16)	2.22 <sup>b</sup> (0.73, 6.76)	No change	2.58 <sup>b</sup> (1.61, 4.14)	2.39 <sup>b</sup> (1.96, 2.93)
Summary Relative Risk Ratio (95% CI)	0.43 <sup>a</sup> (0.18, 1.03)	- <sup>c</sup>	- <sup>c</sup>	0.39 <sup>a</sup> (0.16, 0.95)	No change
Comparison of Summary	0.43 (0.20, 0.92)	0.44 (0.14, 1.40)	0.41 (0.16, 1.04)	0.35 (0.18, 0.70)	0.41 (0.28, 0.60)

Estimates (95% CI)					
-----------------------	--	--	--	--	--

<sup>a</sup> Only 1 study

<sup>b</sup> Statistically significant heterogeneity, fixed effects analysis not methodologically appropriate.

<sup>c</sup> No studies with exclusive estimates for smoking and snus exposures.

#### 3.4.3.4.5 Conclusion criteria for Cardia Stomach Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	0.94	0.43	0.43
Statistical Significance	No	No	Yes
Consistency of Direction/Magnitude of Included Studies	No,  Two of the three studies is less than one, while the remaining study is greater than one	Only one study could be assessed	NA
Consistency of Statistical Significance of Included Studies	Yes,  All studies are statistically non-significant	Only one study could be assessed	NA
Statistically significant heterogeneity	No, only 32% of variance is due to between study variation.	Only one study could be assessed	NA
Qualitative Assessment	Three moderate studies	One moderate study	NA
Sensitivity Analysis	Supports the main analysis.  Shows all summary estimates remain below one and without statistical significance	Does not support the main analysis.  Preference for current use changes to a statistically significant effect below one	Does not support the main analysis  The magnitude and direction of effect remain roughly consistent, however preference for adjusted estimates and the exclusion of the unclear snus exposure

			result in lack of statistical significance.
Other Limitations	<ul style="list-style-type: none"> <li>Two studies (Ye et al. 1999; Lagergren et al. 2000) required derivation of ever smoking exposure through a fixed effect meta-analysis</li> <li>Several potential confounders of the association with stomach cancer are not considered.</li> <li>Although cigarette usage is not a focus of this evaluation, there was statistically significant heterogeneity of reported smoker effect measures that may affect reported relative risk ratios</li> </ul>		

### 3.4.3.4.6 Discussion of Cardia Stomach Cancer Incidence

#### **Overall results**

The main analysis of this section summarized the effect estimates of stomach cancer from three studies to obtain a statistically non-significant summary estimate of 0.94 (95% CI: 0.62-1.43) for snus users compared to never smokers or never snus users. For smokers within these studies a statistically significant summary estimate of 2.19 (95% CI: 1.15-4.16) was obtained. Due to lack of stratification in some studies, there may be residual confounding in these estimates. A statistically non-significant relative risk ratio of 0.43 (95% CI: 0.18-1.03) was obtained for within study comparisons of risk based on one study. The comparison of summary estimates yielded a comparable statistically significant estimate of 0.43 (95% CI: 0.20-0.92).

These results are also in line with the statistical significance of dose- or duration-response trends reported in the three studies. Although Zendehdel et al. (2008) observed no significant dose-response for smokers, the remaining two studies (Lagergren et al. 2000; Ye et al. 1999) did observe statistically significant smoking dose and duration response trends. Only these latter two studies assessed dose- and duration-response trends for snus users and found no statistically significant effect.

#### **The Effect of Snus**

Sensitivity analyses support the main analyses as methodological choices that preferred multivariate adjusted estimates, exclusion of unclear exposures, current snus use, and fixed-effect analysis result in statistically non-significant summary estimates below one. Unlike the effect of snus on overall stomach cancer, the effect of snus on cardia stomach cancer appear to be consistently suggestive of no effect with low heterogeneity regardless of varying methodological preferences.

Prior meta-analyses did not focus on cardia stomach cancer, however, they presented similar statistically non-significant summary estimates below one. These meta-analyses results were discussed in the previous section and additionally available in the Appendix G.

Overall, results of the main meta-analyses provide support for the qualitative evaluation that the available evidence is *limited/suggestive of no association* between snus and cardia stomach cancer incidence.

#### **The Effect of Smoking**

Our main analysis shows consistent magnitudes of risk for stomach cancer in smokers compared to never tobacco users or never smokers, however one sensitivity analyses was statistically significant.

The lack of statistical significance occurs in the sensitivity analysis preferring adjustment of tobacco exposure. The consistent magnitudes above two, however align with previous knowledge of adverse effects of smoking. The effects of smoking on stomach cancer related mortality in three major U.S cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates or with the specific outcome of *cardia* stomach cancer, the mortality estimates provide some additional U.S. context to the cigarette estimate results.

Unlike the overall stomach cancer summary estimate consistently around 1.4 for meta-analyses and sensitivity analyses, the smoker effect estimates for the *cardia* subtype are consistently above two and all show statistically significant heterogeneity. This results from the variation in the smoking relative risks in each study as each one has a relative risk or odd ratio of 1.25 (95% CI: 0.83-1.87), 2.1 (95% CI: 1.48-2.97), and 3.89 (95% CI: 2.85-5.30).

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks shows a consistently low relative risk ratio across sensitivity analyses and a statistically significant lower risk when current use is preferred as the exposure characterization, however these relative risk ratios are based on only one study limiting its significance.

Comparison of summary estimates is statistically significant and lower than one in the main analyses with a consistent magnitude across sensitivity analyses, however statistical significance is not supported by two sensitivity analyses. Sensitivity analyses that preferred adjusted estimates or exclusion of the unclear snus exposure in Zendejdel et al. (2008) results in a lack of statistical significance.

Overall both methods of comparing risk of *cardia* stomach cancer in snus users compared to smokers show a decreased risk for snus users although with uncertain statistical significance. Further studies may reveal consistent statistical significance, especially when considering the consistency of the snus summary measures around one and the prior knowledge of the increased risk among smokers. The heterogeneity of smoking effect measures may have limited the ability to draw statistically significant inferences with these studies.

## **3.4.4 Lung Cancer**

### **3.4.4.1 Overview of Evidence for Lung Cancer**

Smoking accounts for 80% of all lung cancer deaths in the United States and lung cancer constitutes 32% of all deaths among smokers (CDC 2008). Qualitative evaluation found the available studies provide *limited/suggestive evidence of no association* between snus use and lung cancer.

### **3.4.4.2 Outcome Comparability**

In this evaluation, "Lung Cancer" refers to the range of outcomes represented by ICD7,8,9: 162, ICD10: C33-C34. This encompasses all histological types of lung cancers including the four main types: small cell lung cancer, adenocarcinoma, squamous cell lung cancer, and large cell lung cancer. There were sufficient studies to perform an overall meta-analysis of lung cancer incidence.

Three studies (Bolinder et al. 1994, Boffetta et al. 2005, Luo et al. 2007) identified in the systematic search evaluated lung cancer outcomes as defined nominally and by ICD code, however differed in

reporting of incidence or mortality. Two studies (Luo et al. 2007; Boffetta et al. 2005) reported overall lung cancer incidence while Bolinder et al. (1994) reported overall lung cancer mortality. Additionally, Boffetta et al. (2005) reported effect measures of adenocarcinoma – the most common type of lung cancer. Further consideration for meta-analyses was done for the two studies (Boffetta et al. 2005; Luo et al. 2007) of overall lung cancer incidence.

#### **3.4.4.3 Comparability of studies for Lung Cancer Incidence**

The two cohort studies (Boffetta et al. 2005; Luo et al. 2007) of overall lung cancer incidence had independent study populations, comparable methods of control for tobacco, comparable snus exposures, variation in smoking exposure characterization, comparable reference group specificity, and variation in control for risk factors.

The two studies (Boffetta et al. 2005; Luo et al. 2007) evaluated incidence of lung cancer with an analysis of a cohort from a systematic sample of the Swedish 1960 census and the Swedish Construction worker cohort. All studies used a different study population.

Method of control for tobacco was comparable between studies. Both studies controlled for tobacco through adjustment and stratification, however Boffetta et al. (2005) reported stratified estimates for ever snus exposure only. Stratified estimates were preferred for inclusion in the main analyses for calculation of within study relative risk ratios. Sensitivity analyses that preferred adjusted estimates was performed.

The available snus exposure characterizations varied between studies but had comparable stratified ever exposures. Boffetta et al. (2005) report adjusted effect measures for ever, current, and former snus exposure, but report stratified effect measures for only ever exposure. In contrast, Luo et al. (2007) report adjusted effect measures for only ever exposure, but report stratified effect measures for ever, former, and current snus users. Sensitivity analysis that preferred current exposures was conducted, however this also changed the method of control for tobacco.

The smoking exposure characterizations varied. Boffetta et al. (2005) only reports smoking effect measures among ever users of snus that could not be compared to snus effect estimates. Luo et al. (2007) report ever, former, and current exposure to smoking. However, the authors note that “combined use of snus and smoking tobacco was allowed in these analyses” although the smoking exposure group exclude exclusive snus users. The smoking estimates from Luo et al. (2007) therefore represents the mixed effect between exclusive smokers and dual users. Since this group excludes snus users, these two exposure groups within the study can be compared, however the results need to be interpreted accordingly. The ever smoker exposure effect estimate was selected for comparability with ever snus exposures.

Only Luo et al. (2007) reported dose-response exposure groups for snus users, while no studies reported dose-response exposure groups for smokers. There were consequently insufficient comparable studies to further assess meta-analyses based on snus dose- or duration exposure groups. Dose-response results were included in the discussion section to better interpret meta-analyses results.

Reference groups were either never tobacco or “never or occasional snus”. These reference groups were considered sufficiently comparable between studies. Notably, Boffetta et al. (2005) explicitly



states the reference group as “never or occasional” use of snus. The definition of “occasional” is unclear. This was still considered directly comparable, because many studies use a definition of current or ever *regular* smoking or snus use but do not explicitly state this in their effect estimate reporting. For example, this is equivalent to reports by Roosaar et al. (2008) of never *daily* use of snus/smoking. Interpretations of summary estimates take this into account.

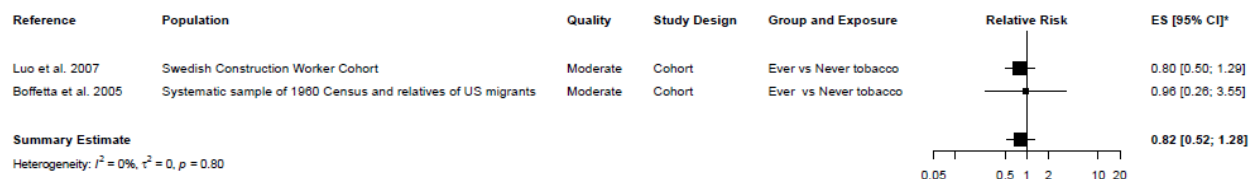
All studies controlled for age and sex, but otherwise varied in possible confounders considered. The American Cancer Society (2013a) has identified the following as important risk factors for lung cancer: age, air pollution, family history, and radon. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

#### 3.4.4.4 Control for Confounders Table

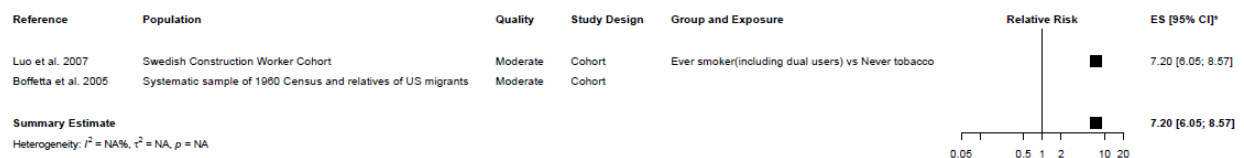
	Age	Sex	BMI	Region of Origin	Air pollution	Asbestos exposure	Family history	Radon	Snus, Cigs
Bolinder et al. 1994	X	X		X					X
Boffetta et al. 2005	X	X	X						X
Luo et al. 2007	X	X							X

#### 3.4.4.5 Incidence of Lung Cancer (ICD7,8,9: 162, ICD10: C33-C34)

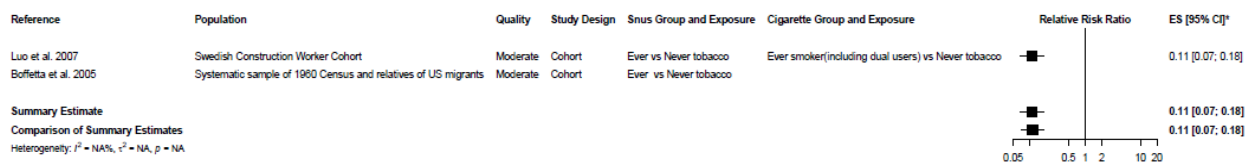
##### Lung Cancer Incidence in Snus users



##### Lung Cancer Incidence in Smokers



##### Lung Cancer Incidence in Snus users compared to Smokers



#### 3.4.4.6 Sensitivity Analysis Summary Table

Four sensitivity analyses were run to assess potential changes in summary estimates and risk comparisons in response to four key limitations of the main analyses: 1) Inappropriate preference for ever exposure 2) Inappropriate preference for stratified effect measures, 3) Inappropriate a priori

decisions to use random-effects meta-analysis, and 4) Inappropriate exclusion of studies identified by systematic search

	Main Analysis	1) Preference for current exposure when available	2) Preference for adjusted estimates when available	3) Fixed Effect model	4) Inclusion of all studies <sup>a</sup>
Summary Estimate for Snus Users (95% CI)	0.82 (0.52, 1.28)	0.80 (0.58, 1.11)	0.71 (0.66, 0.76)	No change	0.83 (0.54, 1.26)
Summary Estimate for Smokers (95% CI)	7.20 <sup>b</sup> (6.05, 8.57)	10.20 <sup>b</sup> (8.56, 12.15)	- <sup>c</sup>	No change	No change
Summary Relative Risk Ratio (95% CI)	0.11 (0.07, 0.18)	0.08 (0.04, 0.15)	- <sup>c</sup>	No change	No change
Comparison of Summary Estimates (95% CI)	0.11 (0.07, 0.18)	0.08 (0.05, 0.14)	- <sup>c</sup>	No change	No change

<sup>a</sup> This includes the lung cancer mortality results of the full cohort reported in Bolinder et al. (1994), which did not include a comparable smoking exposure group. This risk is the combined risk of lung cancer mortality or incidence.

<sup>b</sup> Only one study

<sup>c</sup> Effects for smoking estimates adjusted for snus were not available, comparison of adjusted snus measures to stratified smoking estimates was not done.

#### 3.4.4.7 Conclusion criteria for Lung Cancer Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	0.82	0.11	0.11
Statistical Significance	No	Yes	Yes
Consistency of Direction/Magnitude of Included Studies	Yes, both studies below one	Only one study	NA
Consistency of Statistical Significance of Included Studies	Yes, both studies not statistically significant	Only one study	NA
Statistically significant	No	NA	NA

heterogeneity			
Qualitative Assessment	Two moderate studies	One moderate study	NA
Sensitivity Analysis	Does not support main analyses.  All estimates below one, but the estimate calculated with preference for adjustment is statistically significant and below one	Supports main analysis.  All estimates below one and statistically significant	Supports main analysis.  All estimates below one and statistically significant.
Other Limitations	Lack of control for other known confounders.	Only one study, which has a unique cigarette comparison group that included dual users. Changing interpretability of result.	Only one study with a cigarette group, which has a unique cigarette comparison group that included dual users. Changing interpretability of result.

### 3.4.4.8 Discussion of Lung Cancer Incidence

#### **Overall results**

The main analysis of this section summarizes the effect estimate of lung cancer incidence from two studies to obtain a summary estimate of 0.82 (95% CI: 0.52, 1.28) for ever snus users compared to never users of snus/tobacco. For smokers and dual users, a relative risk of 7.20 (95% CI: 6.05, 8.57) compared to never tobacco users was obtained based on one study. The summary estimate for the relative risk ratios of the single study with exclusive exposure groups resulted in 0.11 (95% CI: 0.07, 0.18). The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.11 (95% CI: 0.07, 0.18).

#### **The Effect of Snus**

The main analysis shows a statistically non-significant summary estimate for snus use below one. Sensitivity analyses show consistency in magnitude below one, but the sensitivity analysis that preferred adjusted estimates when available had a statistically significant 0.71 (95% CI: 0.66-0.76) summary estimate for snus users.

Additionally, Luo et al. (2007) presented dose-exposure groups for current snus users that support the findings of this meta-analysis. Luo et al. (2007) reported current snus use of 1-9 g/day had a statistically non-significant relative risk of 1.0 (95% CI: 0.5-1.3), while snus use of  $\geq 10$  g/day had a

statistically non-significant relative risk of 0.7 (95% CI: 0.4-1.3). There was a statistically non-significant p-value for trend of 0.20.

Our results are consistent with three prior meta-analyses (Lee and Hamling 2009b; Lee 2011; Boffetta et al. 2008). Lee and Hamling (2009b) and Lee (2011) presented a smoking-adjusted summary estimate of 0.71 (95% CI: 0.66-0.76) and a summary estimate for never-smokers of 0.82 (95% CI: 0.52-1.28). Boffetta et al. (2008) report an estimate for ever use of 0.8 (95% CI: 0.6-1.0). This difference in the latter meta-analysis may be due to the use of fixed-effects meta-analysis and/or different selection of relative risks. Nevertheless, the summary estimate is in line with our summary estimate and sensitivity analyses.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that the evidence for an effect of snus on lung cancer incidence is *limited/suggestive evidence of no association*.

### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases in the risk of lung cancer in smokers compared to never tobacco users. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on lung cancer related mortality in five major U.S. cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates, the mortality estimates provide some additional U.S. context.

All selected U.S. cohorts presented results for lung cancer mortality and so are not directly comparable with our estimates on lung cancer incidence, however lung cancer incidence rates are generally higher than lung cancer mortality rates (Wong et al. 2017). Cigarette/Smoker lung cancer mortality relative risk estimates in large U.S. cohorts are 8.4 (95% CI: 7.5-9.4) for ever smokers in McLaughlin et al. (1995), similar to the risk estimate for ever smokers of 7.20 (95% CI: 6.05-8.57) used in this meta-analysis. The remaining U.S. cohorts only presented estimates for current smokers, which in general were higher than the risk estimates for ever smokers, such as seen in our study. These estimates ranged from 8.1 (95% CI: 4.4-15.0) to as high as 22.36 (95% CI: 17.77-28.13) (Friedman et al. 1997; USDHHS 1989).

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for only one study (Luo et al. 2007) that resulted in a statistically significant relative risk ratio of 0.11 (95% CI: 0.07-0.18). The value remains of similar magnitude and statistical significance in all sensitivity analyses.

Similarly, the comparison of summary estimates 0.11 (95% CI: 0.07-0.18) suggests a statistically significant lower risk of lung cancer in snus users compared to smokers/cigarette users. The value remains of similar magnitude and statistical significance in all sensitivity analyses.

Both methods of comparing risk of lung cancer in snus users compared to smokers consistently show a lower statistically significant risk for snus users. Furthermore, considering the higher magnitude of lung cancer mortality for smokers in some U.S. cohorts, the results likely would be confirmed with subsequent studies.

### 3.5 Chronic Cardiovascular Disease

#### 3.5.1 Overview of Evidence for cardiovascular disease

Smoking accounts for overall 16% of all ischemic heart disease (IHD) deaths in the United States and constitutes 32.7% of all deaths among smokers (CDC 2008). Qualitative evaluation found the available studies provide:

- *limited/suggestive evidence of no association* between snus use and incident ischemic heart disease, myocardial infarction, or heart failure.
- *balanced/mixed evidence of an association* between snus use and fatal myocardial infarction or sudden cardiac death.
- *limited/suggestive evidence of no association* between snus use and incident CVD.
- *balanced/mixed evidence of an association* between snus use and fatal CVD.
- *limited/suggestive evidence of no association* between snus use and atrial fibrillation.
- *limited/suggestive evidence of no association* between snus use and incident stroke, including the subtypes: ischemic and hemorrhagic.
- *balanced/mixed evidence of an association* between snus use and fatal stroke and its subtypes.

#### 3.5.2 Outcome Comparability

In this evaluation, "cardiovascular disease" refers to the overall range of disease outcomes represented in ICD-8,9: 390-458 and ICD-10:I00-I99. This encompasses studies of IHD, CHD, MI, heart failure, stroke, sudden cardiac death, and atrial fibrillation. Sufficient studies were available to perform five meta-analyses of overall cardiovascular disease mortality, IHD and MI incidence, IHD and MI mortality, stroke incidence, and stroke mortality.

Nineteen studies (Arefalk et al. 2011; Arefalk et al. 2014; Asplund et al. 2003; Bolinder et al. 1992; Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2005; Hergens et al. 2007; Hergens et al. 2008b; Hergens et al. 2014; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Janzon and Hedblad 2009; Johansson et al. 2005; Koskinen and Blomstedt 2006; Roosaar et al. 2008; Wennberg et al. 2007) identified in the systematic search had outcomes related to cardiovascular disease defined nominally or by ICD code.

Four studies (Bolinder et al. 1992; Bolinder et al. 1994; Hansson et al. 2009; Roosaar et al. 2008) explicitly assess the overall category of cardiovascular disease, but differ in focus on prevalence, incidence, or mortality. Bolinder et al. (1992) reports cardiovascular prevalence, while Hansson et al. (2009) reports incidence. The remaining two studies (Bolinder et al. 1994; Roosaar et al. 2008) each report on cardiovascular mortality.

Ten studies (Bolinder et al. 1994; Hansson et al. 2009; Haglund et al. 2007; Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Janzon and Hedblad 2009; Johansson et al. 2005; Wennberg et al. 2007) define ischemic heart disease or myocardial infarction outcomes by ICD7, 8, 9: 410-414, ICD-10: I20-I25, or nominally. Nine of these studies (Haglund et al. 2007; Hansson et al. 2009; Hergens et al. 2005; Hergens et al. 2007; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Janzon and Hedblad 2009; Johansson et al. 2005; Wennberg et al. 2007) evaluated IHD/MI incidence. Six of these studies (Bolinder et al. 1994; Haglund et al. 2007; Hergens et al. 2005; Hergens et al. 2007; Huhtasaari et al. 1999; Wennberg et al. 2007) evaluate IHD mortality. Three studies

(Wennberg et al. 2007; Hansson et al. 2009; Hergens et al. 2007) although agreeing in nominal definition, had peculiar outcome ascertainment that differed from the other studies. Wennberg et al. (2007) include unspecified cardiovascular disease (ICD9: 429.2) as part of its outcome definition. Additionally, two studies discussed ischemic heart disease incidence or acute myocardial infarction incidence and mortality had outcome ascertainment that overlapped the outcome definition for these categories but did not neatly fit in based on the ICD codes described. Hansson et al. (2009) assessed ischemic heart disease incidence but explicitly excludes ICD10: I22 and I25.2. Hergens et al. (2007) assessed acute MI incidence and mortality defined as ICD7: 420.10-420.17, ICD8: 410, ICD9: 410, or ICD10: I21-I22. A sensitivity analyses excluding these three studies in the relevant meta-analysis was performed.

Three studies (Arefalk et al. 2011; Arefalk et al. 2014; Hergens et al. 2014) have unique outcomes. Arefalk et al. (2011) report on first hospitalization for heart failure and non-ischemic heart failure defined nominally in the Uppsala longitudinal study of adult men and by ICD codes (ICD-7: 434.1, 434.2, 440.99, 441.99; ICD-8: 427.00, 427.10, 428.99; ICD-9: 428; ICD-10: I50, I11.0) in the Swedish construction worker cohort. Arefalk et al. (2014) focused on post-myocardial infarction mortality. Hergens et al. (2014) focused on atrial fibrillation incidence. Meta-analyses were not performed on any of these outcomes due to insufficient studies.

Eight studies (Asplund et al. 2003; Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2008b; Janzon and Hedblad 2009; Koskinen and Blomstedt 2006) had outcomes related to stroke as defined nominally or with an ICD code in ICD8,9: 430-438. Four of these eight studies (Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2014; Hergens et al. 2008b) assessed stroke mortality. All but Bolinder et al. (1994) assessed stroke incidence. Importantly, there are only two sets of outcomes that align perfectly with each other. Bolinder et al. (1994) and Haglund et al. (2007) each defined fatal stroke as ICD8, 9: 430-438. Hansson et al. (2014) and Janzon and Hedblad (2009) each defined incident stroke as ICD9: 430, 431, 434, 436. The remaining studies defined the outcomes uniquely. These differences in outcome specification were assessed further for meta-analyses and any necessary sensitivity analyses.

Further consideration for meta-analyses was done for two studies (Bolinder et al. 1994; Roosaar et al. 2008) of overall cardiovascular disease mortality, seven studies (Haglund et al. 2007; Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Janzon and Hedblad 2009; Johansson et al. 2005; Wennberg et al. 2007) of IHD/MI incidence, five studies (Bolinder et al. 1994; Haglund et al. 2007; Hergens et al. 2005; Huhtasaari et al. 1999; Wennberg et al. 2007) of IHD mortality, seven studies (Asplund et al. 2003; Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2008b; Janzon and Hedblad 2009; Koskinen and Blomstedt 2006) on stroke incidence, and four studies (Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2014; Hergens et al. 2008b) on stroke mortality.

### **3.5.3 Cardiovascular disease mortality**

#### **3.5.3.1 Comparability of studies for cardiovascular disease mortality**

The two cohort studies (Bolinder et al. 1994; Roosaar et al. 2008) that reported cardiovascular disease mortality had independent study populations, comparable methods of control for tobacco, variation in snus and smoking exposure characterization, comparable reference group specificity, and variation in control for risk factors.

The two studies (Bolinder et al. 1994; Roosaar et al. 2008) had independent study populations. Bolinder et al. (1994) assessed cardiovascular disease mortality in the Swedish construction worker cohort, while Roosaar et al. (2008) assessed cardiovascular disease mortality in the Uppsala county, central Sweden cohort.

Each study had a comparable method of control for tobacco. Bolinder et al. (1994) presented effect measures for exclusive snus users and exclusive smokers among the full cohort. Roosaar et al. (2008) presented effect measures for snus users among never users, as well as adjusted effect measures. Stratified estimates were preferred for inclusion in the main analyses for calculation of within study relative risk ratios. Sensitivity analysis that preferred adjusted estimates was performed

The available snus exposure characterizations varied. Bolinder et al. (1994) presented exclusive effect measures for only exclusive current snuff users, while Roosaar et al. (2008) presented stratified and adjusted effect measures for only ever daily snus users. No sensitivity analyses could be performed regarding exposure characterization.

The available smoking exposure characterizations varied. Roosaar et al. (2008) reported only adjusted effect measures for ever daily smokers stratified by 75 years of age. Bolinder et al. (1994) reported mortality for exclusive cigarette smokers stratified by cigarette dosage of 15 cigarettes. In each case, the independent strata were combined to obtain an overall estimate of mortality for smokers. Importantly, the adjusted effect measures in Roosaar et al. (2008) could not be used for within study risk comparisons as it is not necessarily of exclusive smokers.

No studies reported dose-response exposure groups for snus users, although Bolinder et al. (1994) reported related exposure groups for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose- or duration response results were included in the discussion section to better interpret meta-analyses results.

Reference groups were either never tobacco users, never smokers, or never snus users as appropriate. These reference groups were considered sufficiently comparable between studies.

All studies controlled for age and sex, but otherwise varied in possible confounders considered. The American Heart Association (AHA 2012) has identified the following as important risk factors: age, male gender, high cholesterol, physical inactivity, high blood pressure, obesity, diabetes, stress, alcohol consumption. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

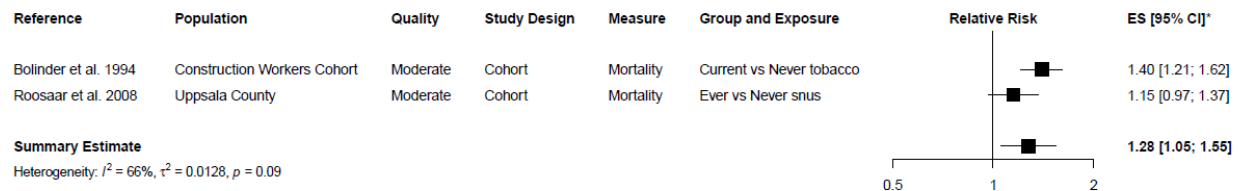
### 3.5.3.2 Control for Confounders Table

	Bolinder et al. 1994	Roosaar et al. 2008
Age	X	X
Sex	X	X
BMI	X	
Diabetes	X	
Blood pressure, Hypertension	X	

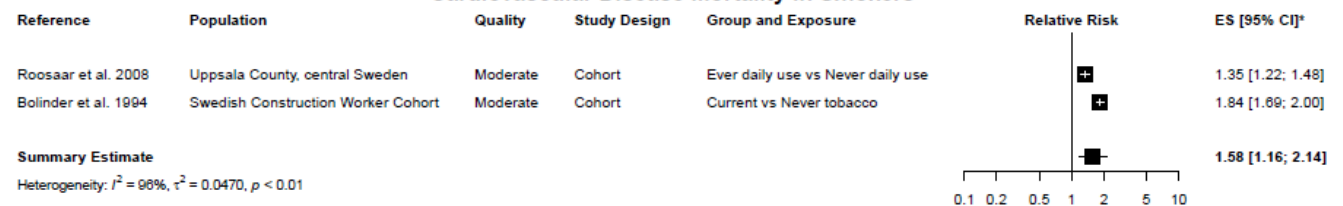
Physical Activity		
Education level, SES		
Cholesterol level, hyperlipidemia		
Alcohol		X
Stress / Job strain		
Family History		
Snus, Cigs	X	X

### 3.5.3.3 Cardiovascular Disease Mortality (ICD-8,9: 390-458; ICD-10:I00-I99)

#### Cardiovascular Disease Mortality in Snus users



#### Cardiovascular Disease Mortality in Smokers



#### Cardiovascular Disease Mortality in Snus users compared to Smokers



### 3.5.3.4 Sensitivity Analysis Summary Table

Two sensitivity analyses were run to assess changes in summary estimates risk comparisons in response to two key limitations of the main analysis: 1) Inappropriate preference for stratified effect measures, and 2) Inappropriate a priori decision to use random-effects meta-analysis.

	Main Analysis	1) Preference for adjusted estimates when available	2) Fixed-effects meta-analysis
Summary Estimate for Snus Users (95% CI)	1.28 (1.05, 1.55)	1.24 (0.99, 1.56)	No change
Summary Estimate for Smokers	1.58 (1.16, 2.14)	No change	No change



(95% CI)			
Summary Relative Risk Ratio (95% CI)	0.76 (0.64-0.90)	No change	No change
Comparison of Summary Estimates (95% CI)	0.81 (0.56, 1.16)	0.79 (0.54-1.15)	No change

### 3.5.3.5 Conclusion Criteria for Cardiovascular disease mortality

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.28	0.76	0.81
Statistical Significance	Yes	Yes	No
Consistency of Direction/Magnitude of Included Studies	Yes,  All studies above one	Only one study	NA
Consistency of Statistical Significance of Included Studies	No,  One study has a statistically significant effect above one	Only one study	NA
Statistically significant heterogeneity	No	-	-
Qualitative Assessment	Two moderate studies	One moderate study	-
Sensitivity Analysis	Does not support main analysis  Preference for adjusted estimates when available results in statistical non-significance	Supports main analysis	Supports main analysis

Other Limitations	Different exposure groups	Single study of moderate quality	
-------------------	---------------------------	----------------------------------	--

### **3.5.3.6 Discussion of cardiovascular disease mortality**

#### ***Overall results***

The main analysis of this section summarized the effect estimates of cardiovascular mortality from two studies to obtain a statistically significant summary estimate of 1.28 (95% CI: 1.05, 1.55) for snus users that have never smoked. Smokers within these studies had a statistically significant summary estimate of 1.58 (95% CI: 1.16, 2.14) based on two studies. A statistically significant relative risk ratio of 0.76 (95% CI: 0.64, 0.90) was obtained from one study. The comparison of summary estimates yielded a statistically non-significant relative risk ratio of 0.81 (95% CI: 0.56-1.16)

#### ***The Effect of Snus***

Although our main analysis shows a statistically significant summary estimate for snus use above one, sensitivity analyses suggests inconsistency in statistical significance based on a methodological choice. Preference for adjusted estimates resulted in a lack of statistical significance, although the magnitude of the effect remained similar.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that the evidence is *balanced/mixed* between snus use and mortality due to cardiovascular disease.

#### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases cardiovascular disease mortality in smokers. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on cardiovascular disease mortality in four major U.S. cohorts is presented in Appendix G to provide some additional U.S. context.

#### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for only one study (Bolinder et al. 1994) that had a statistically significant relative risk ratio of 0.76 (95% CI: 0.34-3.71) that was consistent in all sensitivity analyses.

On the other hand, the comparison of summary estimates had a similar magnitude but was statistically non-significant 0.81 (95% CI: 0.56-1.16).

Although both methods of comparing risk of CVD mortality in snus users compared to smokers consistently show a lower magnitude of risk for snus users, the statistical significance of this risk is unclear. Further cohort studies comparing risks in snus users and smokers will be necessary to determine if the observed lower risk in snus users is statistically significant.

### **3.5.4 Incidence of MI and IHD (ICD8,9: 410-414, ICD10:I20-I25)**

#### **3.5.4.1 Comparability of studies of MI/IHD incidence**

The four case-control (Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Wennberg et al. 2007) and five cohort studies (Haglund et al. 2007; Janzon and Hedblad 2009; Johansson et al. 2005; Hansson et al. 2009; Hergens et al. 2007) had overlapping study populations, comparable methods of tobacco control, comparable snus and smoking exposure groups, comparable reference group specificity, and variation in control for risk factors.

Nine studies (Haglund et al. 2007; Hansson et al. 2009; Hergens et al. 2005; Hergens et al. 2007; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Janzon and Hedblad 2009; Johansson et al. 2005; Wennberg et al. 2007) explicitly evaluated incidence of myocardial infarction and IHD using the Swedish Survey of Living Conditions, Stockholm County Residents Cohort, MONICA cohort, Vasterbotten Intervention Project (VIP), Swedish Construction Worker Cohort, Malmo Diet and Cancer study, the SALLS Survey, and Swedish Twin Registry. Exclusivity between studies was not maintained for three studies (Huhtasaari et al. 1992, Huhtasaari et al. 1999, and Wennberg et al. 2007) that utilized the same population drawn from the MONICA cohort albeit with slight differences. The studies by Huhtasaari et al. (1992, 1999) differed in the time range of cases considered (April 1989–April 1991; May 1991–1993). Wennberg et al. (2007) was selected for the main analyses due to its inclusion of the additional VIP cohort and its focus on the broader time range of 1985-1999 that encompassed both time periods analyzed in Huhtasaari et al.'s (1992, 1999) studies. A sensitivity analysis was performed using each of the older estimates in Huhtasaari et al. (1992) and Huhtasaari et al. (1999) in place of the estimate from Wennberg et al. (2007), although this results in a loss of the additional information from the VIP cohort. The Swedish Survey of Living Conditions and Swedish Annual Level-of-Living Survey (SALLS) are very similar and may be the same study population. Thus, Haglund et al. (2007) may be an update of Johansson et al. (2005). However, as this was unclear both studies remained in the main analysis. Johansson et al. (2005) was excluded in a sensitivity analysis.

Methods of control for tobacco were comparable between studies. All studies had mutually exclusive effect measures for smoking and snus use either by stratification or explicit creation of an exclusive exposure group.

All studies had comparable snus or smoking exposure groups. In particular, all studies had an exposure that represented current use, either reported as “daily”, “current”, or “regular”. Only Hergens et al. (2007) reports ever exposure for snus, but has no corresponding ever smoker exposure group. Sensitivity analysis for ever exposure preference was performed.

Two studies (Hergens et al. 2007; Huhtasaari et al. 1992) reported results for dose-exposure groups for snus users, but none reported results for smokers. Huhtasaari et al. (1992) report results stratified by < 2 cans of snus per week or ≥ 2 cans of snus per week. Hergens et al. (2007) report dose exposure groups for < 12.5 g/day, 12.5-24.9 g/day, 25-49.9 g/day, and ≥ 50 g/day. The dose exposure groups were not comparable. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose-exposure results were included in the discussion section to better interpret meta-analyses results.

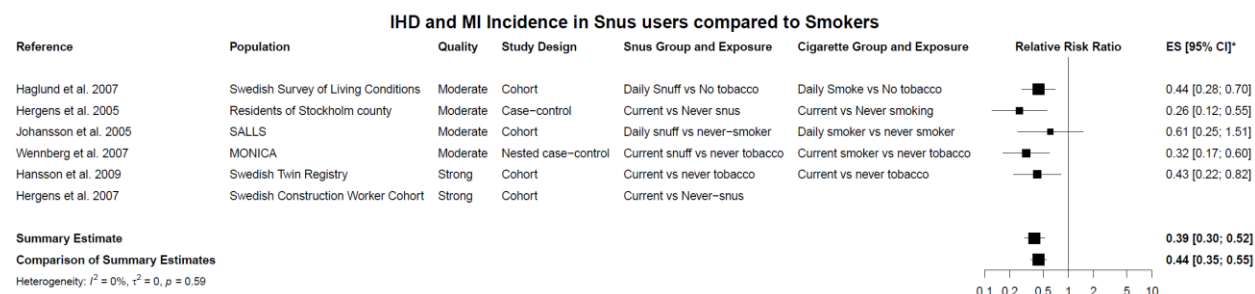
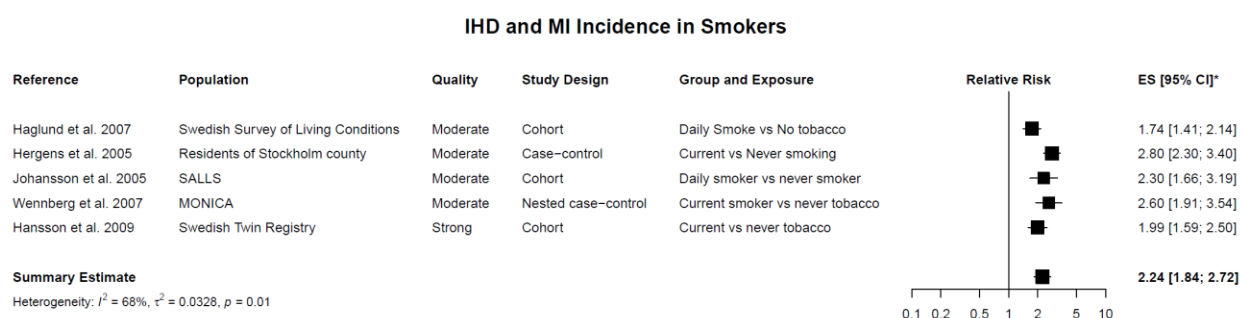
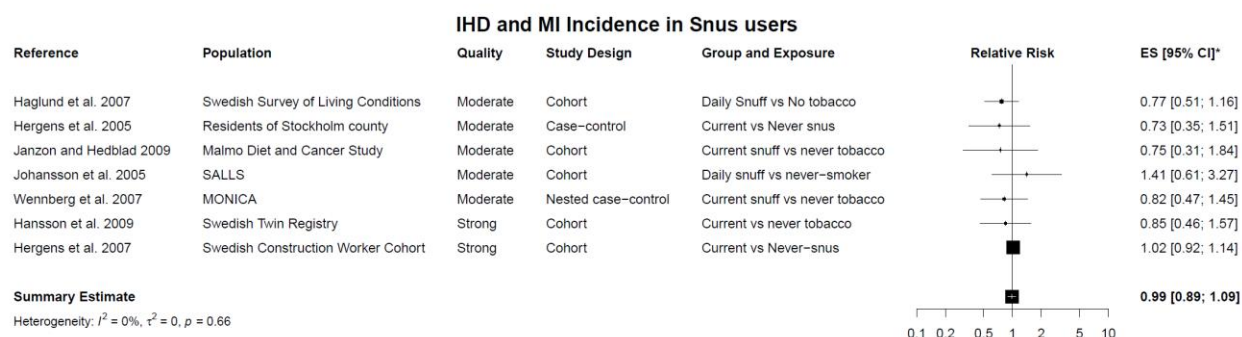
Reference groups were considered sufficiently comparable between studies, and were either never snus, never tobacco, or never smoker as appropriate.

All studies controlled for age and sex, but otherwise varied in possible confounders considered. The American Heart Association (AHA 2012) has identified the following as important risk factors: age, male gender, high cholesterol, physical inactivity, high blood pressure, obesity, diabetes, stress, alcohol consumption. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

### 3.5.4.2 Control for Confounders Table

	A g e	S e x	B M I	D i a b e t e s	R e g i o n	Blood pressure, Hyperten.	Phys. act.	Ed. level, SES	Cholest. level, hyperlip.	A l c o h o l	Stress/J ob strain	Fam. Hist.	Snus, Cigs.
Haglund et al. 2007	X	X					X	X					X
Hansson et al. 2009	X	X		X		X			X				X
Hergens et al. 2005	X	X	X	X		X	X		X		X		X
Hergens et al. 2007	X	X	X		X								
Huhtasaar i et al. 1992	X	X											X
Huhtasaar i et al. 1999	X	X		X		X		X				X	X
Janzon and Hedblad 2009	X	X	X	X		X	X	X					
Johansson et al. 2005	X	X	X	X		X	X	X					X
Wennberg et al. 2007	X	X	X				X	X	X				X

### 3.5.4.3 IHD and MI Incidence Meta-Analysis (ICD7, 8, 9: 410-414, ICD-10: I20-I25)



#### 3.5.4.4 Sensitivity Analysis Summary Table

Seven sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to seven key limitations of the main analyses: 1) Inappropriate preference for current exposure, 2) Inappropriate inclusion of studies with slight variations in ICD code, 3) Inappropriate exclusion of the MONICA cohort from 1989-1991, 4) Inappropriate exclusion of the MONICA cohort from 1991-1993, 5) Inappropriate inclusion of a possible duplicate study population, 6) Inappropriate inclusion of case-control studies, and 7) Inappropriate a priori decision to use random-effects meta-analysis

Main Analysis	1) Preference for ever exposure when available	2) Exclusion of studies with different outcome ascertainment	3) MONICA cohort 1989-1991 preferred (Huhtasaari et al. 1992)	4) MONICA cohort 1991-1993 preferred (Huhtasaari et al. 1999)	5) Exclusion of possible duplicate study population (Johansson et al. 2005)	6) Only cohort studies	7) Fixed-effects meta-analysis

Summary Estimate for Snus Users (95% CI)	0.99 (0.89, 1.09)	0.97 (0.88, 1.06)	0.82 (0.61, 1.12)	0.99 (0.89, 1.08)	0.88 (0.73, 1.07)	0.98 (0.89, 1.08)	1.00 (0.90, 1.10)	No change
Summary Estimate for Smokers (95% CI)	2.24 (1.84, 2.72)	2.24 (1.84, 2.72)	2.24 (1.63, 3.07)	2.11 (1.75, 2.56)	2.35 (1.86, 2.98)	2.23 (1.76, 2.82)	1.93 (1.67, 2.23)	2.23 (2.00, 2.48)
Summary Relative Risk Ratio (95% CI)	0.39 (0.30, 0.52)	0.39 (0.30, 0.52)	0.41 (0.28, 0.61)	0.43 (0.33, 0.56)	0.34 (0.22, 0.53)	0.38 (0.28, 0.51)	0.46 (0.33, 0.65)	0.39 (0.30, 0.52)
Comparison of Summary Estimates (95% CI)	0.44 (0.35, 0.55)	0.43 (0.35, 0.53)	0.37 (0.24, 0.57)	0.47 (0.38, 0.58)	0.37 (0.28, 0.51)	0.44 (0.34, 0.57)	0.52 (0.43, 0.62)	0.44 (0.38, 0.51)

### 3.5.4.5 Conclusion criteria for IHD and MI Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	0.99	0.39	0.44
Statistical Significance	No	Yes	Yes
Consistency of Direction/Magnitude of Included Studies	Yes  All studies one or below	Yes  All studies below one	NA
Consistency of Statistical Significance of Included Studies	Yes  No study is statistically significant	No,  Only one study statistically non-significant	NA
Statistically significant heterogeneity	No	No	NA
Qualitative Assessment	Five moderate and two strong studies	Four moderate and two strong studies	NA
Sensitivity Analysis	Supports main analysis	Supports main analysis	Supports main analysis
Limitations	<ul style="list-style-type: none"> <li>Statistical significance of between study heterogeneity for smoker summary estimate present in the main analysis and all sensitivity analyses. Although this is accounted for by the random effects model, it indicates excess variation in cigarette effect estimates between studies.</li> </ul>		

### **3.5.4.6 Discussion of IHD and MI Incidence**

#### ***Overall results***

The main analysis of this section summarized the effect estimates of IHD and MI incidence from seven studies to obtain a statistically non-significant summary estimate of 0.99 (95% CI: 0.89-1.09) for snus users. Smokers within these studies had a statistically significant summary estimate of 2.24 (95% CI: 1.84, 2.72) based on five studies. A statistically significant summary estimate of 0.39 (95% CI: 0.30-0.52) was obtained for within study comparisons of risks based on five studies. The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.44 (95% CI: 0.35-0.55).

#### ***The Effect of Snus***

Sensitivity analysis shows supporting evidence in line with our main analyses. The statistical significance of any result does not change across seven different sensitivity analyses to address limitations of our study regarding outcome comparability, study selection for main analyses, and varying exposure characterization between studies. Only in the case of restricting analyses to only cohort studies does the direction of the summary estimate change for snus users from 0.99 to 1.00, however this well within the bounds of every confidence interval for the summary estimate of snus users.

These results are in line with the statistically non-significant results for each dose-exposure group in Hergens et al. (2007) and Huhtasaari et al. (1992).

Overall, the quantitative evaluation supports the qualitative evaluation conclusion of *limited/suggestive evidence of no association* between snus use and incident ischemic heart disease, myocardial infarction, or heart failure.

#### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases in the incidence of MI and IHD in smokers compared to never smoker/tobacco users. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on MI and IHD related mortality in four major U.S. cohorts is presented in Appendix G. Although mortality is not directly comparable with the incidence summary estimates, the mortality estimates provide some additional U.S. context.

#### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for five studies and resulted in a consistently statistically significant summary estimate below one. This indicates that within each study snus users had significantly lower risks than smokers within the same study.

Sensitivity analyses of the comparison of summary estimates also found consistently statistically significant summary estimates below one.

Both methods of comparing incidence of IHD and MI in snus users compared to smokers consistently showed a statistically significant lower magnitude of risk for snus users.

Based on available evidence there is a significantly lower risk of incident IHD and MI for snus users compared to smokers.

### **3.5.5 Mortality due to IHD and MI (ICD8,9: 410-414, ICD10:I20-I25)**

#### **3.5.5.1 Study comparability for IHD and MI mortality**

The three case-control (Hergens et al. 2005; Huhtasaari et al. 1999; Wennberg et al. 2007) and three cohort studies (Bolinder et al. 1994; Haglund et al. 2007; Hergens et al. 2007) had overlapping study populations, comparable methods of tobacco control, comparable snus and smoking exposure groups, comparable reference group specificity, and variation in control for risk factors.

Six studies (Bolinder et al. 1994; Haglund et al. 2007; Hergens et al. 2005; Hergens et al. 2007; Huhtasaari et al. 1999; Wennberg et al. 2007) evaluated IHD and MI mortality using the Swedish Construction Worker Cohort, Swedish Survey of Living Conditions, Stockholm Country Residents Cohort, Vasterbotten Intervention Project (VIP), and the MONICA Project. Exclusivity between studies was not maintained between two studies (Huhtasaari et al. 1999; Wennberg et al. 2007) that utilized the same population drawn from the MONICA cohort albeit with slight differences. The studies by Huhtasaari et al. (1999) considered the time range from May 1991–1993, while Wennberg et al. (2007) focused on the broader time range of 1985–1999. Wennberg et al. (2007) was selected for the main analyses due to its inclusion of the additional VIP cohort and its use of a broader time range than Huhtasaari et al. (1999). A sensitivity analysis was performed using the older estimates in Huhtasaari et al. (1999) in place of the estimate from Wennberg et al. (2007) although this loses the additional information from the VIP cohort. Exclusivity between study populations was not maintained for another two studies (Hergens et al. 2007 and Bolinder et al. 1994) that utilized the same population drawn from the Swedish Construction Workers Cohort albeit with slight differences. Hergens et al. (2007) looked at the period from 1978 to 2004, while Bolinder et al. (1994) looked at only the period from 1971–1985. Bolinder et al. 1994 was selected for the main analyses due to presence of a within study comparison group. A sensitivity analyses that uses the estimates from Hergens et al. (2007) in place of estimates from Bolinder et al. (1994) was performed.

Methods of control for tobacco were comparable between studies. All studies had mutually exclusive effect measures for smoking and snus use either by stratification or explicit creation of an exclusive exposure group.

All studies had comparable snus or smoking exposure groups. All studies had an exposure that represented current use, either reported as “daily”, “current”, or “regular”. Only Hergens et al. (2007) reports ever exposure for snus but had no corresponding ever smoker exposure group. Sensitivity analysis for ever exposure preference was performed.

Only Hergens et al. (2007) reported results for snus dose-exposure groups, while no study reported this for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose-exposure results were included in the discussion section to better interpret meta-analyses results.

All studies controlled for age and sex, but otherwise varied in possible confounders considered. The American Heart Association (AHA 2012) has identified the following as important risk factors: age, male gender, high cholesterol, physical inactivity, high blood pressure, obesity, diabetes, stress,



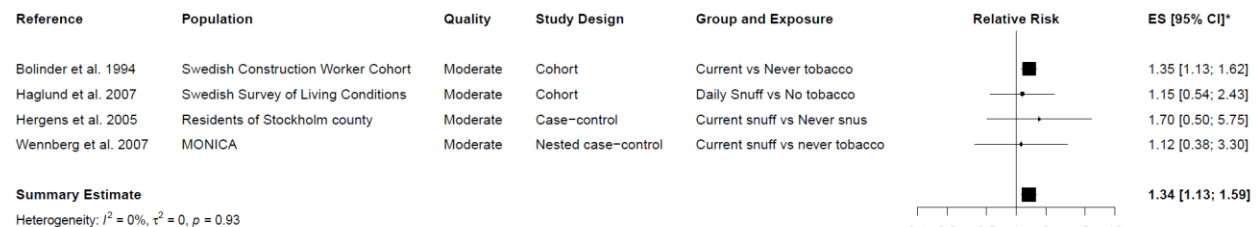
alcohol consumption. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

### 3.5.5.2 Control for Confounders Table

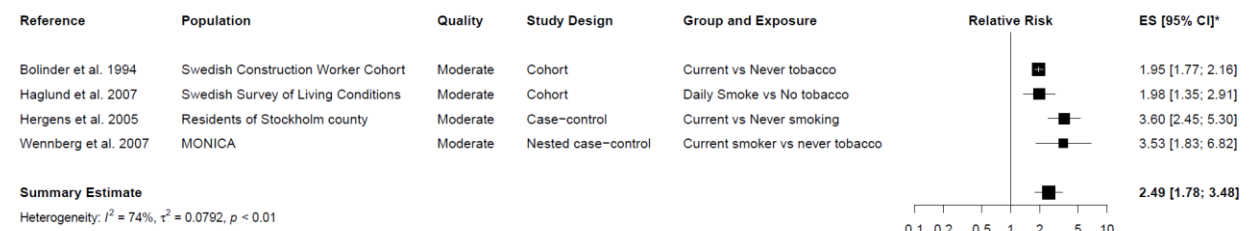
	A g e	S e x	B M I	D i a b e t e s	Region	Blood pressure, Hyperten .	Phys act.	Ed level, SES	Cholest. level, hyperlip.	Alcohol	Stress /Job strain	Fam Hist	Snus, Cigs.
Bolinder et al. 1994	X	X	X	X		X							X
Haglund et al. 2007	X	X					X	X					X
Hergens et al. 2005	X	X	X	X		X	X		X		X		X
Hergens et al. 2007	X	X	X		X								X
Huhtasaari et al. 1999	X	X		X		X		X				X	X
Wennberg et al. 2007	X	X	X				X	X	X				X

### 3.5.5.3 IHD and MI Mortality Meta-Analysis

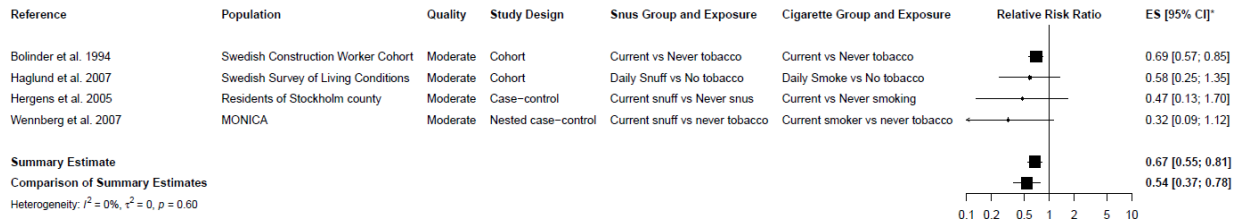
#### IHD and MI Mortality in Snus users



#### IHD and MI Mortality in Smokers



### IHD and MI Mortality in Snus users compared to Smokers



#### 3.5.5.4 Sensitivity Analysis Summary Table

Six sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to six key limitations of the main analyses: 1) Inappropriate preference for current exposures, 2) Inappropriate inclusion of studies with variations in ICD code, 3) Inappropriate exclusion of MONICA cohort from 1991-1993, 4) Inappropriate exclusion of latest update of Swedish construction worker cohort, 5) Inappropriate inclusion of case-control studies, and 6) Inappropriate a priori decision to use random effects meta-analysis.

	Main Analysis	1)Preference for ever exposure when available	2) Exclusion of studies with different outcome ascertainment (Wennberg et al. 2007)	3) MONICA cohort 1991-1993 preferred (Huhtasaari et al. 1999)	4) Prefer latest update of Swedish construction worker cohort (Hergens et al. 2007)	5) Only cohort studies	6) Fixed-effects meta-analysis
Summary Estimate for Snus Users (95% CI)	1.34 (1.13, 1.59)	1.28 (1.07, 1.53)	1.35 (1.14, 1.60)	1.35 (1.14, 1.60)	1.31 (1.09, 1.58)	1.34 (1.13, 1.62)	1.34 (1.13, 1.59)
Summary Estimate for Smokers (95% CI)	2.49 (1.78, 3.48)	2.85 (1.86, 4.38)	2.34 (1.64, 3.33)	2.62 (1.75, 3.91)	2.85 (1.86, 4.38)	1.95 (1.78, 2.15)	2.05 (1.87, 2.24)
Summary Relative Risk Ratio (95% CI)	0.67 (0.55, 0.81)	0.48 (0.26, 0.89)	0.68 (0.56, 0.83)	0.67 (0.55, 0.81)	0.48 (0.26, 0.89)	0.69 (0.56, 0.84)	0.67 (0.55, 0.81)
Comparison of Summary Estimates (95% CI)	0.54 (0.37, 0.78)	0.46 (0.28, 0.71)	0.58 (0.39, 0.85)	0.52 (0.33, 0.80)	0.46 (0.29, 0.73)	0.69 (0.56, 0.84)	0.66 (0.54, 0.79)

#### 3.5.5.5 Conclusion criteria for IHD and MI Mortality

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.34	0.67	0.54
Statistical Significance	Yes	Yes	Yes

Consistency of Direction/Magnitude of Included Studies	Yes All studies above one	Yes All studies below one	NA
Consistency of Statistical Significance of Included Studies	No, One study is statistically significant, but the three others are not	No, One study is statistically significant, but the three others are not	NA
Statistically significant heterogeneity	No	No	NA
Qualitative Assessment	All moderate studies	All moderate studies	NA
Sensitivity Analysis	Supports main analysis	Supports main analysis	Supports main analysis
Limitations	<ul style="list-style-type: none"> <li>Statistical significance of between study heterogeneity for smoker summary estimate present in the main analysis and some sensitivity analyses. Although this is accounted for by the random effects model, it indicates excess variation in cigarette effect estimates between studies.</li> </ul>		

### 3.5.5.6 Discussion of IHD and MI Mortality

#### **Overall results**

The main analysis of this section summarized the effect estimates of IHD and MI mortality from four studies to obtain a statistically significant summary estimate of 1.34 (95% CI:1.13-1.59) for snus users. Smokers within these studies had a statistically significant summary estimate of 2.49 (95% CI: 1.78-3.48) based on four studies. A statistically significant summary estimate of 0.67 (95% CI: 0.55-0.81) was obtained for within study comparisons of risks based on four studies. The comparison of summary estimates yielded a statistically significant 0.54 (95% CI: 0.37-0.78).

#### **The Effect of Snus**

The sensitivity analyses show supporting evidence in line with our main analyses. The statistical significance of any result does not change across six different sensitivity analyses to address limitations of our study.

A dose-response analysis by Hergens et al. (2007) found a statistically significant relative risk of fatal MI for current snus consumption of < 12.5 g/day and ≥ 50 g/day. However, no statistically significant results for current snus consumption of 12.5-24.9 g/day or 25-49.9 g/day. Hergens et al. (2007) did not assess the statistical significance for trend, however there does not appear to be any indication of one.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion of *balanced/mixed evidence of an association* between snus use and fatal myocardial infarction or sudden cardiac death.

### ***The Effect of Smoking***

The main analysis shows consistent statistically significant increases in fatal MI and IHD in smokers. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on MI and IHD related mortality in four major U.S. cohorts is presented in Appendix G to provide some additional U.S. context.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was possible for four studies and resulted in a consistently statistically significant summary estimate below one. This indicates that within each study snus users had significantly lower risks than smokers within the same study.

Sensitivity analyses of the comparison of summary estimates also found consistently statistically significant summary estimates below one.

Both methods of comparing incidence of IHD and MI in snus users compared to smokers consistently showed a statistically significant lower magnitude of risk for snus users.

Based on available evidence there is a significantly lower risk of fatal IHD and MI for snus users compared to smokers. Importantly, this occurs despite our finding of an increased risk of IHD and MI for snus users.

## **3.5.6 Incidence of Stroke**

### **3.5.6.1 Study comparability for incident stroke**

The two case-control (Asplund et al. 2003; Koskinen and Blomstedt 2006) and five cohort studies (Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2008b; Janzon and Hedblad 2009) had various outcome specification, overlapping study populations, comparable methods of tobacco control, comparable snus and smoking exposure groups

Seven studies (Asplund et al. 2003; Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2008b; Janzon and Hedblad 2009; Koskinen and Blomstedt 2006) explicitly evaluated incidence of "stroke", however only two studies (Hansson et al. 2014; Janzon and Hedblad 2009) present matching ICD codes. Additionally, the three studies (Asplund et al. 2003; Hergens et al. 2008b; Koskinen and Blomstedt 2006) that describe the outcome without ICD codes differ in description of the outcome. The descriptions were assessed further to match them to the corresponding ICD code. The available study descriptions, ICD codes, and interpretation is presented below in Tables 3-3 and 3-4. Given the information in Table 3-4, it appears the most common outcome definition remained ICD9: 430, 431, 434, 436; ICD10: I60-I61, I63, I64 used in three studies (Hansson et al. 2014, Hergens et al. 2008b; Janzon and Hedblad 2009). Two studies (Asplund et al. 2003; Hansson et al. 2009) have fairly close ICD outcomes. Asplund et al. (2003) differs only by exclusion of ICD10: I60, while Hansson et al. (2009) differs only by inclusion of ICD10: G45. The results from the two remaining studies (Haglund et al. 2007; Koskinen and Blomstedt 2006) differ by several ICD codes. Haglund et al. (2007) additionally ascertains outcomes corresponding to ICD10: I65-I69, while Koskinen and Blomstedt (2006) ascertain only outcomes corresponding to ICD10: I60.

Meta-analyses of the three studies (Hansson et al. 2014, Hergens et al. 2008b; Janzon and Hedblad 2009) with the same outcome definition of ischemic, hemorrhagic, and unspecified stroke (ICD9: 430, 431, 434, 436; ICD10: I60, I61, I63, I64) were considered further. Additional analyses that includes the two studies (Asplund et al. 2003; Hansson et al. 2009) with fairly similar outcome definitions was performed. Sensitivity analyses that included all studies was also performed. These latter two analyses correspond to risk of any stroke.

**Table 3-3: ICD Definitions relevant to included studies**

ICD8	ICD9	ICD10
430 Subarachnoid haemorrhage	430 Subarachnoid haemorrhage	I60 Subarachnoid haemorrhage
431 Cerebral haemorrhage	431 Intracerebral haemorrhage	I61 Intracerebral haemorrhage
432 Occlusion of precerebral arteries	432 Other and unspecified intracranial haemorrhage	I62 Other nontraumatic intracranial haemorrhage
433 Cerebral thrombosis	433 Occlusion and stenosis of precerebral arteries	I63 Cerebral infarction
434 Cerebral embolism	434 Occlusion of cerebral arteries	I64 Stroke, not specified as haemorrhage or infarction
435 Transient cerebral ischaemia	435 Transient cerebral ischaemia	I65 Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction
436 Acute but ill-defined cerebrovascular disease	436 Acute but ill-defined cerebrovascular disease	I66 Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction
437 Generalised ischaemic cerebrovascular disease	437 Other and ill-defined cerebrovascular disease	I67 Other cerebrovascular diseases
438 Other and ill-defined cerebrovascular disease	438 Late effects of cerebrovascular disease	I68 Cerebrovascular disorders in diseases classified elsewhere
		I69 Sequelae of cerebrovascular disease
		G45 Transient cerebral ischaemic attacks and related syndromes

**Table 3-4: Description of outcome, likely ICDs in study, and reported ICDs per study**

Author	Outcome ( <i>Difference from main analysis italicized</i> )
Asplund et al. 2003	<p><b>Description:</b> "All cases of stroke, fatal and nonfatal...", "Subtyping of stroke into brain infarction, intracerebral hemorrhage, and subarachnoid hemorrhage", "Patients with subarachnoid hemorrhage were excluded"</p> <p><b>ICD interpretation:</b> I61 ("Intracerebral hemorrhage"), I63 ("cerebral infarction"), I64 ("all cases of stroke")</p> <p><i>Noteworthy that it explicitly excludes subarachnoid haemorrhage (ICD9: 430, ICD10: I60)</i></p>
Bolinder et al. 1994	<p>Stroke/cerebrovascular disorders.</p> <p>ICD8: 430-438</p>
Haglund et al. 2007	<p><b>Description:</b> "stroke"</p> <p><b>ICD:</b> ICD9: 430, 431, 432, 433, 434, 435, 436, 437, 438; ICD10: I60, I61, I62, I63, I64, I65, I66, I67, I68, I69</p>
Hansson	Description: "haemorrhagic"

et al. 2009	<p>"acute ischemic stroke, intracerebral haemorrhage, subarachnoid haemorrhage, transient ischemic attack, and unspecified cerebral haemorrhage"</p> <p><b>ICD:</b> ICD10: I60-I61, I63-I64, G45; ICD9: 430, 431, 433, 434, 435, 436</p>
Hansson et al. 2014	<p><b>Description:</b> "defined as ICD codes I60–I61 (haemorrhagic), I63 (ischaemic) and I64 (unspecified) in ICD-10th edition"</p> <p><b>ICD:</b> ICD10: I60-I61, I63, I64; ICD9: 430, 431, 434, 436</p>
Hergens et al. 2008b	<p><b>Description:</b> "Ischemic, hemorrhagic, and unspecified stroke"</p> <p><b>ICD interpretation:</b> (Based on description in Hansson et al. 2014) ICD9: 430, 431, 434, 436; ICD10: I60-I61, I63, I64</p>
Janzon and Hedblad 2009	<p><b>Description:</b> "Stroke"</p> <p><b>ICD:</b> ICD9: 430, 431, 434, 436</p>
Koskinen and Blomstedt 2006	<p><b>Description:</b> "Subarachnoid haemorrhage"</p> <p><b>ICD interpretation:</b> ICD9: 430; ICD10: I60 <i>Noteworthy that it assesses only one specific ICD code</i></p>

The seven studies (Asplund et al. 2003; Haglund et al. 2007; Hansson et al. 2009; Hansson et al. 2014; Hergens et al. 2008b; Janzon and Hedblad 2009; Koskinen and Blomstedt 2006) use the Vasterbotten Intervention Project, MONICA project, Swedish Survey of Living Conditions, Swedish Twin Registry, the Swedish Collaboration on Health Effects of Snus Use pooled cohort, the Swedish Construction Workers Cohort, the Malmö Diet and Cancer cohort, and a case-control from Umea University. The pooled cohort overlapped with several cohorts in the other available studies including the Swedish construction workers cohort, the Malmo Diet and cancer cohort, MONICA, and the Screening Across the Lifespan Twin Study (i.e. Swedish Twin Registry). Except for the pooled cohort, none of the other studies have overlapping study populations. Only two studies (Haglund et al. 2017; Koskinen and Blomstedt 2006) do not overlap with the pooled cohort in Hansson et al. (2014). Additionally, Asplund et al. (2003) only partially overlaps with the pooled cohort due to the use of the VIP cohort in Asplund et al. (2003). Hansson et al. (2014) reports an estimate that excludes the Swedish construction worker cohort, which could then be combined with the Swedish construction worker effect measure in Hergens et al. (2008). However, under our methodology, when studies have overlapping study populations and have exclusive effect measures, the latest update should be selected. In this case, Hansson et al. (2014) would contain the latest update of the Swedish construction worker cohort and Malmo Diet and Cancer study cohort used in Hergens et al. (2008) and Janzon and Hedblad (2009). As these three studies were the only studies with matching ICD codes, a meta-analysis containing Hergens et al. (2008) and/or Janzon and would represent older estimates from these cohorts than contained in the full result from Hansson et al. (2014). Additionally, neither of these studies presented effect measures for smokers precluding within study comparisons. Considering this, the full results from Hansson et al (2014) are presented to compare with the results from a meta-analysis of Hergens et al. (2008) and Janzon and Hedblad (2009). Each of these results represented ischemic, hemorrhagic, and unspecified stroke (ICD9: 430, 431, 434, 436; ICD10: I60-I61, I63, I64).

Sensitivity analyses that included studies with slightly different outcome specification (Asplund et al. 2003; Hansson et al. 2009) were performed only with the meta-analysis of Hergens et al. (2008) and

Janzon and Hedblad (2009) as the additional studies had populations that overlapped with Hansson et al. (2014). A sensitivity analyses of all studies except for Hansson et al. (2014) was performed to avoid population overlap. A meta-analysis of Hansson et al. (2014) that includes estimates from the non-overlapping study populations in Haglund et al. (2017) and Koskinen and Blomstedt (2006) was performed to supplement the existing evidence of any stroke. The latter meta-analysis of any stroke presents the latest updated evidence from all study populations.

Methods of control for tobacco were generally comparable between studies except for Koskinen and Blomstedt (2009). Koskinen and Blomstedt (2009) give no indication that the effect estimates were controlled for tobacco. All the other studies had mutually exclusive effect measures for smoking and snus use either by stratification or explicit creation of an exclusive exposure group. Importantly, three studies (Hergens et al. 2008b; Hansson et al. 2014; Janzon and Hedblad 2009) did not report any effect estimate for smokers.

All studies had comparable snus or smoking exposure groups when effect measures were available. All studies had an exposure that represented current use, either reported as "daily", "current", or "regular". Only Hergens et al. (2008) reports ever exposure for snus but had no corresponding ever smoker exposure group. Sensitivity analysis for ever exposure preference was performed.

Only Hergens et al. (2008) reported results for dose-exposure groups for snus users, but none reported results for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose-exposure results were included in the discussion section to better interpret meta-analyses results.

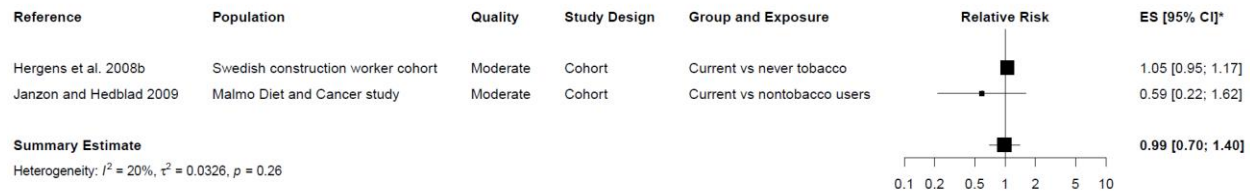
All studies controlled for age and sex, but otherwise varied in possible confounders considered. The US Surgeon General (USDHHS 2004) identified hypertension as a risk factor, while Shinton and Beevers (1989) identified age, blood pressure, obesity, female gender. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

### 3.5.6.2 Control for Confounders Table

	Age	Sex	Region of Residence	Physical activity	Diabetes	High Cholesterol	SES	BMI	High Blood pressure/hypertension	Snus, Cigs
Asplund et al. 2003	X	X			X	X	X		X	X
Haglund et al. 2007	X	X		X			X			X
Hansson et al. 2009	X	X			X	X			X	X
Hansson et al. 2014	X							X		X
Hergens et al. 2008b	X	X	X					X		X
Janzon and Hedblad 2009	X	X		X	X		X	X	X	X
Koskinen and Blomstedt 2006	X	X								

### 3.5.6.3 Ischemic, Hemorrhagic, and Unspecified Stroke Incidence Results and Meta-Analysis (ICD8,9: 430, 431, 434, 436; ICD10: I60-I61, I63, I64)\*

#### Stroke Incidence in Snus users



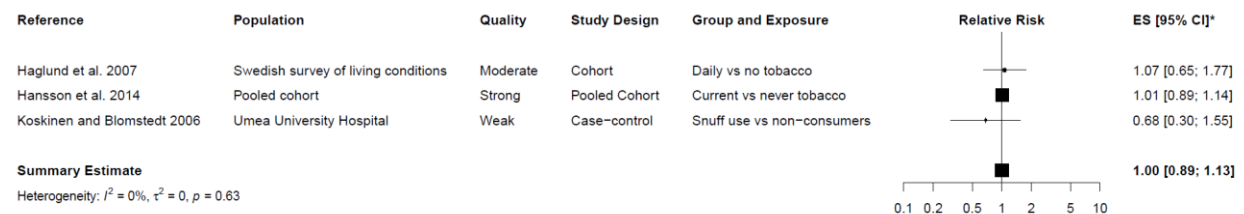
\*No smoking effect measures

#### Hansson et al. (2014) analyses for never smokers:

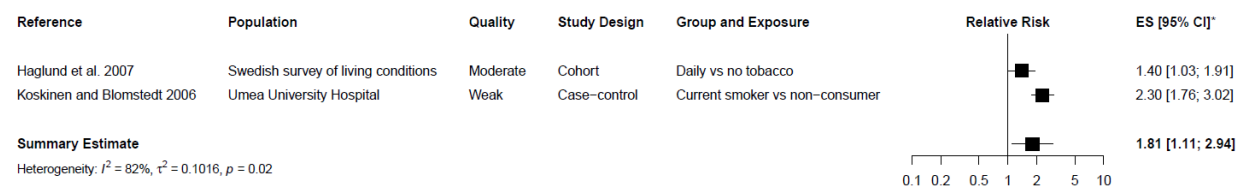
	Stroke	Ischemic Stroke	Haemorrhagic stroke	Unspecified stroke	Excluding Swedish Construction Worker cohort
Current snus vs. Never Snus	1.04 (0.92-1.17)	1.06 (0.91-1.23)	0.94 (0.73-1.22)	1.1 (0.78-1.54)	1.13 (0.79-1.6)
Current snus vs. Never tobacco	1.01 (0.89-1.14)				

### 3.5.6.4 Any incident stroke meta-analyses with Hansson et al. (2014) (ICD9: 430-438; ICD10: I60-I69)

#### Stroke Incidence in Snus users

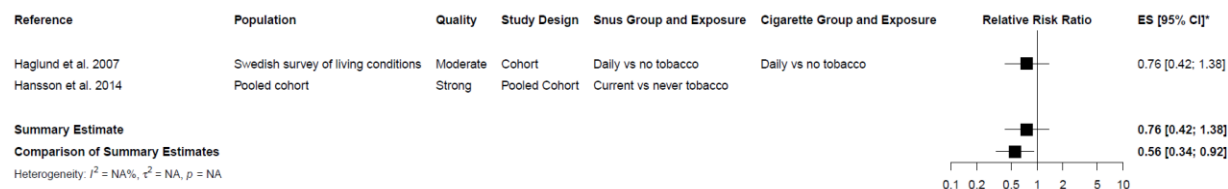


#### Stroke Incidence in Smokers





### Stroke Incidence in Snus users compared to Smokers



### 3.5.6.5 Sensitivity Analysis Summary Table for Ischemic, Hemorrhagic, and Unspecified Incident stroke

Two sensitivity analyses were run to compare results of snus summary estimates whenever snus exposure is preferred or when fixed-effects meta-analysis is preferred.

	Results from Hansson et al. (2014) for Ischemic, Hemorrhagic, and Unspecified Incident stroke.	Meta-analysis for ischemic, hemorrhagic and unspecified incident stroke using older estimates from the Swedish construction worker cohort and Malmo Diet and Cancer Study	1) Preference for ever estimates in meta-analyses of ischemic, hemorrhagic and unspecified incident stroke using older estimates	2) Fixed-effects meta-analyses of ischemic, hemorrhagic and unspecified incident stroke using older estimates
Summary Estimate for Snus Users (95% CI)	1.01 (0.89-1.14)	0.99 (0.70, 1.40)	0.98 (0.76, 1.28)	1.04 (0.94, 1.16)

### 3.5.6.6 Sensitivity Analysis Summary Table for any incident stroke

Four sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to three key limitations of the main analyses of any stroke: 1a-b) Inappropriate use of updated studies, 2) Inappropriate a priori decision to use random effects meta-analysis, and 3) Inappropriate exclusion of any study.

	Meta-analyses of any stroke (Hansson et al. 2014; Haglund et al. 2007; Koskinen and Blomstedt 2006)	1a) Meta-analyses of any stroke using older estimates (i.e. all studies except Hansson et al. (2014))	1b) Meta-analyses of any stroke using older estimates only with slight variations in outcome specificity (Asplund et al. 2003; Hansson et al. 2009)	2) Fixed-effects meta-analyses of any stroke (Hansson et al. 2014; Haglund et al. 2007; Koskinen and Blomstedt 2006)	3) All studies*
Summary Estimate for Snus Users (95% CI)	1.00 (0.89, 1.13)	1.04 (0.94, 1.15)	1.04 (0.94, 1.16)	1.00 (0.89, 1.13)	1.03 (0.95, 1.11)

Summary Estimate for Smokers (95% CI)	1.81 (1.11, 2.94)	1.74 (1.36, 2.23)	1.63 (1.25, 2.11)	1.85 (1.51, 2.27)	1.74 (1.36, 2.23)
Summary Relative Risk Ratio (95% CI)	0.76 (0.42, 1.38)	0.71 (0.47, 1.05)	0.66 (0.39, 1.13)	0.76 (0.42, 1.38)	0.71 (0.47, 1.05)
Comparison of Summary Estimates (95% CI)	0.56 (0.34, 0.92)	0.60 (0.46, 0.78)	0.64 (0.49, 0.85)	0.54 (0.43, 0.69)	0.59 (0.45, 0.76)

\*This meta-analysis unduly weights results from the Swedish construction worker cohort, the Malmo Diet and Cancer study, MONICA, and the Swedish Twin Registry

### 3.5.6.7 Conclusion criteria for Ischemic, Hemorrhagic, and Unspecified Stroke Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	<i>Older estimates:</i> 0.99 (0.70-1.40) <i>Newer estimate</i> (Hansson et al. 2014): 1.01 (0.89-1.14)	-	-
Statistical Significance	No	-	-
Consistency of Direction/Magnitude of Included Studies	No  One study above one, while the other below one	-	-
Consistency of Statistical Significance of Included Studies	Yes,  All studies statistically non-significant	-	-
Statistically significant heterogeneity	No	-	-
Qualitative Assessment	All moderate studies	-	-
Sensitivity Analysis	Supports main analysis	-	-

Limitations	<ul style="list-style-type: none"> <li>No comparison with smokers possible with the study results</li> </ul>
-------------	--

### 3.5.6.8 Conclusion criteria for any stroke incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.00	0.76	0.56
Statistical Significance	No	No	Yes
Consistency of Direction/Magnitude of Included Studies	No,  Two studies above one, while the other study below one	Only one study	NA
Consistency of Statistical Significance of Included Studies	Yes,  All studies statistically non-significant	Only one study	NA
Statistically significant heterogeneity	No	Only one study	NA
Qualitative Assessment	One strong, one moderate, and one weak study	One moderate study	NA
Sensitivity Analysis	Supports main analysis	Supports main analysis	Supports main analysis
Limitations	<ul style="list-style-type: none"> <li>Only one within study risk comparison</li> <li>Studies with different ICD outcomes included</li> </ul>		

### **3.5.6.9 Discussion of Stroke Incidence**

#### ***Overall results for Ischemic, Hemorrhagic, and Unspecified Stroke Incidence***

Analyses restricted to ischemic, hemorrhagic, and unspecified stroke incidence found statistically non-significant results for new meta-analyses and sensitivity analyses that supported the updated results in Hansson et al. (2014) of 1.04 (95% CI: 0.92-1.17) that included eight different study populations. No effect measures for smokers were available in this restricted set of stroke outcomes.

#### ***Overall results for any stroke Incidence***

A more relaxed outcome specification to include more studies of incident stroke supported the results for ischemic, hemorrhagic, and unspecified stroke incidence. Analyses for incidence of any stroke summarized the effect estimates from three studies consisting of 10 different study populations to obtain a statistically non-significant summary estimate of 1.00 (95% CI: 0.89-1.13) for snus users. Smokers within one of these studies had a statistically significant relative risk of 1.81 (95% CI: 1.11-2.94). A statistically non-significant relative risk ratio of 0.76 (95% CI: 0.42-1.38) was obtained for within study comparisons of risks based on one study. The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.56 (95% CI: 0.34-0.92).

#### ***The Effect of Snus***

All analyses of the effect of snus show consistent statistically non-significant summary estimates near one. These results are in line with dose-exposure results in Hergens et al. (2008b). Hergens et al. (2008b) report statistically non-significant effect measures for snus dose exposure groups of < 12.5 g/day, 12.5-24.9 g/day, 25-49.9 g/day, and ≥ 50 g/day.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion of *limited/suggestive evidence of no association* between snus use and incident stroke, including the subtypes: ischemic and hemorrhagic.

#### ***The Effect of Smoking***

In analyses that contain smoking summary measures, all results show consistently statistically significant risk of incident stroke. This is in line with previous knowledge of the adverse effects of smoking. The effects of smoking on stroke related mortality in five major U.S. cohorts is presented in Appendix G to provide some additional U.S. context.

#### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks in sensitivity analyses resulted in a consistently statistically non-significant summary estimate below one.

All analyses of the comparison of summary estimates found consistently statistically significant summary estimates below one.

Both methods of comparing incident stroke in snus users compared to smokers consistently showed a lower magnitude of risk for snus users, however the statistical significance of this magnitude is unclear.

### 3.5.7 Stroke Mortality

#### 3.5.7.1 Comparability of studies of Stroke Mortality

The four cohort studies (Bolinder et al. 1994; Haglund et al. 2007; Hansson et al. 2014; Hergens et al. 2008b) had differences in outcome definitions, overlapping study populations, comparable methods of tobacco control, comparable snus and smoking exposure groups.

Four studies (Bolinder et al. 1994, Haglund et al. 2007, Hansson et al. 2014, Hergens et al. 2008b) assessed stroke mortality explicitly, but only two studies (Bolinder et al. 1994; Haglund et al. 2007) matched in outcome ascertainment. Bolinder et al. (1994) and Haglund et al. (2007) each defined fatal stroke as ICD8, 9: 430-438. Hansson et al. (2014) exclude ICD8,9: 432, 437, and 438 corresponding to other "unspecified" or "ill-defined" stroke diagnoses. Hergens et al. (2008b) offers a nominal description of "ischemic, hemorrhagic, and unspecified" stroke that matches ICD9: 430, 431, 434, 436; ICD10: I60-I61, I63, I64. Due to these differences in outcome ascertainment, only Bolinder et al. (1994) and Hergens et al. (2008b) were included in the main analysis. A sensitivity analyses included each and both of the excluded studies was performed.

The four stroke mortality studies assessed the Swedish construction worker cohort and the Swedish survey of living conditions cohort. Exclusivity between study populations was not maintained for three studies (Bolinder et al. 1994; Hansson et al. 2014; Hergens et al. 2008b) that utilized the Swedish construction worker cohort. Sensitivity analyses including these three studies therefore unduly weight the Swedish construction worker cohort. Hansson et al. (2014) includes various other cohorts, such as the Malmo Diet and Cancer study, MONICA, National March cohort, Scania Public Health Survey, Stockholm Public Health Survey, Screening Across the Lifespan Twin Study, and the Work, Lipids, and Fibrinogen study. Due to its size and moderate quality, the results from Hansson et al. (2014) will be discussed despite the stricter outcome definition they described.

Methods of control for tobacco were comparable between studies. All studies had mutually exclusive effect measures for smoking and snus use either by stratification or explicit creation of an exclusive exposure group.

Each study had comparable snus and smoking exposure groups. All studies reported exposures that represented current use, reported as "daily" or "current". Notably, Hergens et al. (2008b) did report any estimates for smokers. Additionally, Hergens et al. (2008b) is the only study to report effects for ever exposure to snus. Bolinder et al. (1994) reported smoking estimates stratified by smoking dose and stratified by age, these strata were each joined in a fixed-effects meta-analysis to obtain an overall effect measure for those ages 35 to 65. Similarly, Bolinder et al. (1994) reported snus effect measures stratified by age, these were combined in a fixed-effects meta-analysis to obtain an overall effect measure for those ages 35-65.

A sensitivity analyses that preferred inclusion of ever exposure was performed.

Only Hergens et al. (2008b) reported results for dose-exposure groups for snus users, but none reported results for smokers. There were consequently insufficient studies to further assess meta-analyses based on snus dose-exposure groups. Dose-exposure results were included in the discussion section to better interpret meta-analyses results.

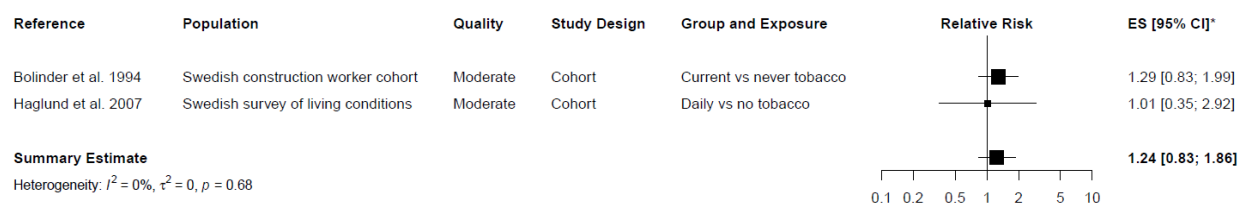
All studies controlled for age and sex, but otherwise varied in possible confounders considered. The US Surgeon General (USDHHS 2004) identified hypertension as a risk factor, while Shinton and Beevers (1989) identified age, blood pressure, obesity, female gender. Comparison with confounders in the studies (see table below) show no study has controlled for all these possible risk factors and that no study controlled for the same set of confounders.

### 3.5.7.2 Control for Confounders Table

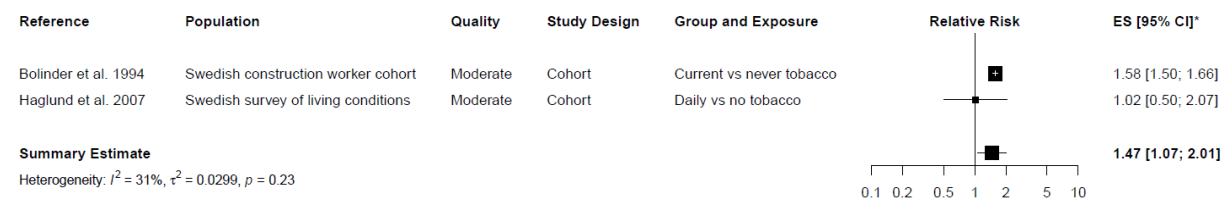
	Age	Sex	Region of Residence	Physical activity	Diabetes	High Cholesterol	SES	BMI	High Blood pressure/hypertension	Snus, Cigs
Bolinder et al. 1994	X	X			X			X	X	X
Hansson et al. 2014	X							X		X
Hergens et al. 2008b	X	X	X					X		X

### 3.5.7.3 Stroke Mortality Meta-Analyses (ICD8, 9: 430-438; ICD10: I60-I69)

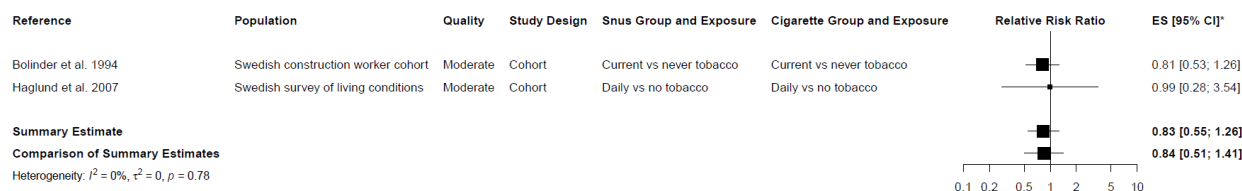
#### Stroke Mortality in Snus users



#### Stroke Mortality in Smokers



#### Stroke Mortality in Snus users compared to Smokers



### 3.5.7.4 Sensitivity Analysis Summary Table

Sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to six key limitations of the main analyses: 1) Inappropriate preference for current exposure,

2) Inappropriate exclusion of Hansson et al. (2014) due to outcome ascertainment, 3) Inappropriate exclusion of Hergens et al. (2008b) due to outcome ascertainment, 4) Inappropriate preference for Bolinder et al. (1994) instead of Hansson et al. (2014), 5) Inappropriate exclusion of any stroke mortality study, 6) Inappropriate a priori decision to use random-effects meta-analysis

	Main Analysis	1) Preference for ever estimates when available	2) Inclusion of Hansson et al. (2014) <sup>a</sup>	3) Inclusion of Hergens et al. (2008b) <sup>a</sup>	4) Updated Swedish construction worker cohort	5) All studies <sup>a</sup>	6) Fixed-effects meta-analysis
Summary Estimate for Snus Users (95% CI)	1.24 (0.83, 1.86)	1.25 <sup>b</sup> (0.91, 1.70)	1.30 (1.09, 1.56)	1.32 (1.03, 1.71)	1.31 (1.07, 1.59)	1.32 (1.13, 1.55)	No change
Summary Estimate for Smokers (95% CI)	1.47 (1.07, 2.01)	1.02 <sup>c</sup> (0.5, 2.07)	No change	No change	1.02 <sup>c</sup> (0.5, 2.07)	No change	1.57 (1.5, 1.66)
Summary Relative Risk Ratio (95% CI)	0.83 (0.55, 1.26)	0.99 <sup>c</sup> (0.28, 3.54)	No change	No change	0.99 <sup>c</sup> (0.28, 3.54)	No change	No change
Comparison of Summary Estimates (95% CI)	0.84 (0.51, 1.41)	1.22 (0.56, 2.64)	0.89 (0.62, 1.27)	0.90 (0.60, 1.35)	1.28 (0.62, 2.67)	0.90 (0.63, 1.28)	0.79 (0.53, 1.18)

<sup>a</sup> Meta-analyses place excess weight on Swedish construction worker cohort

<sup>b</sup> The ever snus exposure in Hergens et al. (2008b) replaced the current snus exposure in Bolinder et al. (1994) to avoid overlapping study populations

<sup>c</sup> Only one study

### 3.5.7.5 Conclusion criteria for stroke mortality

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.24	0.83	0.84
Statistical Significance	No	No	No
Consistency of Direction/Magnitude of Included Studies	Yes,  All studies above one	Yes,  All studies below one	NA
Consistency of Statistical Significance of Included Studies	Yes,  All studies statistically non-significant	Yes,  All studies statistically non-significant	NA
Statistically significant heterogeneity	No	No	NA
Qualitative Assessment	All moderate studies	All moderate studies	NA
Sensitivity Analysis	Does not support main analysis  All sensitivity analyses that include additional	Supports main analysis	Supports main analysis  Although the direction of effect changes in two sensitivity analyses, the effects remain statistically

	studies are statistically significant		non-significant
Limitations	<ul style="list-style-type: none"> <li>Multiple fixed-effects meta-analyses to obtain a comparable smoking effect estimate in Bolinder et al. (1994)</li> </ul>		

### 3.5.7.6 Discussion of Stroke Mortality

#### **Overall Results**

The main analysis of this section summarized the effect estimates of stroke mortality from two studies to obtain a statistically non-significant summary estimate of 1.24 (95% CI: 0.70-1.40) for snus users. Smokers within these studies had a statistically significant summary estimate of 1.47 (95% CI: 1.07-2.01). A statistically non-significant summary estimate of 0.83 (95% CI: 0.55-1.26) was obtained for within study comparisons of risks based on four studies. The comparison of summary estimates yielded a statistically non-significant 0.84 (95% CI: 0.51-1.41).

#### **The Effect of Snus**

Sensitivity analyses show a consistent magnitude and direction of the effect above one but differ in statistical significance. The addition of results from either Hergens et al. (2008b) or Hansson et al. (2014) result in a statistically significant effect measure for snus users. It is worth considering the effect measures independently reported by Hansson et al. (2014) as it presented an update of the Swedish cohort study in Bolinder et al. (1994). In a pooled analysis of eight cohort populations, Hansson et al. (2014) reported an overall 1.32 (95% CI: 1.08-1.61) relative risk of stroke. This changes slightly to 1.31 (95% CI: 1.07, 1.59) in a sensitivity analyses of Hansson et al. (2014) with Haglund et al. (2007), which had a study population not included in the pooled cohort.

Additionally, Hergens et al. (2008b) report statistically non-significant effect measures for snus dose exposure groups of < 12.5 g/day, 12.5-24.9 g/day, 25-49.9 g/day, and ≥ 50 g/day.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion of *balanced/mixed evidence of an association* between snus use and stroke mortality.

#### **The Effect of Smoking**

In sensitivity analyses that present smoking summary measures, the results do not show consistent statistically significant increases in stroke mortality. The statistically non-significant results for smokers arose when only the results of Haglund et al. (2007) provided estimates for smokers as they report a relative risk of 1.02 (95% CI: 0.5, 2.07). This is not in line with previous knowledge of the adverse effects of smoking. The effects of smoking on stroke related mortality in five major U.S. cohorts is presented in Appendix G to provide some additional U.S. context.

#### **Comparison of Effects of Snus with Effects of Smoking**

Comparison of within study relative risks in sensitivity analyses resulted in a consistently statistically non-significant summary estimate below one.



Sensitivity analyses of the comparison of summary estimates found consistently statistically non-significant summary estimates. In the case of preference for exposure the magnitude changed direction.

Both methods of comparing stroke mortality in snus users compared to smokers consistently showed no statistically significant results.

### **3.6 Metabolic Effects**

#### **3.6.1 Diabetes**

##### **3.6.1.1 Outcome Comparability**

In this evaluation, "diabetes" refers to the health outcome represented by ICD9: 250 and ICD10: E11, E14. This includes type 2 diabetes and diabetes of an unspecified type.

Nine studies (Wandell et al. 2008; Eliasson et al. 2004; Ostenson et al. 2012; Persson et al. 2000; Hilding et al. 2005; Janzon and Hedblad 2009; Rasouli et al. 2017; Byhamre et al. 2017; Carlsson et al. 2017) were identified in the systematic search as related to diabetes. Five of the studies (Eliasson et al. 2004, Persson et al. 2000, Wandell et al. 2008; Janzon and Hedblad 2009; Rasouli et al. 2017) reported on prevalence of diabetes, while six studies (Eliasson et al. 2004, Ostenson et al. 2012; Hilding et al. 2005; Rasouli et al. 2017; Byhamre et al. 2017; Carlsson et al. 2017) reported on diabetes incidence. Further review of Janzon and Hedblad (2009) revealed that an effect measure of diabetes was not determined. However, they reported no statistically significant difference in prevalence between snus users compared to snus non-users among each men and women. This study was excluded from further review as it could not be incorporated into the meta-analyses.

##### **3.6.1.2 Prevalence of Type II Diabetes**

###### **3.6.1.2.1 Comparability of studies for meta-analyses of diabetes prevalence.**

The four cross-sectional studies that reported on diabetes prevalence had independent study populations, comparable methods of control for tobacco, variation in snus and smoking exposure characterizations, comparable reference specificity, and variation in control for risk factors.

Four studies (Eliasson et al. 2004, Persson et al. 2000, Wandell et al. 2008; Rasouli et al. 2017) explicitly evaluated prevalence of diabetes with an analysis of the Northern Sweden MONICA study, Stockholm Diabetes Prevention Programme, 1997-1999 Stockholm county, and the Norwegian HUNT study. All studies used a separate source population.

There was a comparable method of control for each study. Persson et al. (2000) and Rasouli et al. (2017) controlled for tobacco through stratification and multivariate adjustment, while Eliasson et al. (2004) used only stratification. Wandell et al. (2008) used multivariate adjustment with interaction terms. This method creates exclusive effect estimates for snus users and smokers. Thus, all studies could have within study comparisons of prevalence provided both estimates were available. Sensitivity analyses that preferred adjusted estimates was performed.

The snus exposure characterization varied for all studies. Eliasson et al. (2004) reported stratified estimates for ever, current, and former snus users and smokers. Wandell et al. (2008) reported only estimates for current and former exposures. Persson et al. (2000) reported estimates for current and

former multivariate adjusted exposures, but only current exposures for tobacco-stratified estimates. Lastly, Rasouli et al. (2017) reported only ever exposure for snus users. Current exposure was prioritized for inclusion in the main analysis as it was available in three out of four studies. Sensitivity analyses that preferred ever exposure was also performed.

Exposure characterization for smoking echoed the variation seen with snus exposure, however Rasouli et al. (2017) did not report any smoking effect estimates.

Three studies (Persson et al. 2000; Rasouli et al. 2017; Wandell et al. 2008) report dose- or duration-response effects in snus users and two studies (Persson et al. 2000; Wandell et al. 2008) report these effects in smokers. The groups for smokers were not comparable, as Wandell et al. (2008) reported duration of smoking, while Persson et al. (2000) reported dose of cigarettes per day. The dose-exposure groups for snus use were potentially comparable, as each study reported on whether less than three cans were consumed or greater than or equal to three cans of snus. However, Rasouli et al. (2017) reported dose among ever users, and the other two studies reported dose among current users only. Additionally, no comparison between smoking and snus use would be possible as it is difficult to judge whether greater than or equal to three boxes per week is equivalent to greater than or equal to 25 cigarettes per day. Although no meta-analyses were performed, the dose-response results are included in the discussion section to better interpret meta-analyses results.

Reference groups between smoker and snus exposure groups were comparable. These reference groups for the selected estimates were never user of tobacco, never cigarettes/snuff, and never smoker or snuff. These reference groups were considered comparable between studies.

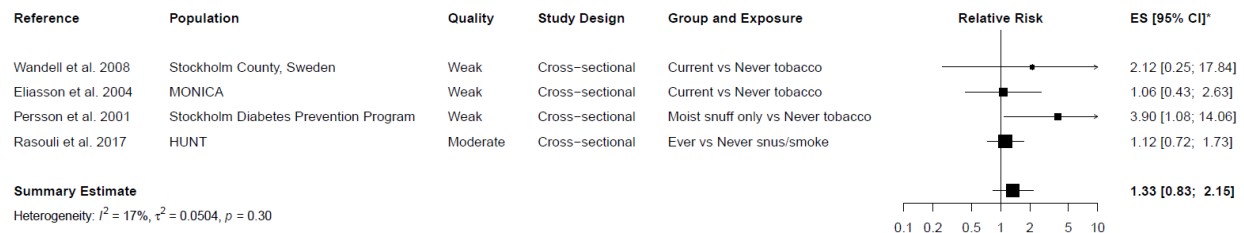
All studies considered controlled for age, sex, and BMI/weight but otherwise varied in confounders considered. The CDC (2011) has identified the following as important risk factors: older age, obesity, physical inactivity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism, and race/ethnicity (African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians or Other Pacific Islanders). Comparison with confounders in the studies (see table below) show that at least one study has controlled for each of these risk factors apart from race and impaired glucose metabolism.

**3.6.1.2.2 Control for Confounders Table**

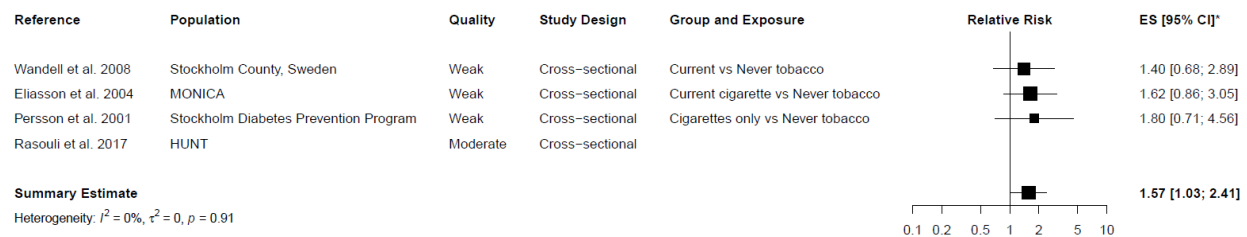
	A g e	S e x	BMI	Physical activity	Family history	Impaired glucose metabolism	Race	D i e t	A l c o h o l	Residence	Education	SES	Snus, Cigs
Eliasson et al. 2004	X	X	X										X
Persson et al. 2000	X	X	X	X	X				X				X
Wandell et al. 2008	X	X	X						X			X	X
Rasouli et al. 2017 – HUNT cross- sectional	X	X	X		X								X

### 3.6.1.2.3 Prevalence of Type 2 Diabetes (ICD9: 250, ICD10: E11, E14) Meta-analyses

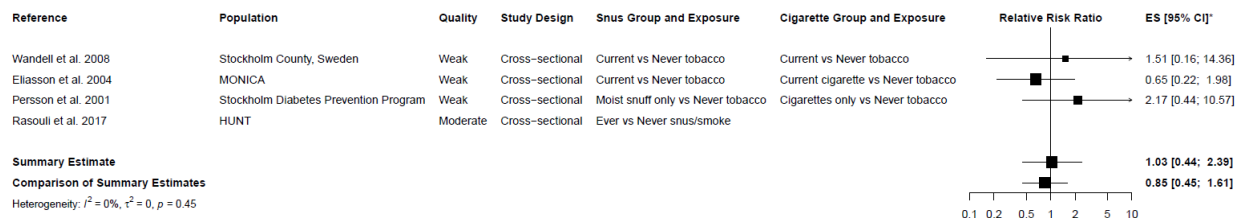
#### Diabetes Prevalence in Snus users



#### Diabetes Prevalence in Smokers



#### Diabetes Prevalence in Snus users compared to Smokers



### 3.6.1.2.4 Sensitivity Analysis Summary Table

Three sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to three key limitations of the main analyses: 1) Inappropriate preference for stratified effect estimates, 2) Inappropriate preference for current exposure, and 3) Inappropriate a priori decision to use random-effects meta-analyses.

	Main Analysis	1) Preference for adjusted estimates when available	2) Preference for ever exposure when available	3) Fixed Effect
Summary Estimate for Snus Users (95% CI)	1.33 (0.83, 2.15)	0.96 (0.80, 1.14)	1.42 (0.89, 2.28)	1.25 (0.87, 1.82)

Summary Estimate for Cigarette Users (95% CI)	1.57 (1.03, 2.41)	1.45 (0.97, 2.17)	1.60 (1.17, 2.19)	1.57 (1.03, 2.41)
Summary Relative Risk Ratio (95% CI)	1.03 (0.44, 2.39)	0.77 (0.29, 2.08)	1.06 (0.50, 2.21)	1.03 (0.44, 2.39)
Comparison of Summary Estimates (95% CI)	0.85 (0.45, 1.61)	0.66 (0.42, 1.02)	0.82 (0.51, 1.31)	0.80 (0.45, 1.40)

### 3.6.1.2.5 Conclusion criteria for Diabetes Prevalence

	Absolute Risk among Snus users compared to Never/Non-users of snus/smoking	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.33	1.03	0.85
Statistical Significance	No	No	No
Consistency of Direction/Magnitude of Included Studies	Yes,  All studies above one	No,  Two studies above one, and one study below one	NA
Consistency of Statistical Significance of Included Studies	No,  One out of the four studies were statistically significant.	Yes,  All studies are statistically non-significant.	NA
Statistically significant heterogeneity	No	No	NA
Qualitative Assessment	Three weak studies and one moderate study	Three weak studies	Effect estimates mostly based on weak studies
Sensitivity Analysis	Supports main analyses.  Although preference for adjusted estimates changes the direction of the effect, it remains statistically non-significant.	Supports main analyses.  Although preference for adjusted estimates changes the direction of the effect, it remains statistically non-significant.	Supports the main analyses.  All estimates are statistically non-significant and below one.

Limitations	<ul style="list-style-type: none"> <li>• Prevalence odds ratios do not indicate causality</li> </ul>
-------------	--

### **3.6.1.2.6 Discussion of Diabetes Prevalence**

#### ***Overall results***

The main analysis of this section summarized the effect estimates of prevalence for type 2 diabetes from four studies to obtain a statistically non-significant summary estimate of 1.33 (95% CI: 0.83-2.15) for snus users. For smokers within these studies a statistically significant summary estimate of 1.57 (95% CI: 1.03-2.41) was obtained. These studies likely have no residual confounding from smoking due to exclusivity between snus and smoking effect measures within each study. A statistically non-significant summary relative prevalence ratio of 1.03 (95% CI: 0.44-2.39) was obtained for within study comparisons of prevalence. A comparison of summary estimates yielded a lower statistically non-significant estimate of 0.85 (95% CI: 0.45, 1.61).

These results are not quite in line with the dose- or duration- response results reported in the studies. Although no analysis of trend was done in any study, three studies (Persson et al. 2000; Rasouli et al. 2017; Wandell et al. 2008) evaluated effects of different doses of snus compared to non-snus users. One study found a statistically significant effect of 3 or more boxes of snus per week. The other two studies did not have a statistically significant effect. Rasouli et al. (2017) reported an effect estimate of 0.89 (95% CIL 0.21-3.78), while Wandell et al. (2008) reported an effect estimate of 1.80 (95% CI: 0.67-4.85). Out of the two studies that reported a dose- or duration- effect for smokers, only one reported a dose-response effect for greater than 25 cigarettes per day of 2.6 (95% CI: 1.1-5.8), while the other study found no statistically significant effect for greater than 20 years of use.

#### ***The Effect of Snus***

Although our main analysis shows a statistically non-significant summary estimate above one, the sensitivity analyses that preferred adjusted estimates suggests a different direction in effect. However, all sensitivity analyses are statistically non-significant with wide confidence intervals. No prior meta-analyses of diabetes prevalence have been performed to compare our results.

#### ***The Effect of Smoking***

The main analysis shows a statistically significant effect above one, however sensitivity analyses shows a statistically non-significant effect when adjusted estimates were preferred. This is at odds with expert opinion that show an association of smoking with diabetes. This may indicate that the included studies vary from other study populations, that adjusted estimates are subject to confounding by some other unmeasured risk factor, or that a lack of power results from use of stratified estimates. Nevertheless, the effect estimates are around the same high magnitude for all sensitivity analyses.

#### ***Comparison of Effects of Snus with Effects of Smoking/Cigarettes***

The summary relative prevalence ratios are statistically non-significant in all sensitivity-analyses and in all constituent studies, however differed in a sensitivity analyses that preferred adjusted estimates. This difference is likely driven by the change in estimates from Persson et al. (2000) study from a high stratified snus effect measure of 3.90 (95% CI: 1.08-14.06) to a lower adjusted estimate of 1.50 (95% CI: 0.77-2.90). This effect estimates and the one from Wandell et al. (2008) have very wide

confidence intervals suggesting a low number of diabetes cases for snus users in these two studies. Nevertheless, current evidence has no statistically significant heterogeneity to indicate a substantial statistical difference in snus effect estimates and all analyses indicate a statistically non-significant effect close to one.

The comparison of summary estimates is consistently lower than one and statistically non-significant for all analyses. These align with the statistical non-significance observed of the summary relative prevalence ratios. It also aligns with discussion on the possibility that further studies may reveal a lower effect of snus use compared to smoking by providing further statistical power.

Overall both methods of comparing prevalence of diabetes show a statistically non-significant difference in prevalence associated with snus compared to prevalence associated with smoking.

### **3.6.1.3 Incidence of Type 2 Diabetes**

#### **3.6.1.3.1 Comparability of studies for meta-analyses**

The four cohort, one cross-sectional, and one pooled cohort studies on diabetes incidence had overlap between study populations, comparable methods of control for tobacco, generally comparable snus and smoking exposure characterization, comparable reference specificity, and variation in control for risk factors.

Six studies (Eliasson et al. 2004, Ostenson et al. 2012; Hilding et al. 2005; Rasouli et al. 2017; Byhamre et al. 2017; Carlsson et al. 2017) evaluated incidence of diabetes with an analysis of the Northern Sweden MONICA study, Stockholm Diabetes Prevention Programme, ESTRID case-control, the Lulea Municipality cohort, and a pooled cohort consisting of the Vasterbotten Intervention Programme (VIP), the Stockholm Public Health Cohort, the Malmo Diet and Cancer Study; the National March Cohort; and the Screening Across the Lifespan Twin study (SALT). The pooled cohort did not overlap with other study populations as the Stockholm Public Health cohort and Stockholm Diabetes Prevention Programme cohort were two distinct cohorts with different time periods of interest and study populations. However, Hilding et al. (2005) and Ostenson et al. (2012) each used the Stockholm Diabetes Programme cohort with exact overlap in time periods of study entry and follow-up. Consequently, Hilding et al. (2005) was excluded from the main analyses and a sensitivity analyses was performed that included Hilding et al. (2005) in place of Ostenson et al. (2012). A sensitivity analysis that includes all studies was also performed although it gives excess weight to the Stockholm Diabetes Programme cohort.

Comparable methods of control for tobacco did not exist between exposure groups but did exist between studies for snus exposure. Hilding et al. (2005) was unclear about control for tobacco for either smoking or snus exposure. The remaining five studies (Eliasson et al. 2004; Byhamre et al. 2017; Carlsson et al. 2017; Ostenson et al. 2012; Rasouli et al. 2017) reported stratified or exclusive estimates for snus users, but only Eliasson et al. (2004) reported exclusive estimates for smokers. Three studies (Byhamre et al. 2017; Carlsson et al. 2017; Rasouli et al. 2017) did not report any effect measure for smokers, while Ostenson et al. (2012) reported only adjusted effect measures for smokers. Thus, only Eliasson et al. (2004) reported exclusive effect measures for snus users and smokers, however Eliasson et al. (2004) identified zero cases of diabetes in exclusive snus users. No within study risk comparisons were performed as no studies had exclusive estimates for both snus

users and smokers. Sensitivity analyses that preferred adjusted snus effect measures available in Ostenson et al. (2012) and Rasouli et al. (2017) was performed.

Comparable current snus exposure existed across all studies except for Byhamre et al. (2017). Byhamre et al. (2017) used a sensitive period model in which they assessed the risk of diabetes based on exposure at certain ages (16, 21, 30, 43 years old). This exposure does not really correspond to ever or current exposure as it is specifically focused on exposure at a specific time-period in an individual's lifespan. Furthermore, the reported estimates are not mutually exclusive from each other as the same individual can be exposed at each of those ages given the long 27-year follow-up of the cohort study. Consequently, these estimates cannot be combined through a fixed-effect meta-analysis for an overall effect estimate of snus exposure. No studies report ever exposure and consequently no sensitivity analyses will be done regarding snus exposure characterization. Byhamre et al. (2017) was not included in the main analyses nor sensitivity analyses due to its unique exposure characterization.

Comparable current smoking exposure existed across studies that reported smoking effect estimates (Eliasson et al. 2004; Hilding et al. 2005; Ostenson et al. 2012).

Four studies (Carlsson et al. 2017; Hilding et al. 2005; Ostenson et al. 2012; Rasouli et al. 2017) reported dose- or duration response effects in snus users and two studies (Hilding et al. 2005; Ostenson et al. 2012) reported dose-response effects in cigarette users. The dose exposure groups for cigarettes were not comparable as Ostenson et al. (2012) looked at 1-15 cigarettes per day and > 15 cigarettes per day, while Hilding et al. (2005) looked at only > 10 cigarettes per day. Two studies (Hilding et al. 2005; Carlsson et al. 2017) report dose-exposure groups comparing higher levels of snus use  $\geq 4$  boxes/week to non-users, however a meta-analysis was not undertaken as Hilding et al. (2005) did not control for smoking. Additionally, no comparison between smoking and snus use was possible as it was difficult to judge whether greater than or equal to a certain number of boxes per week is equivalent to greater than or equal to a certain number of cigarettes per day. Notably, Carlsson et al. (2017) provided a pooled estimate of snus dose-exposure controlling for smoking that was included in the discussion section to better interpret meta-analyses results.

Comparable reference groups exist between studies of never tobacco or never snus/smoking for each study as appropriate.

All studies considered controlled for age, sex, and BMI/weight but otherwise varied in confounders considered. The CDC (2011) has identified the following as important risk factors: older age, obesity, physical inactivity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism, and race/ethnicity (African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians or Other Pacific Islanders). Comparison with confounders in the studies (See table below) show that at least one study has controlled for each of these risk factors apart from race/ethnicity

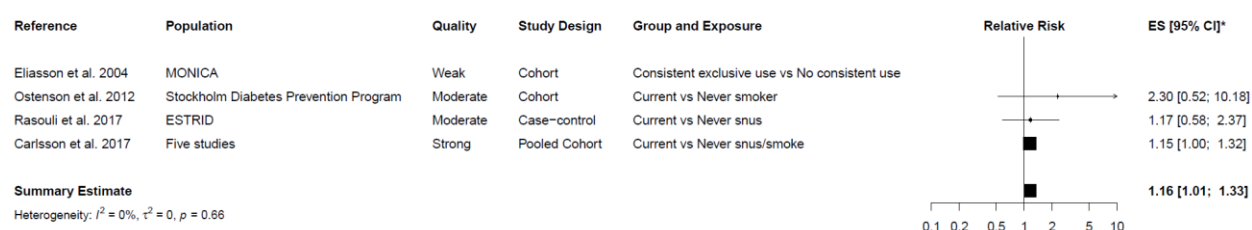
### 3.6.1.3.2 Control for Confounders Table

	Age	Sex	Weight /BMI	Physical activity	Family history	Impaired glucose metabolism	Race	Diet	Alcohol	Residence	Edu.	SES	Snus, Cigs
Eliasson et al. 2004	X	X	X										X
Hilding et al. 2005	X	X	X	X	X								

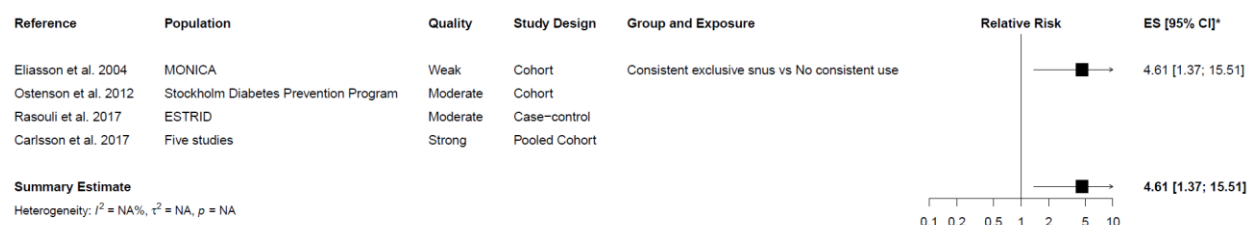
Ostenson et al. 2012	X	X	X	X	X	X			X			X	X
Rasouli et al. 2017 – ESTRID case-control	X	X	X		X					X			X
Byhamre et al. 2017	X	X	X	X	X				X			X	X
Carlsson et al. 2017	X	X	X	X					X		X		X

### 3.6.1.3.3 Incidence of Type 2 Diabetes (ICD9: 250, ICD10: E11, E14)

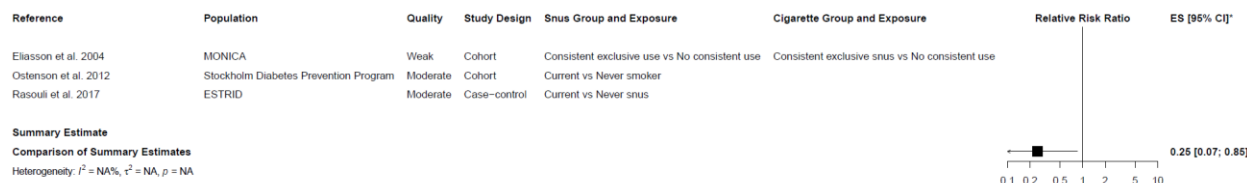
#### Diabetes Incidence in Snus users



#### Diabetes Incidence in Smokers



#### Diabetes Incidence in Snus users compared to Smokers



### 3.6.1.3.4 Sensitivity Analysis Summary Table

Five sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to five key limitations of the study: 1) Inappropriate preference for stratified/exclusive effect measures, 2) Inappropriate exclusion of Hilding et al. (2005) instead of Ostenson et al. (2012), 3) Inappropriate exclusion of any study related to diabetes incidence, and 4) Inappropriate a priori decision to use random-effects meta-analyses.

	Main Analysis	1) Preference for adjusted	2) Inclusion of Hilding et al.	3) All studies <sup>b, c</sup> (Except	4) Fixed-effects meta-
--	---------------	----------------------------	--------------------------------	--	------------------------



		estimates when available	(2005) instead of Ostenson et al. (2012) <sup>b</sup>	Byhamre et al. 2017, which could not be combined)	analyses
Summary Estimate for Snus Users (95% CI)	1.16 (1.01, 1.33)	1.12 (0.99, 1.27)	1.15 (1.01, 1.32)	1.16 (1.02, 1.32)	No change
Summary Estimate for Cigarette Users (95% CI)	4.61 <sup>a</sup> (1.37, 15.51)	2.33 (0.80, 6.83)	2.58 (1.21, 5.47)	2.58 (1.21, 5.47)	No change
Summary Relative Risk Ratio (95% CI)	-	-	-	-	-
Comparison of Summary Estimates (95% CI)	0.25 <sup>a</sup> (0.07, 0.85)	0.48 (0.16, 1.42)	0.45 (0.21, 0.96)	0.45 (0.21, 0.97)	No change

<sup>a</sup> Based on a single study reporting smoking effect,

<sup>b</sup> Hilding et al. (2005) did not control for other tobacco use

<sup>c</sup> Gives excess weight to the Stockholm Diabetes Programme cohort

### 3.6.1.3.5 Conclusion criteria for Diabetes Incidence

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.16	-	0.25
Statistical Significance	Yes	-	Yes
Consistency of Direction/Magnitude of Included Studies	Yes.  All three studies above one.	-	NA
Consistency of Statistical Significance of Included Studies	Yes  No study is statistically significant	-	NA
Statistically significant heterogeneity	No	-	NA
Qualitative Assessment	Two moderate and	-	NA

	one strong study		
Sensitivity Analyses	Does not support main analysis.  Statistically non-significant results in analyses that preferred adjusted estimates	-	Does not support main analysis.  Statistically non-significant results in analyses that preferred adjusted estimates
Limitations	<ul style="list-style-type: none"> <li>Within study relative risk ratios not possible for any study.</li> </ul>		

### 3.6.1.3.6 Discussion of Diabetes Incidence

#### **Overall results**

The main analysis of this section summarized the effect estimates of diabetes incidence from three studies to obtain a statistically significant summary estimate of 1.16 (95% CI: 1.01-1.33) for snus users. Smokers within one of these studies had a statistically significant relative risk of 4.61 (95% CI: 1.37-15.51) based on the one study that reported an exclusive estimate. No within study comparisons of risks were possible. The comparison of summary estimates yielded a statistically significant relative risk ratio of 0.26 (95% CI: 0.07-0.86).

#### **The Effect of Snus**

Although our main analysis shows a statistically significant summary estimate for snus use above one, sensitivity analyses suggests inconsistency in statistical significance based on methodological choice. Preference for adjusted estimates resulted in a lack of statistical significance. There were no prior meta-analyses for comparison.

Four studies (Carlsson et al. 2017; Hilding et al. 2005; Ostenson et al. 2012; Rasouli et al. 2017) reported dose-exposures in snus users and found statistically significant risk for larger doses of snus. Hilding et al. (2005) reports statistically significant risk in larger doses of snus but does not perform a test of trend on the dose-exposure groups:  $\geq 4$  boxes/week OR=1.7 (95% CI: 0.8-3.4),  $\geq 5$  boxes/week OR=2.3 (95% CI: 1.1-4.9),  $\geq 6$  boxes/week OR=3.6 (95% CI: 1.6-8.1). Similarly, Ostenson et al. (2012) found snus users consuming  $> 5$  boxes per week had a statistically significant risk of 3.3 (95% CI: 1.4-8.1), which differed from the statistically non-significant results in the full cohort and in never-smokers. Similarly, Carlsson et al. (2017) reported statistically significant relative risk of 1.43 (95% CI: 1.15-1.79) for snus users consuming greater or equal to four boxes/week. In contrast to the above two studies, Rasouli et al. (2017) finds no statistically significant results for heavy snus users ( $\geq 5$  boxes per week) nor those with  $\geq 10$  box-years of ever snus among the whole cohort, never smokers, or ever smokers.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that the evidence for an effect of snus on diabetes incidence is *balanced/mixed*.

### ***The Effect of Smoking***

The analyses show consistently elevated risk for smokers, but inconsistency in statistical significance when adjusted estimates were preferred. This is not in line with previous knowledge of the adverse effects of smoking. The couple of studies that assess heavier users do show statistically significant results.

Two studies (Hilding et al. 2005; Ostenson et al. 2012) reported results for cigarette dose-exposure groups. Hilding et al. (2005) reported smokers of any dose had a statistically significant OR=2.0 (95% CI: 1.1-4.0), while smokers of greater than 10 cigarettes per day had a statistically significant OR=2.4 (95%). Ostenson et al. (2012) found no statistically significant results for consistent smokers of any dose, but did report statistically significant effects in smokers consuming greater than 15 cigarettes per day.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was not possible for any study as no study reported exclusive estimates between smokers and snus users.

On the other hand, the comparison of summary estimates suggests a statistically significant lower risk of diabetes incidence in snus users compared to smokers. The value for comparisons of summary estimates is statistically significant in all sensitivity analyses except for the sensitivity analysis that preferred adjusted estimates. The analysis of adjusted estimates, however oddly show a lack of statistically significant results for smokers.

Although both methods of comparing risk of diabetes in snus users compared to smokers consistently show a lower magnitude of risk for snus users, the statistical significance of this risk is unclear. Further cohort studies comparing risks in snus users and smokers will be necessary to determine if the observed lower risk in snus users is statistically significant.

## **3.6.2 Metabolic Syndrome**

### **3.6.2.1 Outcome comparability**

In this evaluation "metabolic syndrome" or "MetSy" refers to the International Diabetes Federation (IDF) definition as no studies reported an associated ICD code.

Four studies (Byhamre et al. 2017; Gustafsson et al. 2011b; Norberg et al. 2006; Wandell et al. 2008) identified in the systematic search related to metabolic syndrome. Only one study (Wandell et al. 2008) evaluated prevalence of metabolic syndrome. Due to lack of prevalence studies, a meta-analysis will only be performed for metabolic syndrome incidence. The results of Wandell et al. (2008) are presented in Appendix G and discussed in the qualitative review in this report and the prior 2013 Environ report. The remaining three studies (Byhamre et al. 2017; Gustafsson et al. 2011b; Norberg et al. 2006) evaluated incidence of metabolic syndrome. However, further review of Norberg et al. (2006) revealed that the IDF definition had slightly been modified to "not use the result of 2-h glucose testing in the case definition of MetSy according to IDF as this only added 9 women and 6 men at

follow-up". Evaluation of any differences due to this difference in case definition will be done through a sensitivity analysis excluding Norberg et al. (2006).

### **3.6.2.2 Comparability of studies for metabolic syndrome incidence**

The three cohort studies considered did not all have independent study populations and differed in selected methods of control for tobacco, available exposure characterizations, reference group specification, and control of confounders.

Three studies (Byhamre et al. 2017; Gustafsson et al. 2011b; Norberg et al. 2006) explicitly evaluated incidence of metabolic syndrome with an analysis of the Northern Swedish cohort and Vasterbotten Intervention Programme cohort. Exclusivity between study populations was not maintained for two studies (Byhamre et al. 2017; Gustafsson et al. 2011b) that each assessed the Northern Swedish cohort. Only one of these studies was included in the main analysis due to use of the same study population. Sensitivity analyses were conducted to assess the impact of study exclusion.

The method of control for tobacco use varied for each study. Byhamre et al. (2017) used stratification, Gustafsson et al. (2011b) used multivariate adjustment, and Norberg et al. (2006) did not adjust for other tobacco use. Furthermore, Byhamre et al. (2017) did not report on the effect in smokers, and no within study relative risks could be calculated in this meta-analysis. The impact of lack of control for tobacco in Norberg et al. (2006) will be discussed further to better interpret results.

The reported snus exposure characterization varied for all studies, however fixed-effect meta-analyses within studies improved comparability. Gustafsson et al. (2011b) reported on daily snuff use in men or women, but not overall<sup>a</sup>. Norberg et al. (2006) reported on daily snuff use  $\leq 4$  cans per week and  $> 4$  cans per week, but did not report an overall risk for daily snuff use. A fixed-effect meta-analysis was performed for each of these two studies to create an overall estimate for daily snuff use. Byhamre et al. (2017) uniquely reported risks of metabolic syndrome associated with exclusive snus use at four certain ages (16, 21, 30, and 43 years old) in a sensitive period model. Byhamre et al. (2017) also reported risks associated with the corresponding number of "periods" of exclusive snus use. A fixed-effect meta-analysis was performed using the exclusive strata in the cumulative snus model to obtain an estimate of risk for any *period* of snus use. Sensitivity analyses regarding the estimate from Byhamre et al. (2017) was performed to assess impact of a unique exposure characterization.

The exposure characterization for smokers varied similarly to variation in snus users. Gustafsson et al. (2011b) reported effects only in strata of men and women, which required a fixed effect meta-analyses to obtain an estimate for the overall population. Byhamre et al. (2017) did not report any smoking effect measures. Norberg et al. (2017) reported daily smoking effect estimates. No additional sensitivity analyses were performed due to lack of alternate exposure measures.

---

<sup>a</sup> Most of the study populations evaluated throughout this report contain only men, which preclude the need of any fixed-effect meta-analyses to combine studies that report only sex strata. However, studies of metabolic syndrome report an overall estimate necessitating the need to combine separate sex strata to improve comparability between studies.

Only Norberg et al. (2006) assessed snus doses, so a meta-analysis of dose-response effects was not possible. The dose-response results are included in the discussion section to better interpret meta-analyses results.

Reference groups for studies were either never tobacco user, no daily snuff/smoking, or no current snus use. Comparability between studies seemed reasonable.

All studies controlled for age and sex but differ in control for other possible risk factors. Other known risk factors include abdominal obesity, insulin resistance, physical inactivity, aging, hormonal imbalance and genetic predisposition (AHA 2014).

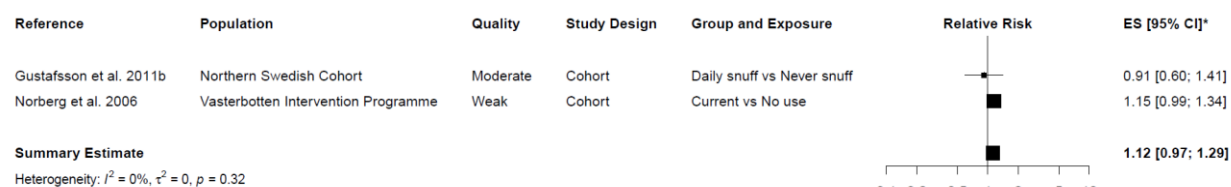
Main analyses will exclude the estimate from Byhamre et al. (2017) due to overlap with the study population in Gustafsson et al. (2011b) and its unique exposure characterization of any exposure in sensitive age periods. A sensitivity analysis including Byhamre et al. (2017) in lieu of Gustafsson et al. (2011b) will be performed as well as a sensitivity analysis that includes all three studies. Sensitivity analyses that exclude Norberg et al. (2006) due to lack of control for tobacco and a modified IDF case definition will not be possible as only one study would remain, however the impact will be further discussed.

### 3.6.2.3 Control for Confounders Table

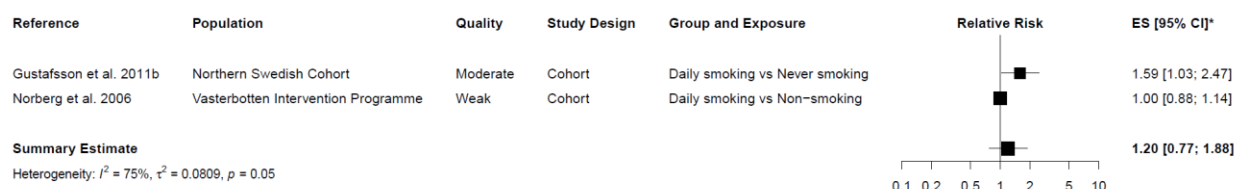
	Age	Sex	Weight / BMI	Physical activity	Family history	Impaired glucose metabolism	Race	Alcohol	BP	SES	Snus, Cigs
Gustafsson et al. 2011b	X	X	X	X				X	X	X	X
Norberg et al. 2006	X	X			X						
Wandell et al. 2008	X	X	X					X		X	X

### 3.6.2.4 Metabolic Syndrome Incidence (International Diabetes Federation Definition)

#### Metabolic Syndrome Incidence in Snus users



#### Metabolic Syndrome Incidence in Smokers



### Metabolic Syndrome Incidence in Snus users compared to Smokers



#### 3.6.2.5 Sensitivity Analysis Summary Table

Three sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to three key limitations of the main analyses: 1) Inappropriate preference for Gustafsson et al. (2011b), 2) Inappropriate exclusion of metabolic syndrome incidence studies, and 3) Inappropriate preference for random-effect meta-analyses.

Other limitations such as preference for adjusted estimates or ever exposure could not be assessed due to the low number of studies and their respective characteristics (see Appendix G for study details).

	Main Analysis	1) Alternative effect measure for Northern Swedish cohort (Replaced estimate of Gustafsson et al. 2011b with Byhamre et al. 2017)	2) All studies on MetSy Incidence	3) Fixed-effect meta-analyses <sup>d</sup>
Summary Estimate for Snus Users (95% CI)	1.12 (0.97, 1.29)	1.13 (0.99, 1.30)	1.11 (0.97, 1.26)	No changes
Summary Estimate for Cigarette Users (95% CI)	1.20 <sup>a</sup> (0.77, 1.88)	1.00 <sup>c</sup> (0.88, 1.14)	1.20 <sup>a</sup> (0.77, 1.88)	1.04 <sup>a</sup> (0.92, 1.18)
Summary Relative Risk Ratio (95% CI)	_ <sup>b</sup>	_ <sup>b</sup>	_ <sup>b</sup>	_ <sup>b</sup>
Comparison of Summary Estimates (95% CI)	0.93 (0.58, 1.49)	1.13 <sup>c</sup> (0.94, 1.37)	0.92 (0.58, 1.47)	1.08 (0.89, 1.31)

<sup>a</sup> Statistically significant heterogeneity, fixed-effects meta-analyses not appropriate

<sup>b</sup> No studies with exclusive within study estimates of snus users and smokers

<sup>c</sup> Only one smoker study

<sup>d</sup> These estimates overweight the results from the Northern Swedish cohort

#### 3.6.2.6 Conclusion criteria for Metabolic Syndrome Incidence

	Absolute Risk among Snus users compared to never snus user	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.12	-	0.93
Statistical Significance	No	-	No
Consistency of Direction/Magnitude of	No, One study is below one and	-	NA

Included Studies	the other above one		
Consistency of Statistical Significance of Included Studies	Yes, Each study is not statistically significant	-	NA
Statistically significant heterogeneity	No	-	NA
Qualitative Assessment	One moderate and one weak study	-	One moderate and one weak study in each meta-analysis
Sensitivity Analysis	Supports main analyses, all sensitivity analyses show a consistent magnitude with no statistical significance	-	Does not support main analyses
Reporting Bias	-	-	
Limitations	<ul style="list-style-type: none"> <li>All studies required fixed-effect meta-analyses to obtain a comparable estimate between studies.</li> <li>Norberg et al. (2006) had a lack of control for tobacco and a modified IDF case definition that impacts the summary estimate.</li> </ul>		

### 3.6.2.7 Discussion for Metabolic Syndrome Incidence

#### **Overall results**

The main analysis of this section summarized the effect estimates of metabolic syndrome from two cohort studies to obtain a statistically non-significant summary estimate of 1.12 (95% CI: 0.97-1.29) for snus users compared to no current snus use or never snus use. For smokers within these studies, a statistically non-significant summary estimate of 1.20 (95% CI: 0.77-1.88) was obtained. There is likely some confounding in these estimates as one study (Norberg et al. 2006) did not control for other tobacco use. Lack of exclusive snus and smoking exposure precluded calculation of within-study comparisons of risks. The comparison of summary estimates yielded a statistically non-significant summary estimate of 0.93 (95% CI: 0.58, 1.49).

#### **The Effect of Snus**

Sensitivity analyses show consistency in statistically non-significant results despite difference in methodological choices. Norberg et al. (2006) reported that exposure to greater than four snus cans per week had a statistically significant relative risk of 1.6 (95% CI: 1.26-2.15) compared to individuals not currently using snus. They also report no statistically significant effect for exposure to less than or equal to four snus cans per week 1.0 (95% CI: 0.85-1.22) compared to individuals not currently using snus. These results would seem to indicate that a certain level of exposure to snus may be needed before any effect. However, Norberg et al. (2006) also reported modifying the original IDF case definition of metabolic syndrome due to lack of cases reported. Consequently, the reported effect estimates in Norberg et al. (2006) do not reflect metabolic syndrome as defined in other studies. Interpreting what this modified IDF definition represents is beyond the scope of this study.

No prior meta-analyses were identified.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that the evidence for an effect of snus on diabetes incidence is limited/suggestive of no association.

### ***The Effect of Smoking***

The main analysis shows consistent statistically non-significant results. No prior U.S. cohorts assessing metabolic syndrome were identified to compare smoking effects seen in the selected studies.

### ***Comparison of Effects of Snus with Effects of Smoking***

Comparison of within study relative risks was not possible with any study.

The comparison of summary estimates was statistically non-significant in all analyses. More evidence with consistent definitions of metabolic syndrome and consistent exposures would be helpful in drawing further insight on the relationship between snus use and metabolic syndrome

## **3.7 All-Cause Mortality**

Qualitative evaluation of two epidemiology studies under the evidence integration guidelines and study quality ratings concluded that there was *limited/suggestive evidence of an association* between snus use and all-cause mortality.

### **3.7.1 Outcome Comparability**

In this evaluation, “all-cause mortality” refers to the overall mortality from all ICD8, ICD9, and ICD10 codes. The systematic search yielded two studies (Roosaar et al. 2008; Bolinder et al. 1994) related to all-cause mortality. Thus, only Roosaar et al. (2008) and Bolinder et al. (1994) had directly comparable outcomes based on designated ICD codes or given nominal definition.

### **3.7.2 Comparability of studies for all-cause mortality meta-analysis**

The two studies (Bolinder et al. 1994; Roosaar et al. 2008) considered had independent study population, similar methods of control for tobacco, but different available exposure characterizations, reference group specification, and control of confounders.

Bolinder et al. (1994) and Roosaar et al. (2008) evaluated all-cause mortality with an analysis of the Swedish Construction Worker cohort and Uppsala County cohort. Neither study were excluded from the main analysis.

Each study also included comparable methods of control for tobacco use. Bolinder et al. (1994) reported estimates for exclusive snus or smoker users, while Roosaar et al. (2008) reported stratified measures for only snus users. Roosaar et al. (2008) additionally reported adjusted estimates for smokers and snus users. The exclusive stratified estimates were prioritized for inclusion in the main analysis. Sensitivity analyses that preferred adjusted estimates was performed.

Exposure characterization of snus users and smokers varied within and between studies. Bolinder et al. (1994) reports current exposure for snus use and cigarette smokers, however reported separate



current cigarette user estimates based on smoking more or less than 15 cigarettes per day. These separate effect estimates were combined by fixed-effect meta-analysis to obtain an estimate for all current cigarette smokers comparable to the snus exposure. Roosaar et al. (2008) reported ever exposure to daily snus and daily smoking, however reported separate estimates for ever daily smokers based on age below or above 75 years old. These separate effect estimates were combined by fixed-effect meta-analysis to obtain an estimate for ever smokers comparable with ever snus exposure. There was no exposure characterization in common between studies.

No meta-analysis of dose- or duration-response exposures was considered because only Bolinder et al. (1994) reported results for smoking dose-exposure groups. These effects were briefly considered in the discussion section to better interpret the meta-analyses results.

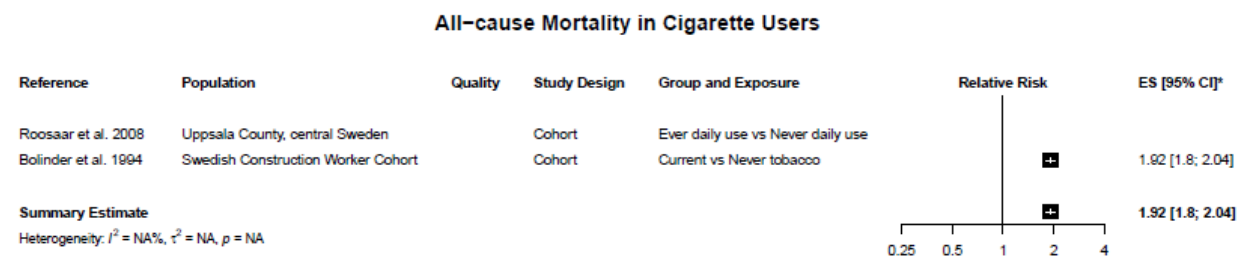
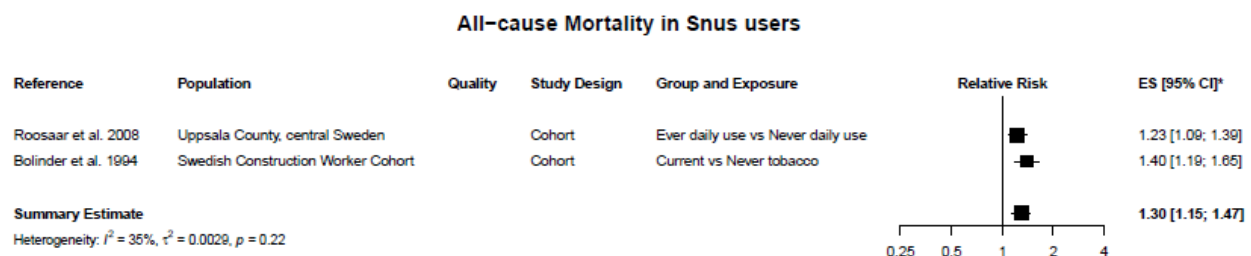
Bolinder et al. (1994) and Roosaar et al. (2008) have different but comparable reference groups. The reference group in Bolinder et al. (1994) is never-users of tobacco for smokers and snus users, while the reference group is never snus user or never smoker in Roosaar et al. (2008). As the stratified estimate for snus use among never smokers was selected in Bolinder et al. (1994), the reference group more closely represents never tobacco users.

Both studies controlled for age, sex, and geography, however Roosaar et al. (2008) additionally controlled for attained calendar period and alcohol consumption.

### 3.7.3 Control for Confounders Table

	Age	Sex	Area of residence/region of origin	Alcohol	Tobacco Use
Bolinder et al. 1994	X	X	X		X
Roosaar et al. 2008	X	X	X	X	X

### 3.7.4 All-Cause Mortality Meta-Analyses





### 3.7.5 Sensitivity Analysis Summary Table

Two sensitivity analyses were run to assess changes in summary estimates and risk comparisons in response to two key limitations of the main analysis: 1) Inappropriate preference for stratified estimates and 2) Inappropriate a priori decision to use random-effects meta-analysis. No additional sensitivity analysis was run as no alternative exposure characterizations were available, no studies were excluded, and all studies were cohort studies.

	Main Analysis of All-cause mortality	1) Preference for adjusted estimates when available	2) Fixed effects
Summary Estimate for Snus Users (95% CI)	1.30 (1.15, 1.47)	1.23 <sup>c</sup> (0.97, 1.56)	1.29 (1.17, 1.43)
Summary Estimate for Cigarette Users (95% CI)	1.92 <sup>a,b</sup> (1.8, 2.04)	1.75 <sup>b,c</sup> (1.45, 2.10)	No changes
Summary Relative Risk Ratio (95% CI)	0.73 <sup>a</sup> (0.61, 0.87)	No changes	No changes
Comparison of Summary Estimates (95% CI)	0.68 (0.59, 0.78)	0.70 (0.52, 0.95)	0.67 (0.60, 0.76)

<sup>a</sup> Only one study

<sup>b</sup> Both studies required a fixed effect meta-analyses for additional stratification of smoking by dose or age.

<sup>c</sup> Statistically significant heterogeneity, fixed effects meta-analyses is not methodologically appropriate

### 3.7.6 Conclusion criteria for all-cause mortality

	Absolute Risk among Snus users compared to Never/Non-users of tobacco	Comparative Risk among Snus users compared to Smokers	Comparison of Summary Estimates
Magnitude	1.30	0.73	0.68
Statistical Significance	Yes	Yes	Yes
Consistency of Direction/Magnitude of Included Studies	Yes, both studies above one	Only one study	NA

Consistency of Statistical Significance of Included Studies	Yes, both studies report statistically significance	Only one study	NA
Statistically significant heterogeneity	No	NA	NA
Qualitative Assessment	Two moderate studies	One moderate study	NA
Sensitivity Analysis	Does not support main analysis  Preference for adjusted estimates is statistically non-significant	Supports main analysis,  Statistical significance and magnitude remain the same	Supports main analysis,  Statistical significance and magnitude remain the same
Limitations	<ul style="list-style-type: none"> <li>• Different exposure characterizations: ever vs current and cigarette use vs. smoking</li> <li>• Single study of moderate quality to assess within study comparative risk</li> <li>• Few potential confounding factors were considered, with only one study controlling for alcohol consumption</li> </ul>		

### 3.7.7 Discussion of all-cause mortality

#### **Overall results**

The main analysis of this section summarized the all-cause mortality effect estimates from two studies to obtain a statistically significant summary estimate of 1.30 (95% CI: 1.15-1.47) for exclusive snus users. For smokers within these studies a statistically significant relative risk of 1.92 (95% CI: 1.8-2.04) was obtained based on one study. As both estimates represented exclusive snus use, residual confounding by smoking is unlikely. A statistically significant relative risk ratio of 0.73 (95% CI: 0.61-0.87) was obtained for within study comparisons of risk based on one study. The comparison of summary estimates yielded a comparable summary estimate of 0.68 (95% CI: 0.59-0.78).

These results are also in line with observed cigarette smoker dose-response effects in Bolinder et al. (1994), however no assessment of snus dose-response is attempted. Bolinder et al. (1994) reported on dose-response groups in smokers showing a larger effect estimate of 2.2 (95% CI: 2.0-2.4) in smokers consuming more than >15 cigarettes per day than the effect estimates of 1.7 (95% CI: 1.6-1.9) in those smoking less than 15 cigarettes per day but did not perform any analysis for statistical significance.

#### **The Effect of Snus**

The main analysis shows a statistically significant increased risk of mortality for exclusive snus users, however sensitivity analyses that preferred adjusted estimates suggests inconsistency in statistical significance. The use of different exposure characterizations may have influenced these results, but

heterogeneity between studies was low and statistically non-significant ( $I^2=35\%$ ,  $p=0.22$ ). These results are however limited by the low number of studies assessing all-cause mortality. An author of another meta-analysis (Lee 2011) previously stated "more evidence is clearly needed." Many health outcomes have been examined and updated for the Swedish Construction Worker cohort in several publications since the Bolinder et al. (1994) study was published, however, updated results for all-cause mortality have not been presented in any of these publications. There may also be some additional limitations in Roosaar et al. (2008), in which a significant excess risk of all-cause mortality among snus users may be due to confounding by other factors, such as smoking, or to exposure misclassification. As mentioned previously, a significant excess risk of respiratory death among snus users over age 80 was also observed in this cohort even though there is no known mechanism by which snus could cause respiratory disease.

A prior meta-analysis (Lee 2011) of all-cause mortality presents the exact same summary estimate of 1.30 (95% CI: 1.15-1.47). The lack of any difference is due to the use of the same studies, risk estimates, and random-effects meta-analysis. This highlights the need for more studies as no new studies have been identified since that time.

Overall, the quantitative evaluation supports the qualitative evaluation conclusion that available studies provide limited/suggestive evidence of an association between snus use and all-cause mortality.

### ***The Effect of Smoking/Cigarettes***

Our main analysis shows consistent statistically significant increases in the risk of stomach cancer in smokers/cigarette users compared to never tobacco or never smokers. This is in line with previous knowledge of adverse effects of smoking. The statistically significant effects of smoking on all-cause mortality in three major U.S cohorts are presented in Appendix G. The effect estimates for current male smokers in two studies (Friedman et al. 1997; USDHHS 1989) are 1.9 (95% CI: 1.7-2.2) and 2.34 (95% CI: 2.26-2.43). The remaining study (McLaughlin et al. 1995) presents an estimate of 1.7 (95% CI: 1.67-1.72) for overall current smokers. All of these estimates can be considered close to the summary estimate in this meta-analysis of 1.92 (95% CI: 1.8-2.04) for smokers/cigarette users. This provides some context supporting similar mortality effects of smoking tobacco products in the included studies.

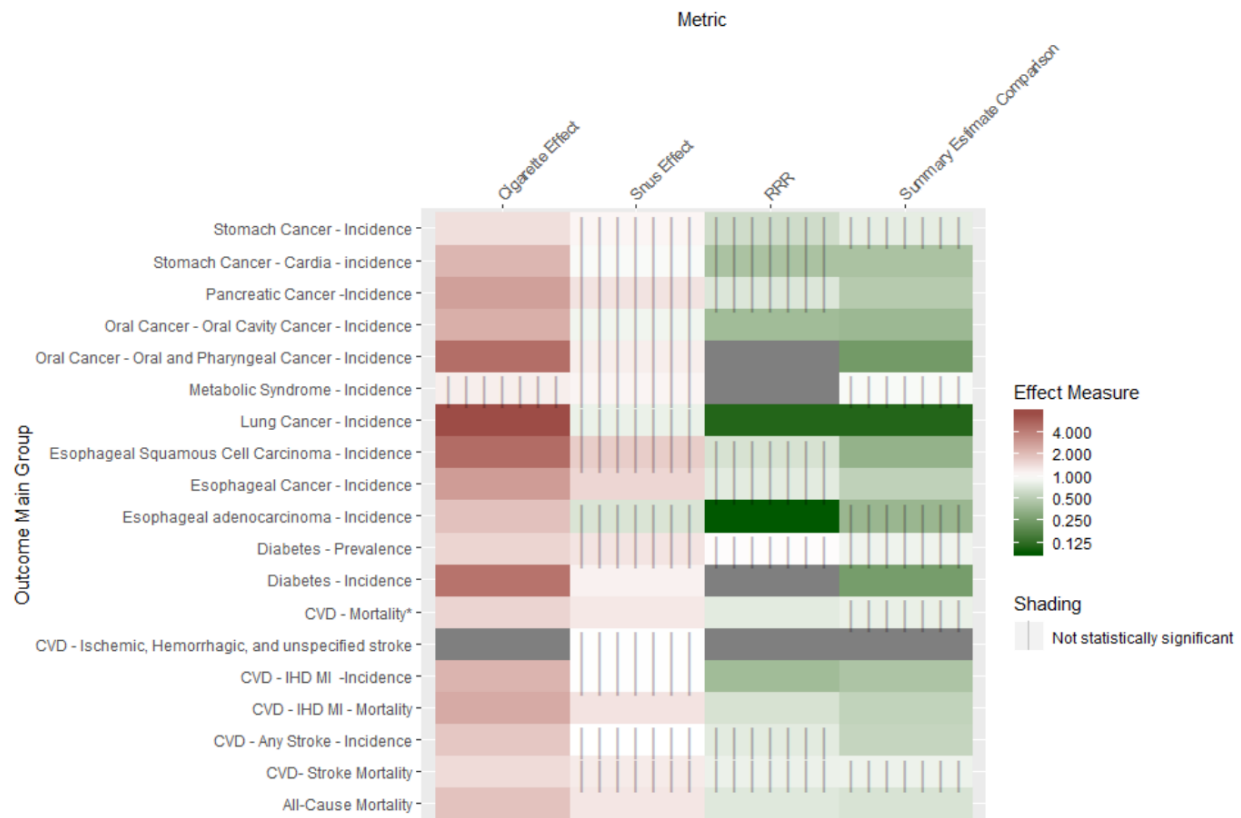
### ***Comparison of Effects of Snus with Effects of Smoking/Cigarettes***

Comparison of within study relative risks shows that the overall current evidence consisting of one study suggests a lower statistically significant risk of all-cause mortality in snus users compared to cigarette smokers. Generalizability of this estimate is limited due to use of only one study. However, this study is of moderate quality with a large sample size and the smoking estimate is comparable to smoking estimates in US cohorts.

The comparison of summary estimates also suggests a statistically significant lower risk of all-cause mortality in snus users compared to smokers/cigarette users. Comparison to only one cigarette effect estimate limits generalizability of this result, however the risk estimate for smokers is similar to previous studies in the U.S.

Overall both methods of comparing risk of all-cause mortality in snus users compared to smokers show a decreased statistically significant risk. Sensitivity analyses support these results for both methods. The limitation of availability of smoker effect measures within these studies is mitigated by similar effect measures seen in large U.S. cohort studies. Nevertheless, further evidence may help generalizability of results in this evaluation. The current evidence reviewed in this evaluation suggests an approximately 30% decreased risk of all-cause mortality in snus users compared to smokers.

### 3.8 Discussion and Graphical Summary of Results per Endpoint



Of the nineteen different endpoints, only one (metabolic syndrome incidence) reported statistically non-significant results for smokers. In contrast, most endpoints had evidence of statistically non-significant risk for snus users. Five endpoints (esophageal cancer, diabetes incidence, cardiovascular disease mortality, IHD/MI mortality, and all-cause mortality) provided evidence of statistically significant risk in snus users compared to never tobacco users. Notably, the magnitude of the risk in these five endpoints were closer to one than the corresponding magnitude of risk in smokers. The statistical significance of this observation was tested by comparing the relative risks in snus users who have never smoked to the relative risks in smokers who have never smoked within the same study. The resulting snus vs smoker estimates found a statistically significant lower risk of five endpoints (oral cancer incidence, lung cancer incidence, esophageal adenocarcinoma, IHD/MI incidence, IHD/MI mortality, and all-cause mortality) in snus users. These results from within study comparisons were supported by comparisons of the summary estimates. Comparison of snus and smoker summary estimates found a statistically significant lower risk of twelve endpoints (cardia stomach cancer incidence, pancreatic cancer incidence, oral cancer incidence, oral and pharyngeal cancer, lung cancer, esophageal squamous cell carcinoma, esophageal cancer, diabetes incidence, IHD/MI incidence, IHD/MI mortality, incidence of any stroke, and all-cause mortality) in snus users. The difference in statistical significance between the two types of comparisons likely result from the requirement of effect measures stratified by tobacco use for within study comparisons. Stratified effect measures

typically have wider confidence intervals due to using a subset of the study population. In contrast, the comparison of summary estimates included effect measures adjusted for other tobacco use. This typically provides more statistical power, although can be subject to residual confounding. Regardless of these differences, the overall results suggest evidence of no statistically significant difference in risk for snus users compared to never snus/tobacco, and evidence of a statistically significant lower risk in snus users compared to smokers for most of the endpoints. No analyses suggested that snus might be more harmful than cigarettes.

## 4. HEALTH RISKS OF DUAL USERS AND SWITCHERS COMPARED TO SMOKERS

### 4.1 Introduction

This section reviews the subset of studies that reported health effect estimates for snus users who concurrently smoke referred to as “dual users” or current snus users who have quit smoking referred to as “switchers”. The effect estimates for dual users and switchers will be compared to effect estimates for former smokers and current smokers. In cases when one or both smoking and snus exposures are noted as “ever” exposure, the term “ever dual user” will be used. This is a distinct exposure as it was unclear whether exposure was ever concurrent. As in section 3, the health outcomes considered for inclusion were those with the highest number of deaths attributable to smoking reported in table 3-1.

### 4.2 Methods

Studies identified in the systematic search were evaluated for inclusion of effect estimates for dual users or switchers. The health outcomes considered for inclusion were those with the highest number of deaths attributable to smoking as in table 3-1. Diabetes, metabolic syndrome, AML, and all-cause mortality were also considered for inclusion. Effect estimates were extracted and compared to within study effect estimates for smokers. Results for switchers were additionally compared to results for former smokers.

As in Section 3, we intended to perform a meta-analysis when at least two studies reported on the same outcome. However, no new studies since the Ramboll 2013 report were identified for the majority of endpoints, and no outcome except for cardiovascular disease had sufficient studies to conduct meta-analyses. However, meta-analyses and comparisons between switchers or dual users with smokers have been performed previously (Lee 2013; Lee 2014). Additionally, these meta-analyses typically perform tests of multiplicative interaction or statistically compare risks in switchers or dual users to smokers. These prior results were referenced in this evaluation in lieu of new meta-analyses and comparisons.

The prior meta-analyses do a standard comparison between relevant exposure groups to compare risks statistically or derive estimates not reported explicitly in the study. For example, Lee (2014) notably derives RR/OR estimates from covariate-adjusted cross-tables to obtain the relevant effect measures to assess interaction. In cases when covariate-adjusted RRs were not provided, unadjusted estimates were calculated directly from numbers of cases and controls. In some cases, Lee (2014) derived estimates from estimates of ever snus among never smokers and an estimate of ever snus among the whole population. Interaction tests in Lee (2014) examined whether the proportional increase in risk associated with snus is greater in smokers than in non-smokers. Specifically, Lee (2014) assessed “whether the proportional increase in risk associated with snus is greater in smokers than in non-smokers (or equivalently whether the proportional increase in risk associated with smokers is greater in snus users than that associated with smoking in non-users of snus), i.e. whether there is any special hazard associated with dual use.”



## 4.3 Oral and Pharyngeal Cancer

### 4.3.1 Overview of evidence compared to previous report

The previous report identified only Schildt et al. (1998b) as related to oral cancer risk for dual users and switchers. No new studies reported oral and pharyngeal cancer effect estimates in dual users or switchers since the 2013 ENVIRON report. Schildt et al. (1998b) is represented in comparative meta-analyses for dual users and switchers published by Lee (2013; 2014). Notably, Lee (2014) reported dual user effect estimates derived from Roosaar et al. (2008) that they did not report explicitly. The discussion of results from Lee (2013; 2014) was integrated with a more comprehensive discussion of Schildt et al. (1998b).

### 4.3.2 Outcome comparability

The two studies (Schildt et al. 1998b; Roosaar et al. 2008) identified in the systematic search differed in outcome specificity. Roosaar et al. (2008) included outcomes reported as ICD7: 140-148 that corresponds to "oral and pharyngeal cancer", while Schildt et al. (1998b) included outcomes reported as ICD7: 140, 141, 143, 144, 145 that correspond to the subset of "oral cancer". Consequently, these studies and study results were assessed separately.

### 4.3.3 Results for oral and pharyngeal cancer incidence in dual users

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests (95% CI)
Lee et al. (2014) <i>unadjusted</i> estimates from Roosaar et al. (2008)	Reference: Ever-exclusive smoker  Ever dual user: 3.66 (1.45-9.24)	Reference: Never smoker/snuff  Ever snus users: 2.30 (0.70-8.30)	<i>Interaction term for ever dual users</i>  1.59 (0.34-7.46)

### 4.3.4 Discussion/Conclusion of oral and pharyngeal cancer incidence

The one study (Roosaar et al. 2008) that considered oral and pharyngeal cancer incidence did not report effect measures for dual users or switchers in their paper. However, Lee (2014) estimated the risk for dual users compared to exclusive smokers using the reported results in the Roosaar et al. (2008) study. Lee (2014) found a statistically significant 3.66 (95% CI: 1.45-9.24) relative risk of oral and pharyngeal cancer compared to ever-exclusive smokers. Lee (2014) reported no evidence of multiplication interaction based on an interaction term of 1.59 (0.34-7.46). In other words, the change in risk associated with dual use is not statistically significantly different from risk observed in snus users.

The secondary analyses of results reported in Roosaar et al. (2008) provide some evidence indicating an increased risk in ever dual users compared to smokers. Lee (2014) also notes that statistically non-significant multiplicative interaction term indicating the reported relative risk in dual users was not statistically significantly different from the relative risk in ever snus users. The wide confidence intervals suggest a lack of statistical power and a need for more studies intended to gauge interaction between these exposures.

## 4.4 Oral cancer

### 4.4.1 Results for oral cancer incidence

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests (95% CI)
Schildt et al. (1998b)	Reference: Never smoker/snuff Current dual users: 1.2 (0.6-2.4) Low consumption: 1.0 (0.4-2.1) High consumption: 2.3 (0.9-5.6) Switchers: 0.6 (0.3-1.3)	Reference: Never smoker/snuff Active exclusive snus user: 0.7 (0.4-1.2) Low consumption: 0.8 (0.4-1.6) High consumption: 1.3 (0.6-2.6) Active exclusive smokers: 1.7 (1.1-2.6) Low consumption: 1.2 (0.7-1.9) High consumption: 1.8 (1.1-2.9) Former exclusive smokers: 0.9 (0.6-1.4)	
Lee (2013; 2014) <i>unadjusted estimates from Schildt et al. (1998b)</i>	Reference: Current exclusive smoker Current dual user: 0.40 (0.17-0.93)  Reference: Ever-exclusive smoker Ever dual user: 0.73 (0.45-1.19)  Reference: Never tobacco Switchers: 0.77 (0.34-1.79)	Reference: Non-current smoker/snuff Current snus users: 0.86 (0.51-1.44)  Reference: Never smoker/snuff Ever snus users: 1.20 (0.67-2.15)  Reference: Never tobacco Current smokers: 1.78 (1.22-2.62) Former smokers: 0.94 (0.61-1.44)	<i>Interaction term for current dual users</i> 0.47 (0.17-1.26)  <i>Interaction term for ever dual users</i> 0.61 (0.29-1.30)  <i>Switchers vs. smokers:</i> 0.43 (0.18-1.02)  <i>Switchers vs. former smokers:</i> 0.83 (0.34-1.99)

### 4.4.2 Discussion

#### ***Effects in dual users and comparisons to smokers***

Based on one study (Schildt et al. 1998b) the risk of incident oral cancer for dual users was statistically non-significant compared to individuals that have never smoked or used snus. They also found statistically non-significant results for "high consumption" and "low consumption" dual users. High consumption refers to greater than 156.0 kg of life consumption for oral snuff and greater than 124.8 kg for smoking tobacco.

In contrast, the risk for smokers in the same study was a statistically significant 1.7 (95% CI: 1.1-2.6) compared to never compared to individuals that have never smoked or used snus. Based on the additional analysis by Lee (2014) of results in Schildt et al. (1998b), risks for dual users were also statistically non-significant compared to either ever exclusive smokers or current exclusive smokers. Additionally, Lee (2014) reported no statistically change in relative risk of dual users compared to the relative risks in smokers indicating no evidence of multiplicative interaction.

### ***Effects in switchers and comparisons to smokers***

Based on one study (Schildt et al. 1998b) the risk of incident oral cancer for switchers was statistically non-significant compared to individuals that have never smoked or used snus. Similarly, the risk for former smokers was statistically non-significant.

In contrast, the risk for smokers in the same study was a statistically significant 1.7 (95% CI: 1.1-2.6) compared to never compared to individuals that have never smoked or used snus. Additional analyses by Lee (2013) found statistically non-significant results for switchers compared to smokers and for switchers compared to former smokers.

### ***Conclusion***

No study reported statistically significant results for dual users compared to current smokers, ever smokers, or individuals that have never smokers or used snus. There was also no evidence of multiplicative interaction between smoking and snus use.

No study reported statistically significant results for switchers compared to current smokers, former smokers, never tobacco users, or individuals that have never smoked or used snus.

## **4.5 Esophageal Cancer**

### **4.5.1 Overview of evidence compared to previous report**

The previous report identified only Zendehdel et al. (2008) as related to esophageal cancer risk for dual users. No new studies that reported esophageal cancer effect estimates for dual users or switchers were published since the 2013 ENVIRON report. However, Zendehdel et al. (2008) was represented in a comparative meta-analysis for dual users published by Lee (2014). Notably, Lee (2014) reported dual user effect estimates derived from Zendehdel et al. (2008) that they did not report explicitly. The discussion of results from Lee (2014) was integrated with a more comprehensive discussion of Zendehdel et al. (2008).

### **4.5.2 Outcome considerations**

Zendehdel et al. (2008) reported effect measures for adenocarcinoma and squamous cell carcinoma subtypes of esophageal cancer. "Esophageal cancer" refers to the overall range of disease outcomes represented by ICD7,8,9-150. In Zendehdel et al. (2008), identification of the outcome is defined by ICD-150 before division into esophageal subtypes based on histological code. These subtypes were combined through a fixed-effect meta-analysis to obtain an effect estimate for dual users of overall esophageal cancer.

### 4.5.3 Results for Esophageal cancer

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests (95% CI)
Zendejdel et al. (2008)	<p><i>Adenocarcinoma among ever-smokers:</i> Reference: Non-user of snus User of snus (Dual user): 1.3 (0.8-2.0)</p> <p><i>Squamous cell carcinoma among ever-smokers:</i> Reference: Non-user of snus User of snus (Dual user): 1.2 (0.8-1.7)</p> <p><i>Esophageal cancer among ever-smokers*:</i> Reference: Non-user of snus User of snus (Dual user): 1.24 (0.93-1.66)</p>	<p><i>Adenocarcinoma among never-smokers</i> Reference: Never users of any tobacco User of snus only: 0.2 (0.0-1.9)</p> <p><i>Squamous cell carcinoma among never smokers:</i> Reference: Never users of any tobacco User of snus only: 3.5 (1.6-7.6)</p> <p><i>Adenocarcinoma:</i> Reference: Never-users of any tobacco Exclusive ever smokers: 2.3 (1.4-3.7) Exclusive Current smokers: 2.9 (1.8-4.8) Previous exclusive smoker: 1.2 (0.6-2.4)</p> <p><i>Squamous cell carcinoma:</i> Reference: Never-users of any tobacco Exclusive Ever smokers: 5.2 (3.1-8.6) Exclusive Current smokers: 7.6 (4.5-12.7) Previous exclusive smoker: 0.9 (0.4-2.0)</p>	
Lee (2014) age-standardized estimates from Zendejdel et al. (2008)	<p><i>Adenocarcinoma</i> Reference: Ever-exclusive smoker Ever dual user: 1.00 (0.60-1.50)</p> <p><i>Squamous cell carcinoma</i> Reference: Ever-exclusive smoker Ever dual user: 0.80 (0.60-1.20)</p>	<p><i>Adenocarcinoma</i> Reference: Never users of any tobacco Ever snus users: 0.20 (0.02-1.90)</p> <p><i>Squamous cell carcinoma</i> Reference: Never users of any tobacco Ever snus users: 3.50 (1.60-7.60)</p>	<p><i>Adenocarcinoma</i> Interaction term for ever dual users: 5.00 (0.50-49.74)</p> <p><i>Squamous cell carcinoma</i> Interaction term for ever dual users: 0.23 (0.10-0.54)</p>
* Estimated through fixed-effect meta-analysis of both estimates			

### 4.5.4 Discussion of esophageal cancer

#### *Effects in dual users compared to smokers*

Based on Zendejdel et al. (2008) the risk of incident esophageal cancer and its subtypes were statistically non-significant in ever dual users compared to non-users of snus among ever smokers. In contrast, the risk for exclusive ever and current smokers compared to never tobacco users were statistically significant within the same study. Additionally, Lee (2014) compared ever dual users to ever exclusive smokers in Zendejdel et al. (2008) and found statistically non-significant results for esophageal cancer subtypes. In an interaction test, Lee (2014) found statistically non-significant results for adenocarcinoma, but statistically significant lower risk of squamous cell carcinoma for dual users compared to risk in smokers. There was a statistically significant change in the relative risk of 0.23 (95% CI: 0.10-0.54) for ever dual users compared to the relative risk in smokers. As prior knowledge links smoking to esophageal cancer, it is unclear why results for dual users would be significantly lower. Others have suggested that dual users may consume less smoking tobacco than exclusive smokers, however no evidence of lower smoking tobacco consumption was presented in the selected study.

### **Conclusion**

No study reported statistically significant results for ever dual users compared to non-users of snus among ever smokers or compared to exclusive ever smokers. There was also no evidence of multiplicative interaction between smoking and snus use for risk of adenocarcinoma, however there was evidence of multiplicative interaction for risk of squamous cell carcinoma. This latter result provides possible support of lower consumption of smoking tobacco by dual users, however no evidence regarding consumption was presented in the selected study.

## **4.6 Pancreatic Cancer**

### **4.6.1 Overview of evidence compared to previous report**

The previous report identified only Boffetta et al. (2005) as related to pancreatic cancer risk for dual users. No new studies that reported pancreatic cancer effect estimates for dual users or switchers were published since the 2013 ENVIRON report. Unlike other endpoints, Boffetta et al. (2005) is not represented in a comparative meta-analysis for dual users published by Lee (2014). This may be due to the lack of effect measures for exclusive smokers that prevents statistical comparison, as well as a lack of reported incidence rates and person years for the exposures of interest that prevents derivation of missing effect measures. The results from Boffetta et al. (2005) were assessed in a more comprehensive manner than previously.

### **4.6.2 Study considerations**

Boffetta et al. (2005) reported risk of pancreatic cancer incidence in ever dual users compared to never or occasional snus users.

### **4.6.3 Results for Pancreatic cancer**

<b>Reference</b>	<b>Effect measures for Exposures of interest (95% CI)</b>	<b>Effect measures for snus users, smokers, and former smokers (95% CI)</b>
Boffetta et al. (2005)	Reference: Never or occasional user of snus Ever regular snus/former smoker: 1.37	Reference: Never or occasional user of snus Ever regular snus/never smoker: 0.85

	(0.59-3.17) Ever regular snus/current smoker: 1.86 (1.13-3.05)	(0.24-3.07)
--	--	-------------

#### 4.6.4 Discussion of pancreatic cancer incidence

##### *Effects in dual users compared to snus users*

Based on Boffetta et al. (2005), the relative risk of incident pancreatic cancer for ever dual users was a statistically significant 1.86 (95% CI: 1.13-3.05) compared to never regular users of snus. Boffetta et al. (2005) did not report relative risks in exclusive smokers but does report a statistically non-significant 0.85 (95% CI: 0.24-3.07) relative risk for exclusive snus users compared to never regular snus users. The statistically significant risk in dual users may be driven by smokers as the results for exclusive snus users indicate no increase in risk. Additionally, the effect measure for dual users overlaps the confidence interval for exclusive snus users. This suggests a statistically significant difference in relative risks between the two groups is unlikely.

The previous 2013 ENVIRON report also discussed results from Bertuccio et al. (2011). Bertuccio et al. (2011) is a pooled analysis of 11 international case-control studies and of cigarette and western population smokeless tobacco users. In this study, dual users and exclusive smokeless tobacco users did not face a significantly increased risk of pancreatic cancer, whereas the risk of pancreatic cancer was significantly increased among smokers. Given that the smokeless tobacco used by participants in these studies likely contained higher levels of TSNA compared to Swedish snus, the principal component of tobacco thought to be associated with the development of pancreatic cancer (Boffetta et al. 2008), it is unlikely that Swedish snus poses a risk for pancreatic cancer. However, this study does not meet our criteria for Swedish snus use in this report.

##### **Conclusion**

One study reported statistically significant increased risk for ever dual users compared to never regular snus users. No comparisons with smokers was possible due to lack of reported effect measures. The effect measure for dual users overlaps the confidence interval for snus users suggesting the relative risk in ever dual users may not statistically differ multiplicatively from the relative risk in exclusive snus users.

#### 4.7 Stomach Cancer

##### 4.7.1 Overview of evidence compared to previous report

The previous report identified two studies (Ye et al. 1999; Zendehdel et al. 2008) that reported stomach cancer effect measures for dual users. No new studies that reported stomach cancer effect estimates for dual users or switchers were published since the 2013 ENVIRON report. Each of these studies were represented in a comparative meta-analysis for dual users published by Lee (2014). Notably, Lee (2014) derived additional estimates from studies to assess dual use, as well as compare them to within study estimates of relevant comparison groups. Additionally, Lee (2013) reports an estimate for "switchers" from Ye et al. (1999), however this does not meet the definition for switchers in this report as it evaluates former smokers who ever used snus rather than current snus users who

formerly smoked. The discussion of results from Lee (2014) was integrated with a more comprehensive discussion of Zendehdel et al. (2008) and Ye et al. (1999).

#### 4.7.2 Outcome considerations

In this report, “stomach cancer” refers to the overall range of disease outcomes represented by ICD7,8,9: 151 and ICD10: C16. This encompasses studies of cardia and non-cardia stomach cancer. Studies differed in reporting on specific subtypes of stomach cancer and overall stomach cancer. Ye et al. (1999) reported dual user effect measures of overall stomach cancer only, while Zendehdel et al. (2008) reported dual user effect measures of stomach cancer subtypes only. In Zendehdel et al. (2008), identification of the outcome is defined by ICD-151 before division into stomach cancer subtypes. These subtypes were combined through a fixed-effect meta-analysis to obtain an effect estimate for overall stomach cancer.

#### 4.7.3 Results for Stomach cancer and its subtypes

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests (95% CI)
Zendehdel et al. (2008)	<p><i>Cardia stomach cancer among ever-smokers:</i> Reference: Non-user of snus User of snus (Dual user): 1.1 (0.8-1.6)</p> <p><i>Non-cardia stomach cancer among ever-smokers:</i> Reference: Non-user of snus User of snus (Dual user): 1.0 (0.9-1.2)</p> <p><i>Stomach cancer among ever-smokers*:</i> Reference: Non-user of snus User of snus (Dual user): 1.01 (0.89- 1.16)</p>	<p><i>Cardia stomach cancer among never-smokers</i> Reference: Never users of any tobacco User of snus only: 0.9 (0.4-2.0)</p> <p><i>Non-cardia stomach cancer among never smokers:</i> Reference: Never users of any tobacco User of snus only: 1.4 (1.1-1.9)</p> <p><i>Cardia stomach cancer among full cohort:</i> Reference: Never-users of any tobacco Exclusive ever smokers: 2.1 (1.5-3.0) Exclusive Current smokers: 2.3 (1.6-3.3) Previous exclusive smoker: 1.8 (1.2-2.7)</p> <p><i>Non-cardia stomach cancer among full cohort:</i> Reference: Never-users of any tobacco Exclusive Ever smokers: 1.3 (1.2-1.6) Exclusive Current smokers: 1.4 (1.2-1.6) Previous exclusive smoker: 1.3 (1.1-1.5)</p>	
Lee (2014)	<i>Cardia stomach cancer</i>	<i>Cardia stomach cancer</i>	<i>Cardia stomach</i>

<i>age-standardized estimates from Zendeheel et al. (1998)</i>	Reference: Ever-exclusive smoker Ever dual user: 0.90 (0.70-1.30)  <i>Non-cardia stomach cancer</i> Reference: Ever-exclusive smoker Ever dual user: 1.00 (0.90-1.20)	Reference: Never users of any tobacco Ever exclusive snus: 0.9 (0.4-2.0)  <i>Non-cardia stomach cancer</i> Reference: Never users of any tobacco Ever exclusive snus: 1.4 (1.1-1.9)	<i>cancer</i> Interaction term for ever dual users: 1.00 (0.42-1.37)  <i>Non-cardia stomach cancer</i> Interaction term for ever dual users: 0.71 (0.52-0.97)
Ye et al. (1999)	<i>Stomach cancer among full cohort:</i> Reference: Never smoker/never snuff Ever snuff user/Current smoker: 1.0 (0.5-1.8)	<i>Stomach cancer among full cohort:</i> Reference: Never smoker/never snuff Current exclusive smoker: 2.0 (1.3-2.9) Previous exclusive smoker: 1.2 (0.8-1.9) Exclusive ever snuff user: 0.5 (0.2-1.2)	
Lee (2014) <i>unadjusted estimates from Ye et al. (1999)</i>	<i>Stomach cancer among full cohort:</i> Reference: Ever-exclusive smoker Ever snuff user/Ever smoker: 0.80 (0.57-1.13) <sup>#</sup>	<i>Stomach cancer among full cohort:</i> Reference: Never snuff/smoker Ever exclusive snus: 0.50 (0.20-1.22)	<i>Stomach cancer</i> Interaction term for ever dual users: 1.60 (0.61-4.18)
* Estimated through fixed-effect meta-analysis of both estimates # Calculated based on Table VII using cases and controls			

#### 4.7.4 Discussion of stomach cancer

##### ***Effects in dual users compared to smokers***

The results from three studies (Ye et al. 1999; Zendeheel et al. 2008; Lee 2014) did not indicate an increased risk of stomach cancer or its subtypes for dual users compared to non-users of snus, ever exclusive smokers, or individuals that have never smoked or used snus. In contrast, the risk in ever and current exclusive smokers within these studies was statistically significantly elevated. Additionally, interaction tests by Lee (2014) do not indicate a statistically significant change in the relative risk of stomach cancer or cardia stomach cancer for dual users compared to the relative risks in smokers. However, Lee (2014) reported a statistically significant 0.71 (95% CI: 0.52-0.97) change in the relative risk of non-cardia stomach cancer for dual users compared to the relative risk in smokers. This provides some evidence for multiplicative interaction in risk of non-cardia stomach cancer

##### ***Conclusion***

No study reported statistically significant results for ever dual users compared to non-users of snus, ever exclusive smokers, or individuals that have never smoked or used snus. There was some evidence of multiplicative interaction between smoking and snus use for risk of non-cardia stomach cancer. As prior knowledge links smoking to stomach cancer, it is unclear why risk in dual users would



be significantly lower than the risk in exclusive smokers. Others have suggested that dual users consume less smoking tobacco than exclusive smokers, however no evidence of lower smoking tobacco consumption was presented in the selected study.

## 4.8 Lung Cancer

### 4.8.1 Overview of evidence compared to previous report

The previous report identified only Boffetta et al. (2005) as related to lung cancer risk for dual users. No new studies that reported lung cancer effect estimates for dual users or switchers were published since the 2013 ENVIRON report. Unlike other endpoints, Boffetta et al. (2005) was not represented in a comparative meta-analysis for dual users published by Lee (2014). This may be due to the lack of reported effect measures for exclusive smokers that prevents statistical comparison. As well as a lack of reported incidence rates and person years for the exposures of interest that prevents derivation of missing effect measures. The results from Boffetta et al. (2005) are assessed in a more comprehensive manner than previously.

### 4.8.2 Study considerations

Boffetta et al. (2005) reported risk of lung cancer incidence in ever dual users compared to never or occasional snus users.

### 4.8.3 Results for Lung cancer

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)
Boffetta et al. (2005)	<p>Reference: Never or occasional user of snus</p> <p>Ever regular snus/former smoker: 0.64 (0.24-1.68)</p> <p>Ever regular snus/current smoker: 0.68 (0.51-0.90)</p>	<p>Reference: Never or occasional user of snus</p> <p>Ever regular snus/never smoker: 0.96 (0.26-3.56)</p>

### 4.8.4 Discussion of Lung cancer

#### *Effects in dual users compared to snus users*

Based on Boffetta et al. (2005), the relative risk of incident pancreatic cancer for ever dual users was a statistically significant 0.68 (95% CI: 0.51-0.90) compared to never regular users of snus. Boffetta et al. (2005) did not report relative risks in exclusive smokers but does report a statistically non-significant 0.85 (95% CI: 0.96-3.56) relative risk for exclusive snus users compared to never regular snus users. The available estimates suggest that ever regular snus users who currently smoke have a

lower risk of lung cancer compared to never regular snus users. The lower and significant effect in dual users is not consistent with knowledge on the risks of smoking. Notably, Boffetta et al. (2005) control for amount of tobacco smoking but the study could be underestimating risk due to a lack of consideration of other confounders as discussed in Section 3. Additionally, the effect estimates for ever dual users overlapped the confidence interval for exclusive ever snus users suggesting that differences in relative risk between these two groups may not be statistically significant.

## **Conclusion**

One study reported a statistically significant *decreased* risk for dual users compared to never regular snus users. No comparisons with smokers was possible due to lack of reported effect measures. The effect measure for dual users overlaps the confidence interval for snus users suggesting the relative risk in ever dual users may not statistically differ multiplicatively from the relative risk in exclusive snus users.

## **4.9 Chronic cardiovascular disease**

### **4.9.1 Overview of evidence compared to previous report**

The previous report identified four studies (Hansson et al. 2009; Hergens et al. 2005; Johansson et al. 2005; Wennberg et al. 2007) that reported risk estimates related to cardiovascular disease for switchers and six studies (Haglund et al. 2007; Hansson et al. 2009; Hergens et al. 2005; Huhtasaari et al. 1999; Johansson et al. 2005; Wennberg et al. 2007) that reported risk estimates for dual users. No new studies that reported cardiovascular disease related outcomes with corresponding risk estimates for dual users or switchers were published since the 2013 ENVIRON report. Each of these studies were represented in comparative meta-analyses by Lee (2013; 2014). Lee (2013) included a risk comparison estimate that compared switchers to current smokers. Lee (2014) compared dual users to smokers and assessed interaction between smoking and snus use. Notably, Lee (2014) reported dual user effect estimates derived from Huhtasaari et al. (1992) that they did not report explicitly. The discussion of results from Lee (2013; 2014) was integrated with a discussion of the results.

### **4.9.2 Outcome considerations**

The four studies (Hansson et al. 2009; Hergens et al. 2005; Johansson et al. 2005; Wennberg et al. 2007) that reported risk estimates for switchers differed in outcome specificity. Only Hansson et al. (2009) reported incidence of overall cardiovascular disease. All four studies (Hansson et al. 2009; Hergens et al. 2005; Johansson et al. 2005; Wennberg et al. 2007) reported incidence of ischemic heart disease and myocardial infarction. Two studies (Hergens et al. 2005; Wennberg et al. 2007) additionally reported IHD and MI mortality.

The seven studies (Haglund et al. 2007; Hansson et al. 2009; Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Johansson et al. 2005; Wennberg et al. 2007) that reported risk estimates for dual users differed in outcome specificity. All seven studies evaluated IHD incidence, however, only three studies (Haglund et al. 2008; Hergens et al. 2005; Wennberg et al. 2007) evaluated IHD mortality in dual users.

One study (Wennberg et al. 2007) assessed sudden cardiac death (SCD) in less than 24 hours and in less than an hour in dual users and switchers.

### 4.9.3 Results for cardiovascular disease related outcomes

#### 4.9.3.1 Overall cardiovascular disease

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests or comparison (95% CI)
Hansson et al. (2009)	<p>Reference: Never snus and never smoking</p> <p>Current Dual users: 1.51 (0.86-2.65)</p> <p>Switchers: 1.04 (0.78-1.39)</p>	<p>Reference: Never snus and never smoking</p> <p>Exclusive current smokers: 1.86 (1.56-2.22)</p> <p>Exclusive former smokers: 1.17 (1.00-1.38)</p> <p>Exclusive current snus: 1.00 (0.69-1.46)</p>	
Lee (2014) estimates from Hansson et al. (2009)	<p>Reference: Exclusive current smokers</p> <p>Current dual users 0.81 (0.46-1.43)</p> <p>Reference: Exclusive ever smokers</p> <p>Ever dual users: 0.91 (0.75-1.11)</p> <p>Reference: Never snus and never smoking</p> <p>Switchers: 1.04 (0.78-1.39)</p>	<p>Reference: Neither current snus or current smoker</p> <p>Exclusive current snus: 0.93 (0.74-1.17)</p> <p>Reference: Neither ever snus or ever smoker</p> <p>Exclusive ever snus: 1.07 (0.79-1.45)</p>	<p>Interaction term for current dual users:</p> <p>0.87 (0.47-1.60)</p> <p>Interaction term for ever dual users:</p> <p>0.85 (0.59-1.22)</p> <p>Switchers vs. current smokers: 0.56 (0.41-0.75)</p> <p>Switchers vs. former</p>

			smokers:  0.89 (0.67-1.19)
--	--	--	----------------------------------

#### 4.9.3.2 Incidence of Ischemic Heart Disease and Myocardial Infarction

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests or comparison (95% CI)
Hansson et al. (2009)	Reference: Never snus and never smoking  Current Dual users: 1.50 (0.73-3.08)  Switchers: 1.22 (0.82-1.74)	Reference: Never snus and never smoking  Exclusive current smokers: 1.99 (1.59-2.50)  Exclusive former smokers: 1.34 (1.10-1.64)  Exclusive current snus: 0.85 (0.51-1.41)	
Haglund et al. (2007)	Reference: No tobacco  Current Dual user: 1.64 (0.96-2.79)	Reference: No tobacco  Current exclusive smoker: 1.74 (1.41-2.14)  Current exclusive snuff: 0.77 (0.51-1.15)	
Hergens et al. (2005)	Reference: Never snus and never smoker  Switchers: 1.60 (1.10-2.20)  Current dual users: 2.30 (1.6-3.4)	Reference: Never snus and never smoker  Exclusive current smokers: 2.8 (2.3-3.4)  Exclusive former smokers 1.31 (1.1-1.6)  Exclusive current snus: 0.73 (0.35-1.5)	

Huhtasaari et al. (1999) (unadjusted)	Reference: Never tobacco  Current dual users: 2.66 (1.24-5.71)	Reference: never tobacco:  Current smoker, no current snuff use: 3.65 (2.67-4.99)  Former smoker, never used snuff: 1.05 (0.77-1.43)  Current snuff user, no current smoking: 0.96 (0.65-1.41)	
Johansson et al. (2005)	Reference: Never-smoker  Switcher: 1.18 (0.67-2.06)  Current dual user: 2.73 (1.35-5.53)	Reference: Never-smoker  Daily smoker: 2.30 (1.66-3.19)  Daily snuffer: 1.41 (0.61-3.28)	
Wennberg et al. (2007)	Reference: Never used tobacco  Switchers: 1.25 (0.80-1.96)  Current Dual Users: 2.14 (1.28-3.60)	Reference: Never used tobacco  Exclusive current smokers: 2.60 (1.91-3.54)  Exclusive former smokers: 1.18 (0.82-1.70)  Exclusive current snuff: 0.82 (0.46-1.43)	
Lee (2014) estimates from Haglund et al. (2007)	Reference: Exclusive current smokers  Current dual users 0.94 (0.56-1.59)	Reference: Neither current snus or current smoker  Exclusive current snus: 0.77 (0.51-1.15)	Interaction term for current dual users:  1.22 (0.63-2.37)
Lee (2014) estimates from Hansson et al. (2009)	Reference: Exclusive current smokers  Current dual users 0.75 (0.36-1.55)  Reference: Exclusive ever smokers	Reference: Neither current snus or current smoker  Exclusive current snus: 0.90 (0.67-1.21)  Reference: Neither ever snus or ever smoker	Interaction term for current dual users:  0.83 (0.38-1.82)  Interaction

	<p>Ever dual users: 0.95 (0.74-1.22)</p> <p>Reference: Never snus and never smoker</p> <p>Switcher: 1.22 (0.82-1.74)</p>	<p>Exclusive ever snus: 0.92 (0.61-1.39)</p>	<p>term for ever dual users:</p> <p>1.03 (0.64-1.67)</p> <p>Switchers vs. current smokers: 0.61 (0.42-0.90)</p> <p>Switchers vs. former smokers:</p> <p>0.91 (0.63-1.32)</p>
<p>Lee (2013; 2014) estimates from Hergens et al. (2005)</p>	<p>Reference: Exclusive current smokers</p> <p>Current dual users 0.80 (0.55-1.16)</p> <p>Reference: Exclusive ever smokers</p> <p>Ever dual users: 0.99 (0.80-1.22)</p> <p>Reference: Never snus and never smoker</p> <p>Switcher: 1.60 (1.10-2.20)</p>	<p>Reference: Neither current snus or current smoker</p> <p>Exclusive current snus: 1.21 (0.89-1.63)</p> <p>Reference: Neither ever snus or ever smoker</p> <p>Exclusive ever snus: 0.87 (0.48-1.55)</p> <p>Reference: Never snus and never smoker</p> <p>Exclusive current smokers: 2.8 (2.3-3.4)</p>	<p>Interaction term for current dual users:</p> <p>0.66 (0.41-1.07)</p> <p>Interaction term for ever dual users:</p> <p>1.14 (0.62-2.13)</p> <p>Switchers vs current smokers:</p> <p>0.57 (0.40-0.81)</p>

			Switchers vs former smokers:  1.23 (0.87-1.73)
Lee (2014) estimates from Huhtasaari et al. (1992)	Reference: Exclusive current smokers  Current dual users 0.68 (0.40-1.17)	Reference: Neither current snus or current smoker  Exclusive current snus: 0.79 (0.54-1.13)	Interaction term for current dual users:  0.87 (0.45-1.67)
Lee (2014) estimates from Huhtasaari et al. (1999)	Reference: Exclusive current smokers  Current dual users 0.73 (0.34-1.57)	Reference: Neither current snus or current smoker  Exclusive current snus: 0.96 (0.65-1.41)	Interaction term for current dual users:  0.76 (0.32-1.80)
Lee (2013; 2014) estimates from Johansson et al. (2005)	Reference: Exclusive current smokers  Current dual users 1.19 (0.60-2.37)  Reference: Never snus and never smoker  Switcher: 1.18 (0.67-2.06)	Reference: Neither current snus or current smoker  Exclusive current snus: 0.99 (0.63-1.56)  Reference: Never snus and never smoker  Exclusive current smokers: 2.3 (1.66-3.19)	Interaction term for current dual users:  1.20 (0.52-2.73)  Switchers vs current smokers: 0.51 (0.30-0.88)  Switchers vs former smokers:

			0.80 (0.47-1.38)
Lee (2013; 2014) estimates from Wennberg et al. (2007)	<p>Reference: Exclusive current smokers</p> <p>Current dual users 0.82 (0.48–1.40)</p> <p>Reference: Never snus and never smoker</p> <p>Switcher: 1.25 (0.80-1.96)</p>	<p>Reference: Neither current snus or current smoker</p> <p>Exclusive current snus: 1.00 (0.71–1.43)</p> <p>Reference: Never snus and never smoker</p> <p>Exclusive current smokers: 2.60 (1.91-3.54)</p>	<p>Interaction term for current dual users:</p> <p>0.82 (0.43–1.55)</p> <p>Switchers vs current smokers: 0.48 (0.30-0.76)</p> <p>Switchers vs former smokers:</p> <p>1.06 (0.64-1.75)</p>
Lee (2014) meta-analyses of IHD/CHD/AMI estimate of change in relative risk in dual users compared to smokers.			0.85 (0.68-1.05)
Lee (2013) meta-analyses of IHD/CHD/AMI in switchers vs. current smokers based on Hansson et al. (2009), Hergens et al. (2005), Johansson et al. (2005), Wennberg et al. (2007)			Switchers vs current smokers: 0.55 (0.45-0.68)
Lee (2013) meta-analyses of IHD/CHD/AMI in switchers vs. former smokers based on Hansson et al. (2009), Hergens et al. (2005), Johansson et al. (2005), Wennberg et al. (2007)			Switchers vs former smokers: 1.02 (0.83-1.26)

#### 4.9.3.3 Mortality related to Ischemic Heart Disease and Myocardial Infarction

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests or comparison (95% CI)



Haglund et al. (2007)	Reference: No tobacco  Current Dual user: 1.69 (0.52-5.46)	Reference: No tobacco  Current exclusive smoker: 1.98 (1.35-2.91)  Current exclusive snuff: 1.15 (0.54-2.41)	
Hergens et al. (2005)	Reference: Never snus and never smoker  Switchers: 1.50 (0.69-3.20)  Current dual users: 3.80 (1.9-7.5)	Reference: Never snus and never smoker  Exclusive current smokers: 3.6 (2.4-5.2)  Exclusive former smokers: 1.7 (1.6-2.6)  Exclusive current snus: 1.7 (0.49-5.5)	
Wennberg et al. (2007)	Reference: Never used tobacco  Switchers: 1.24 (0.44-3.53)  Current Dual Users: 1.11 (0.34-3.69)	Reference: Never used tobacco  Exclusive current smokers: 3.53 (1.83-6.84)  Exclusive former smokers: 1.02 (0.45-2.31)  Exclusive current snuff: 1.12 (0.38-3.29)	
Lee (2014) estimates from Haglund et al. (2007)	Not provided	Not provided	Interaction term for current dual users:  0.74 (0.19-2.97)
Lee (2013; 2014) estimates from Hergens et	Mortality estimates not provided  Reference: Never snus and never	Mortality estimates not provided  Reference: Never snus and never	Interaction term for current dual users:

al. (2005)	<p>smoker</p> <p>Switcher: 1.50 (0.69-3.20)</p>	<p>smoker</p> <p>Exclusive current smokers: 3.60 (2.40-5.20)</p>	<p>0.89 (0.36-2.18)</p> <p>Interaction term for ever dual users:</p> <p>0.50 (0.16-1.58)</p> <p>Switchers vs current smokers:</p> <p>0.42 (0.20-0.86)</p> <p>Switchers vs former smokers:</p> <p>0.88 (0.42-1.87)</p>
Lee (2013; 2014) estimates from Wennberg et al. (2007)	<p>Mortality estimates not provided</p> <p>Reference: Never snus and never smoker</p> <p>Switcher: 1.24 (0.44-3.53)</p>	<p>Mortality estimates not provided</p> <p>Reference: Never snus and never smoker</p> <p>Exclusive current smokers: 3.53 (1.83-6.84)</p>	<p>Interaction term for current dual users:</p> <p>0.25 (0.06-1.03)</p> <p>Switchers vs current smokers: 0.35 (0.12-1.02)</p>

			Switchers vs former smokers:  1.22 (0.38- 3.90)
--	--	--	--

#### 4.9.3.4 Other cardiovascular disease outcomes

Reference	Outcome	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests or comparison (95% CI)
Hergens et al. (2005)	Non-fatal AMI	Reference: Never smoke and never snus  Switchers: 1.60 (1.10-2.20)  Current dual user: 2.1 (1.4-3.1)	Reference: Never tobacco  Current smokers: 2.70 (2.20-3.30)  Former smokers: 1.20 (0.98-1.50)	
Wennberg et al. (2007)	SCD with survival <24 hr	Reference: Never tobacco  Switchers: 1.39 (0.44-4.42)  Current dual user: 0.75 (0.17-3.28)	Reference: Never tobacco  Current smokers: 3.12 (1.53-6.33)  Former smokers: 0.74 (0.28-1.97)	
	SCD with survival <1 hr	Reference: Never tobacco  Switchers: 2.67 (0.52-13.80)  Current dual user: 0.13 (0.01-2.10)	Reference: Never tobacco  Current smokers: 4.54 (1.55-13.25)  Former smokers: 0.35 (0.07-1.78)	
Lee (2013) estimates from	Non-fatal AMI	Reference: Never tobacco	Reference: Never tobacco	Switchers vs. current smokers: 0.59 (0.42-

Hergens et al. (2005)		Switchers: 1.60 (1.10-2.20)	Current smokers: 2.70 (2.20-3.30)  Former smokers: 1.20 (0.98-1.50)	0.83)  Switchers vs. former smokers:  1.33 (0.94-1.88)
Lee (2013;) estimates from Wennberg et al. (2007)	SCD with survival <24 hr	Reference: Never tobacco  Switchers: 1.39 (0.44-4.42)	Reference: Never tobacco  Current smokers: 3.12 (1.53-6.33)  Former smokers: 0.74 (0.28-1.97)	Switchers vs. current smokers:  0.45 (0.14-1.45)  Switchers vs. former smokers:  1.88 (0.48-7.27)
	SCD with survival <1 hr	Reference: Never tobacco  Switchers: 2.67 (0.52-13.80)	Reference: Never tobacco  Current smokers: 4.54 (1.55-13.25)  Former smokers: 0.35 (0.07-1.78)	Switchers vs. current smokers:  0.59 (0.10-3.53)  Switchers vs. former smokers:  7.63 (0.42-137.8)

#### 4.9.4 Discussion

##### ***Effects in dual users and comparisons to smokers***

Based on one study (Hansson et al. 2009), the risk of overall cardiovascular disease for dual users was a statistically non-significant 1.51 (95% CI: 0.86-2.65) compared to never users of snus and smoking tobacco. In contrast, exclusive current smokers in the same study had a statistically significant elevated risk of 1.86 (95% CI: 1.56-2.22) compared to never users of snus and smoking tobacco. Additionally, Lee (2014) reported no statistically significant change in relative risk for current or ever dual users compared to the relative risks in smokers indicating no evidence of multiplicative interaction in the study population from Hansson et al. (2009).

The incident risk of ischemic heart disease and myocardial infarction in dual users was assessed in seven studies (Haglund et al. 2007; Hansson et al. 2009; Hergens et al. 2005; Huhtasaari et al. 1992; Huhtasaari et al. 1999; Johansson et al. 2005; Wennberg et al. 2007). Two studies (Hansson et al.

2009; Haglund et al. 2007) reported statistically non-significant results for current dual users compared to never snus/smoker or no tobacco users. Additionally, Lee (2013) reported statistically non-significant results of current dual users compared to current smokers in the study population from Huhtasaari et al. (1992). The remaining four studies all had statistically significant results above a relative risk of two for current dual users compared to never-smokers, never/no tobacco, or never snus/smoker reference groups. All of these studies reported statistically significant results for exclusive smokers and statistically non-significant results for exclusive snus users. Importantly, Lee (2014) calculated relative risks for current dual users compared to current smokers in each study and found statistically non-significant results for each study. Lee (2014), also reported no statistically significant change in relative risk for current or ever dual users compared to relative risks in smokers indicating no evidence of multiplicative interaction in any of these study populations. The summary estimate for interaction reported by Lee (2014) was a statistically non-significant 0.85 (95% CI: 0.68-1.05). Overall, these results indicate a possible increase in risk of IHD and MI incidence in dual users compared to never tobacco users, but consistent evidence of no difference in risk between dual users and smokers.

The risk of fatal ischemic heart disease and myocardial infarction in dual users was assessed in three studies (Haglund et al. 2008; Hergens et al. 2005; Wennberg et al. 2007). Only Hergens et al. (2005) had a statistically significant increased risk in current dual users compared to never snus/smoker. For comparison, each of these studies reported statistically significant results for exclusive smokers and statistically non-significant results for exclusive snus users. Importantly, Lee (2014) reported no statistically significant change in the relative risk for current or ever dual users compared to the relative risks in smokers indicating no evidence of multiplicative interaction in any of these study populations. Overall, these results indicate a mixed evidence of an increase in risk of IHD and MI mortality in dual users compared to never tobacco users, but consistent evidence of no difference in risk between dual users and smokers.

### ***Effects in switchers and comparisons to smokers***

Based on one study (Hansson et al. 2009), the risk of overall cardiovascular disease for switchers was a statistically non-significant 1.04 (95% CI: 0.78-1.39) compared to never users of snus and smoking tobacco. In contrast, exclusive current smokers in the same study had a statistically significant elevated risk of 1.86 (95% CI: 1.56-2.22) compared to never users of snus and smoking tobacco. Former smokers had a statistically non-significant risk of 1.17 (95% CI: 0.69-1.46). Additionally, Lee (2013) reported a statistically significant relative risk of 0.56 (95% CI: 0.41-0.75) for switchers compared to current smokers in the study population from Hansson et al. (2009). Lee (2013) reported a statistically non-significant relative risk of 0.89 (95% CI: 0.67-1.19) for switchers compared to former smokers in the study population from Hansson et al. (2009). These results suggest evidence of a significant decline in risk of incident cardiovascular disease for switchers compared to current smokers.

The incident risk of ischemic heart disease and myocardial infarction in switchers was assessed in four studies (Hansson et al. 2009; Hergens et al. 2005; Johansson et al. 2005; Wennberg et al. 2007). Only Hergens et al. (2005) reported statistically significant increased results for switchers compared to never snus/smokers. For comparison, each of these studies reported statistically significant results for exclusive smokers. Two out of the four studies (Hansson et al. 2009; Hergens et al. 2005; Huhtasaari et al. 1999; Wennberg et al. 2007) that reported effect measures for former smokers had statistically

significant increased risk. Importantly, Lee (2013) calculated relative risks for switchers compared to current smokers and found statistically significant results lower risks in switchers for each study. The summary estimate of switchers compared to current smokers reported by Lee (2013) was a statistically significant 0.55 (95% CI: 0.45-0.68). Lee (2013) also calculated relative risks for switchers compared to former smokers and found statistically non-significant risks for each study. The summary estimate of switchers compared to former smokers reported by Lee (2013) was a statistically non-significant 1.02 (95% CI: 0.83-1.26). Overall, these results provide mixed evidence of an increase in risk of IHD and MI incidence in switchers compared to never tobacco users. The studies provide consistent evidence of a significant decline in risk of incident ischemic heart disease and myocardial infarction in switchers compared to current smokers, as well as a consistently non-significant risk for switchers compared to former smokers.

The risk of fatal ischemic heart disease and myocardial infarction in switchers was assessed in two studies (Hergens et al. 2005; Wennberg et al. 2007). No studies reported statistically significant results for switchers compared to never snus/smokers. In contrast, each of these studies reported statistically significant results for exclusive smokers and one study (Hergens et al. 2005) reported statistically significant increased risk for former smokers. Importantly, Lee (2013) calculated relative risks for switchers compared to exclusive smokers and found statistically significant lower risks in switchers compared to current smokers for each study. Lee (2013) found statistically non-significant risks in switchers compared to former smokers. No summary estimate was calculated for risk of fatal ischemic heart disease and myocardial infarction in switchers. Overall these results provide consistent evidence of no association between switchers and fatal IHD/MI, consistent evidence of significant decline in risk in switchers compared to current smokers, and consistent evidence of no risk in switchers compared to former smokers.

### ***Other cardiovascular disease outcomes***

One study (Wennberg et al. 2007) assessed sudden cardiac death in less than 24 and in less than an hour in current dual users and switchers. Wennberg et al. (2007) reported statistically non-significant risk of these outcomes in switchers, current dual users, and former smokers compared to never tobacco users. In contrast, smokers had statistically significant elevated risk of both outcomes. Additionally, Lee (2013) reported statistically non-significant risk of both outcomes in switchers compared to current smokers or former smokers using the results from Wennberg et al. (2007). Notably, the confidence intervals of each effect measure discussed above is fairly wide suggesting a need for a larger sample size.

One study (Hergens et al. 2005) assessed nonfatal myocardial infarction in current dual users and switchers. They found a statistically significant elevated risk of nonfatal myocardial infarction in dual users and switchers compared to individuals who have never smoked or used snus. They reported a 1.60 (95% CI: 1.10-2.20) relative risk for switchers and a 2.1 (95% CI: 1.4-3.1) for current dual users. For comparison, they reported a statistically significant relative risk of 2.70 (95% CI: 2.20-3.30) in current smokers and a statistically non-significant relative risk of 1.20 (95% CI: 0.98-1.50) in former smokers compared to individuals who have never smoked or used snus. Using these effect estimates from Hergens et al. (2005), Lee (2013) compared switchers to current smokers and found a statistically significant lower relative risk of 0.59 (95% CI: 0.42-0.83). Lee (2013) reported a statistically non-significant risk in switchers compared to former smokers. No statistical comparison between current smokers and dual users was performed by Lee (2014). The effect estimate for

smokers overlaps the confidence interval for dual users. This suggests no statistically significant change in the relative risk of dual users compared to smokers.

## **Conclusion**

### *Overall cardiovascular disease*

One study reported a statistically nonsignificant risk of overall cardiovascular disease for ever dual users compared to non-users of snus among ever smokers or compared to never users of snus and smoking tobacco. There was also no evidence of multiplicative interaction between smoking and snus use. The same study suggests evidence of a significant decline in risk of incident cardiovascular disease for switchers compared to current smokers.

### *Incident IHD and MI*

The results of seven studies provide mixed evidence of a possible increase in risk of IHD and MI incidence in dual users compared to never tobacco users but provide consistent evidence of no difference in relative risk between dual users and smokers.

The results of four studies provide mixed evidence of an increase in risk of IHD and MI incidence in switchers compared to never tobacco users. The studies provide consistent evidence of a significant decline in risk of incident ischemic heart disease and myocardial infarction in switchers compared to current smokers, as well as a consistently non-significant risk for switchers compared to former smokers.

### *Fatal IHD and MI*

The results of three studies provide mixed evidence of an increase in risk of IHD and MI mortality in dual users compared to never tobacco users, but consistent evidence of no difference in relative risk between dual users and smokers.

The results of two studies provide consistent evidence of no association between switchers and fatal IHD/MI, consistent evidence of significant decline in risk in switchers compared to current smokers, and consistent evidence of no risk in switchers compared to former smokers.

### *Other cardiovascular disease outcomes*

Based on one study (Wennberg et al. 2007), there is no evidence for risk of SCD < 24 hr or SCD <1 hr in switchers and current dual users compared to never tobacco users or current smokers.

Based on one study (Hergens et al. 2005), there is evidence of increased risk of nonfatal myocardial infarction in switchers and current dual users compared to individuals who have never smoked or used snus. However, there is also evidence of a significant lower risk in switchers compared to current smokers. There is no evidence of an increased risk in switchers compared to former smokers or in dual users compared to current smokers.

## 4.10 Incident stroke and mortality

### 4.10.1 Overview of evidence compared to previous report

The 2013 ENVIRON report identified only one study (Hansson et al. 2009) that reported risk estimates of stroke for switchers and two studies (Haglund et al. 2007; Hansson et al. 2009) that reported risk estimates for dual users. No new studies that reported stroke risk estimates for dual users or switchers were published since the 2013 ENVIRON report. Each of these studies were represented in comparative meta-analyses by Lee (2013; 2014). Lee (2013) included a risk comparison estimate for Hansson et al. (2009) that compared switchers to continuers (continued smokers). Lee (2014) similarly assesses whether any statistically significant interaction occurs for dual users compared to smokers. The discussion of results from Lee (2013; 2014) was integrated with a discussion of the results.

### 4.10.2 Outcome considerations

Haglund et al. (2007) had a broad outcome definition of any stroke corresponding to ICD9: 430-438, while Hansson et al. (2009) had a more restricted outcome definition corresponding to ICD9: 430-431, 434-436. Additionally, Haglund et al. (2007) was the only study to report effect measures for fatal stroke. Both studies reported measures for incident stroke.

### 4.10.3 Results for Stroke

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests or comparison (95% CI)
Hansson et al. (2009)	Reference: Never snus and never smoking  Current Dual users: 1.45 (0.58-3.62)  Switchers: 0.77 (0.46-1.29)	Reference: Never snus and never smoking  Exclusive current smokers: 1.61 (1.22-2.13)  Exclusive former smokers: 1.01 (0.78-1.30)  Exclusive current snus: 1.18 (0.67-2.08)	
Haglund et al. (2007)	<i>Incidence</i>  Reference: No tobacco  Current dual users: 1.98	<i>Incidence</i>  Reference: No tobacco  Current exclusive smokers: 1.40 (1.03-1.91)  Current exclusive snuff	



	(1.00-3.95)  <i>Mortality</i>  Reference: No tobacco  Current dual users: 4.30 (1.22-15.1)	users: 1.07 (0.65-1.77)  <i>Mortality</i>  Reference: No tobacco  Current exclusive smokers: 1.02 (0.50-2.05)  Current exclusive snuff users: 1.01 (0.35-2.92)	
Lee (2013) reported risk estimates from Hansson et al. (2009)	Reference: Never snus and never smoker  Switcher: 0.77 (0.46-1.29)	Reference: Never snus and never smoker  Current exclusive smoker: 1.61 (1.22-2.13)	Switchers vs current smokers: 0.48 (0.28-0.82)  Switchers vs former smokers: 0.76 (0.45-1.28)
Lee (2014) reported risk estimates from Hansson et al. (2009)	Reference: Exclusive smokers  Current dual users: 0.90 (0.36-2.27)  Ever dual users: 0.83 (0.59-1.16)	Reference: Never snus and never smoker  Current exclusive snus user: 0.89 (0.61-1.31)  Ever exclusive snus user: 1.24 (0.78-1.97)	Interaction term for current dual users: 1.01 (0.37-2.73)  Interaction term for ever dual users: 0.67 (0.38-1.19)
Lee (2014) reported risk estimates from Haglund et al. (2007)	<i>Incidence</i>  Reference: Exclusive smokers  Current dual users: 1.41 (0.71-2.83)	<i>Incidence</i>  Reference: No tobacco  Current snus user: 1.07 (0.65-1.77)	<i>Incidence</i>  Interaction term for current dual users: 1.32 (0.56-3.11)  <i>Mortality</i>  Interaction term for current

			dual users
			4.17 (0.78-22.36)

#### 4.10.4 Discussion of Stroke

##### ***Effects in dual users and comparisons***

Based on two studies (Haglund et al. 2007; Hansson et al. 2009), the risk of incident stroke for dual users was statistically non-significant compared to smokers or never-users of snus and smoking tobacco. The risk for current smokers within the same studies, however were statistically significantly elevated. Additionally, Lee (2014) reported no statistically significant change in relative risk for dual users compared to relative risks in smokers indicating no evidence of multiplicative interaction.

The one study (Haglund et al. 2007) that considered fatal stroke in dual users reported a statistically significant relative risk of 4.30 (1.22-15.1) compared to non-tobacco users. In contrast with prior knowledge, Haglund et al. (2007) reported a statistically non-significant 1.02 (0.50-2.05) relative risk in current smokers compared to non-tobacco users. However, Lee (2014) found no statistically significant change in relative risk for dual users compared to relative risks in smokers indicating no evidence of multiplicative interaction. The three fatal stroke cases in Haglund et al. (2007) likely contribute to the wide confidence intervals for risk of fatal stroke as the risk of fatal stroke in smokers within this study were not significantly elevated.

##### ***Effects in switchers and comparisons***

In the one study (Hansson et al. 2009) that considered switchers, the risk of incident stroke in switchers was statistically non-significant compared to never-users of snus and smoking tobacco. The risk for current smokers were statistically significantly elevated. Additionally, Lee (2013) compared switchers in Hansson et al. (2009) to current smokers in the same study and found a statistically significant lower risk of 0.48 (95% CI: 0.28-0.82) in switchers compared to current smokers. Lee (2013) also found a statistically non-significant risk of 0.76 (95% CI: 0.45-1.28) in switchers compared to former smokers

##### ***Conclusion***

Except for statistically significant results for fatal stroke in dual users, no study reported statistically significant results for dual users or switchers compared to non-users. There were also no statistically significant differences in either incident or fatal stroke risk in dual users when compared to smokers. There was a statistically significant lower risk of incident stroke in switchers compared to current smokers within the same study, but statistically non-significant results for switchers compared to former smokers.

#### 4.11 Metabolic Effects: Diabetes and Metabolic syndrome

##### 4.11.1 Overview of evidence compared to previous report

The previous report discussed only Wandell et al. (2008) as related to risk of diabetes and metabolic syndrome for dual users and switchers. The 2013 ENVIRON report also identified Eliasson et al. (2004)

as related to diabetes but did not discuss the results for switchers reported in the study. Only one related new study (Rasouli et al. 2017) that reported risk of diabetes in dual users has been published since the 2013 ENVIRON report. This study however evaluates two distinct study populations. No new studies related to metabolic syndrome risk in dual users or switchers was identified. Wikstrom et al. (2010b) is represented in a comparative meta-analysis for dual users published by Lee (2014). Notably, Lee (2014) report dual user effect estimates derived from Wikstrom et al. (2010b) that they did not report explicitly. The discussion of results from Lee (2014) was integrated with the other relevant studies

#### 4.11.2 Metabolic Syndrome

##### 4.11.2.1 Metabolic syndrome study considerations

The one study that reported risk of metabolic syndrome in dual users considered three definitions of metabolic syndrome, however in this report “metabolic syndrome” refers to the International Diabetes Federation (IDF) definition. Only results for IDF-defined metabolic syndrome were considered here.

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)
Wandell et al. (2008)	Reference: Never smoke or snuff  Switcher: 1.18 (0.76-1.83)  Current snuffer/smoker: 0.85 (0.36-2.02)	Reference: Never smoke or snuff  Current exclusive snuffer: 1.81 (0.65-5.02)  Exclusive Ex-smoker: 1.44 (1.14-1.83)  Current exclusive smoker: 1.00 (0.74-1.35)

##### 4.11.2.2 Results and Discussion for Metabolic Syndrome

In a cross-sectional study of 60-year old Swedish men, Wandell et al. (2008) found no statistically significant results for current dual users, switchers, current exclusive snuffers, or current exclusive smokers compared to never smokers/snuffers. The only statistically significant result reported is for exclusive ex-smokers who have a prevalence odds ratio of 1.44 (95% CI: 1.14-1.83). This effect estimate overlaps the confidence interval for switchers and dual users suggesting no statistically significant risk difference between these groups. The generalizability of results is greatly limited as the study is only of 60-year old Swedish men.

#### Conclusion

The evidence for metabolic syndrome is limited to one prevalence study that indicates no increased risk in switchers, dual users, current smokers, or current snus users compared to never smokers/snuffers among 60-year old Swedish men. Comparison of confidence intervals suggests no statistically significant risk of switchers compared to former smokers.

### 4.11.3 Diabetes

#### 4.11.3.1 Diabetes' study consideration

Three studies (Eliasson et al. 2004; Rasouli et al. 2017; Wandell et al. 2008) assessed Type II diabetes as defined previously in this report. Two studies (Wandell et al. 2008; Rasouli et al. 2017) assessed diabetes prevalence, and two studies (Rasouli et al. 2017; Eliasson et al. 2017; Lee 2014) assessed incident diabetes. Lee (2014) derives estimates of risk for current dual users from Wikstrom et al. (2010b).

The results for diabetes prevalence and incidence are presented separately.

#### 4.11.3.2 Results for Diabetes

Reference	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests (95% CI)
Wandell et al. (2008)	<i>Prevalence:</i>  Reference: Never smoke or snuff  Switcher: 1.71 (0.67-4.35)  Current snuffer/smoker: 2.48 (0.52-11.82)	<i>Prevalence:</i>  Reference: Never smoke or snuff  Current exclusive snuffer: 2.12 (0.25-17.71)  Exclusive Ex-smoker: 1.41 (0.76-2.60)  Current exclusive smoker: 1.40 (0.68-2.89)	
Rasouli et al. (2017)  <i>ESTRID matched case-control</i>	<i>Among ever smokers:</i>  Reference: Never snus  Current snus/ever smoker: 0.91 (0.39-1.01)	<i>Among never smokers:</i>  Reference: Never snus  Exclusive current snus: 1.17 (0.58-2.37)	
Rasouli et al. (2017)  <i>HUNT cross-sectional</i>	<i>Prevalence:</i>  <i>Among ever smokers:</i>  Reference: Never snus  Ever dual user: 0.86 (0.70-	<i>Prevalence:</i>  <i>Among never smokers:</i>  Reference: Never snus  Exclusive ever snus:	

	1.07)	1.12 (0.72-1.72)	
Eliasson et al. (2004)	Reference: Consistent no tobacco  Smokers who switched to snus: 3.25 (0.78-13.6)	Reference: Consistent no tobacco  Consistent exclusive snus users: 0 cases  Consistent exclusive smokers: 4.61 (1.37-15.5)  Ex-smokers: 3.13 (1.13-8.67)	
Lee (2014) estimates from Wikstrom et al (2010b)	Reference: Current Smoker  Current Dual user: 0.88 (0.42-0.84)	Reference: No tobacco  Current Snuff: 0.93 (0.76-1.14)	Interaction term for current dual users:  0.95 (0.44-2.04)

#### 4.11.3.3 Discussion of Diabetes

##### ***Diabetes Prevalence***

Based on two studies (Wandell et al. 2008; Rasouli et al. 2017) the prevalence of diabetes in ever or current dual users was statistically non-significant compared to individuals that have never smoked or used snus. Similarly, Wandell et al. (2008) reported statistically non-significant prevalence in current smokers compared to individuals that have never smoked or used snus. No studies reported evidence of increased prevalence of diabetes in ever or current dual users.

Based on one study (Wandell et al. 2008) the prevalence of diabetes in switchers was statistically non-significant compared to individuals that have never smoked or used snus. Similarly, neither current or former smokers had statistically significant results. No studies reported evidence of increased prevalence of diabetes in switchers.

##### ***Diabetes Incidence***

Based on one study (Rasouli et al. 2017), the risk of diabetes in ever dual users was a statistically non-significant 2.48 (95% CI: 0.52-11.82) compared to ever smokers that have never used snus. Additionally, Lee (2014) used the results from Wikstrom et al. (2010b) to derive effect measures for current dual users. Lee (2014) found current dual users have a statistically significant lower risk of diabetes (0.88 95% CI: 0.42-0.84) compared to current smokers. The interaction test by Lee (2014) showed no statistically significant change in relative risk for dual users compared to the relative risk in snus users indicating no multiplicative interaction. The two studies provided mixed evidence of risk of

diabetes in ever or current dual users compared to ever or current smokers. One study presented statistically non-significant results, while the other study presented a statistically significant lower risk of diabetes in dual users. As prior knowledge links smoking to diabetes, it is unclear why results for dual users would be significantly lower. Others have suggested that dual users consume less smoking tobacco than exclusive smokers, however no evidence of lower smoking tobacco consumption was presented in the selected study.

Based on one study (Eliasson et al. 2004), the risk of diabetes in switchers is statistically non-significant compared to consistent non-tobacco users. In contrast, the same study reported statistically significant risk in current smokers and former smokers compared to non-tobacco users. The effect measures for each exposure group overlap each other's confidence intervals suggesting no statistically significant multiplicative difference in risk between the groups.

### **Conclusion**

No studies reported evidence of increased prevalence or risk of diabetes in ever or current dual users compared to ever smokers, current smokers, non-tobacco users, or individuals that have never smoked or used snuff. One study (Lee 2014) provided evidence for a lower risk in current dual users compared to current smokers. There was no evidence of multiplicative interaction in the same study. Others have suggested that dual users consume less smoking tobacco than exclusive smokers, however no evidence of lower smoking tobacco consumption was presented in the selected study. There was no evidence of multiplicative interaction in the same study.

No studies reported evidence of increased prevalence or risk of diabetes in switchers compared to non-tobacco users or individuals that have never smoked or used snuff.

## **4.12 Acute Myeloid Leukemia**

### **4.12.1 Overview of evidence**

Out of the other outcomes described in the 2013 ENVIRON report, only acute myeloid leukemia (AML) is on the list of smoking-related outcomes. Only Fernberg et al. (2007) assessed AML in dual users, while no studies assessed AML in switchers. No AML studies have been published since the 2013 ENVIRON report.

### **4.12.2 Study considerations**

Fernberg et al. (2007) did not report a "mixed user" effect measure defined as "users of at least two tobacco products, either snuff and smoking tobacco or more than one type of smoking tobacco". Results for only snus users and smokers was not available.

### **4.12.3 Results for AML**

<b>Reference</b>	<b>Effect measures for Exposures of interest (95% CI)</b>	<b>Effect measures for snus users, smokers, and former smokers (95% CI)</b>
Fernberg et al.	Reference: Never tobacco use	Reference: Never tobacco user  Pure cigarette smoker: 1.29 (0.89-

(2007)	Mixed user: 1.38 (95% CI: 0.96-1.98)	1.86)  Pure pipe smoker: 1.38 (0.85-2.24)  Pure snuff dippers: 0.81 (0.41-1.60)
--------	--------------------------------------	---

#### 4.12.4 Discussion

One study (Fernberg et al. 2007) reported a statistically non-significant 1.38 (95% CI: 0.96-1.98) relative risk for mixed users compared to never tobacco users. This study similarly reported statistically non-significant results for pure snuff dippers, pure pipe smokers, and pure cigarette smokers. It was not possible to separate the effects in only concurrent snus users and smokers. However, it is not likely dual users of snus and smoking tobacco had a statistically significant elevated risk as every exposure group is statistically non-significant and the magnitude of risk for exclusive snus users is below one.

#### Conclusion

There is limited evidence suggesting no statistically significant increased risk for “mixed users” compared to never tobacco users.

### 4.13 All-cause mortality

#### 4.13.1 Overview of evidence compared to previous report

The 2013 ENVIRON report did not identify any study that reported all-cause mortality. No new studies related to these outcomes for dual users or switchers were published since the 2013 ENVIRON report. However, Roosaar et al. (2008) was represented in a comparative meta-analysis for dual users published by Lee (2014). Notably, Lee (2014) reported dual user effect estimates derived from Roosaar et al. (2008) that they did not report explicitly. The results from Lee (2014) are discussed.

#### 4.13.2 Results for Endpoints

Reference	Endpoints	Effect measures for Exposures of interest (95% CI)	Effect measures for snus users, smokers, and former smokers (95% CI)	Interaction tests (95% CI)
Lee (2014) <i>unadjusted</i> estimates from Roosaar et al. (2008)	Smoking-related cancer-incidence <sup>a</sup>	Dual Users vs. exclusive smokers: 0.79 (0.54-1.16)	Exclusive snus vs neither:  1.60 (1.10-2.50)	0.50 (0.28-0.87)
	Any cancer-incidence	Dual Users vs. exclusive smokers: 0.94 (0.78-1.12)	Exclusive snus vs neither:	0.85 (0.64-1.13)

			1.10 (0.90-1.40)	
	Any cancer-mortality	Dual Users vs. exclusive smokers:  0.80 (0.62-1.04)	Exclusive snus vs neither:  1.28 (0.96-1.69)	0.63 (0.74-0.91)
	All-cause mortality	Dual Users vs. exclusive smokers:  0.97 (0.85-1.11)	Exclusive snus vs neither:  1.23 (1.09-1.40)	0.79 (0.66-0.95)

<sup>a</sup> It includes oral, pharyngeal, esophageal, gastric, pancreatic, laryngeal and pulmonary cancer, as well as cancer of the kidney, bladder and other urinary organs

#### **4.13.3 Discussion of total mortality, cancer-related mortality, incidence of any cancer, and smoking-related cancer incidence.**

##### ***Effects in dual users and comparison to snus users***

Lee (2014) calculated relative risks for current dual users compared to current smokers in Roosaar et al. (2008) and found statistically non-significant results for smoking-related cancer incidence, any-cancer incidence, any-cancer mortality, and all-cause mortality. Lee (2014), also reported statistically significant change in relative risk for dual users compared to the relative risk in snus users. This indicated evidence of multiplicative interaction in the Roosaar et al. (2008) study population for each outcome reported. It is unclear why there would be a statistically significant decrease in the relative risk for dual users compared to the relative risk in snus users considering that prior knowledge links smoking to smoking-related cancer incidence, any-cancer incidence, any-cancer mortality, and all-cause mortality. Others have suggested that dual users consume less smoking tobacco than exclusive smokers, however no evidence of lower smoking tobacco consumption was presented in the selected study.

##### ***Conclusion***

Overall, these results indicate a statistically non-significant risk of smoking-related cancer incidence, any-cancer incidence, any-cancer mortality, and all-cause mortality in dual users compared to current smokers. There was also evidence of multiplicative interaction between smoking and snus use.

#### **4.14 Summary of Results**

This report assessed the following outcomes: oral and pharyngeal cancer, oral cancer, esophageal cancer and subtypes, pancreatic cancer, stomach cancer and subtypes, lung cancer, overall cardiovascular disease, incident and fatal ischemic heart disease and MI, nonfatal MI, incident and fatal stroke, sudden cardiac death, metabolic syndrome, diabetes prevalence and incidence, acute myeloid leukemia, and total mortality related-outcomes.



#### **4.14.1 Dual users compared to never tobacco or never snus/smoke**

The majority of endpoints had statistically non-significant results for the comparison of dual users to never tobacco or never snus/smoke, however eight endpoints varied in evidence. Results did not exist for oral and pharyngeal cancer. Lung cancer had evidence of a lower risk in dual users, while four endpoints (non-fatal MI, fatal stroke, total mortality-related outcomes, and pancreatic cancer) had evidence of an increased risk. Two endpoints (IHD/MI incidence and mortality) had mixed evidence of increased risk and statistically non-significant results. The remaining ten outcomes have statistically non-significant results only. Notably endpoints with statistically significant increased, decreased, or mixed evidence of risk in dual users did not have evidence for significant risk compared to smokers and/or no evidence of statistical interaction.

#### **4.14.2 Dual users compared to smokers**

Except for three endpoints (oral and pharyngeal cancer, lung cancer, and pancreatic cancer), all studies present some evidence of statistical non-significance either through statistical comparison, tests of interaction, or effect measures that overlap confidence intervals. Dual users compared to smokers was not assessed in two endpoints (lung cancer, pancreatic cancer) due to a lack of smoking effect estimates. Oral and pharyngeal cancer was the only study to report increased risk in dual users, although with evidence of statistically non-significant interaction. Two endpoints (fatal stroke and fatal IHD/MI) did not have a statistical comparison reported but had evidence of a statistically non-significant interaction between smoking and snus use. Two endpoints (diabetes incidence and total mortality related outcomes) had mixed evidence of lower risk and statistical non-significance. Five endpoints (non-fatal MI, SCD, MetSy, Diabetes prevalence, AML) had neither a statistical comparison between dual users and smokers or an assessment of interaction, however all of these had dual user effect measures that overlapped the confidence interval for the smoker effect measure suggesting no statistically significant difference in relative risks. The remaining six endpoints (IHD/MI incidence, oral, esophageal, stomach, overall cardiovascular disease, and incident stroke) had statistically non-significant results assessed through a statistical test.

#### **4.14.3 Effects in switchers and comparison to smokers**

Only ten endpoints presented results for switchers in this report: non-fatal MI, incident and fatal IHD/MI, diabetes incidence and prevalence, oral cancer, overall cardiovascular disease, stroke incidence, sudden cardiac death, and metabolic syndrome.

##### **4.14.3.1 Switchers compared to never tobacco or never smoke/snus**

Only evidence for non-fatal MI suggests an increased risk for switchers. Evidence for IHD/MI incidence is mixed with studies suggesting increased risk and statistical non-significance. Notably, these two endpoints (IHD/MI incidence and non-fatal MI) have evidence suggesting a significant lower risk in dual users compared to smokers. The remaining eight endpoints have evidence of statistical non-significance through a statistical test.

##### **4.14.3.2 Switchers compared to current smokers**

In the comparison of switchers to current smokers, evidence for all endpoints suggested either lower risk, mixed evidence of lower or non-significant risk, or statistical non-significance. Four endpoints (non-fatal MI, IHD/MI incidence, overall cardiovascular disease, and incident stroke) had lower risk, while one endpoint (Fatal IHD/MI) had mixed evidence of lower or non-significant risk. The remaining

five endpoints had evidence that suggested statistical non-significance due to effect measures overlapping confidence intervals or a statistical test.

#### **4.14.3.3 Switchers compared to former smokers**

All studies had evidence suggesting statistical non-significance either due to a statistical test or effect measures overlapping confidence intervals.

### **4.15 Discussion**

Some studies provided evidence for an increased or decreased risk in dual users compared to never tobacco users, however most studies also provided evidence for statistical non-significant risks in dual users compared to smokers. Similarly, studies of switchers provide some evidence for increased risk compared to never tobacco users, however all studies provide evidence of decreased or statistically non-significant risk in switchers compared to smokers.

These conclusions regarding switchers differ from those reported by Henley and colleagues (2007) who investigated the potential health effects of switching from cigarettes to smokeless tobacco in the US American Cancer Society Cancer Prevention Study II cohort. The authors reported that men who switched from smoking cigarettes to using smokeless tobacco (using data that was collected at baseline only) had a higher rate of death from all causes, lung cancer, coronary heart disease, and stroke than those who had never used tobacco or those who were former cigarette smokers and quit using tobacco entirely following adjustment for several relevant potential confounders. The authors noted that switchers, compared to those who quit tobacco entirely, were less educated, more often employed in blue-collar occupations, and had a less healthy diet. Because information on tobacco use was collected only at baseline and not updated during follow-up, it is possible that men who quit smoking before enrollment, but resumed during the follow-up period, and those who initiated or discontinued using spit tobacco after enrolment, could have been misclassified, in fact, a subset of the cohort whose smoking status was updated after 10 years, had low overall rate of recidivism, but was statistically significantly higher among switchers (3.0%) than among those who quit using tobacco entirely (1.4%). Additional limitations of the study include lack of information on intensity of smoking, and the possibility that addiction may have influenced both smoking behavior and use of smokeless tobacco. Former smokers who switched may have been more addicted on average and may have smoked differently than those who quit tobacco entirely.

A limitation of these studies is that most of the studies of dual users did not provide qualitative or quantitative information on consumption of individual tobacco types among dual users with the exception of two of the studies (Hergens et al. 2005; Ye et al. 1999). In both of these studies, the authors reported that dual users smoked slightly less compared to exclusive smokers, and in the Ye et al. (1999) study, smoked for a shorter duration. Though dual users smoked less in these two studies, the authors of at least one US study have reported that dual users smoked more than exclusive smokers in that particular study population (Accortt et al. 2002). Among the studies where the amount of tobacco consumption by type is not provided, it is not known how smoking intensity may affect the interpretation of the reported risk estimates.

Additionally, though most of the studies reported relative risk estimates among concurrent users of snus and cigarettes (those who used both tobacco types at the same time, typically daily), four of the studies reported relative risk estimates among dual users who were either ever users of snus,

cigarettes, or both (Bertuccio et al. 2011; Boffetta et al. 2005; Ye et al. 1999; Zendejdel et al. 2008). Thus, it is likely that not all of the participants were concurrent users of both tobacco types, or were concurrent users for different time frames, before they developed a disease.

It is also possible that the lifestyles, especially unhealthy habits known to affect disease risk, may differ significantly among the various tobacco groups, and may not be accounted for in the studies. Several individual studies have found that unhealthy lifestyle habits to be more prevalent among dual users of tobacco compared to exclusive tobacco user groups, and nontobacco users. Engstrom and colleagues (2010) reported that unhealthy lifestyle was strongly associated with dual use among Swedish men and women. This included risky alcohol consumption, binge drinking, low fruit and vegetable consumption, and a sedentary lifestyle. Bombard and colleagues (2009) reported that lifetime polytobacco users in Canada were more likely to use drugs and alcohol. Klesges and colleagues (2011) reported that US Air Force recruits, who were dual users, had a higher prevalence of heavier alcohol consumption, more risk-taking behaviors, and were more likely to be surrounded by smokers. Johansson and colleagues (2005) reported that the highest percentage of "no physical activity" was observed among daily smokers and dual users in a Swedish population. The highest percentage of overweight and obesity was also found among dual users in this study. Aro and colleagues (2010) found that the high alcohol consumption (>100 g/week) was highest among dual users in a Northern Swedish study population.

Dual use of cigarettes and nicotine replacement therapy (NRT) products has also been reported. Hughes and colleagues (2005) investigated the potential off-label use of a nicotine inhaler that had recently been prescribed to US smokers in a prospective study. Off-label use included using the inhaler and cigarettes concurrently or using the inhaler for non-cessation reasons. The authors reported that many smokers used the inhaler and cigarettes concurrently on the same day (43-55%) at some time during the six month follow-up period but found that this behavior did not persist in most individuals. Repeated concurrent use (weekly concurrent use for at least a month) was reported by only 7-12% of participants. The participants did not appear to become dependent on the inhaler (only 1.4% self-reported the DSM-IV or ICD-10 criteria for dependence, but a clinician who interviewed them did not believe any were dependent). The authors concluded that although concurrent use of NRT and cigarettes occurs in some users, harm from and dependence on NRT is rare.

Despite the potential limitations of the studies of dual users of Swedish snus and cigarettes, the evidence from several different cohorts suggests that dual users do not face a higher disease risk than exclusive smokers, and that generally, the health risks among dual users appear to be similar to those observed among exclusive smokers. A number of smoking-related diseases were examined, including various cardiovascular outcomes, smoking-related cancers and other non-smoking-related diseases. Thus, no unique or multiplicative health risks were identified among dual users of tobacco. These conclusions are consistent with that reached by Frost-Pineda and colleague (2010), who reviewed the available literature on the health effects of dual use from US and European epidemiology studies. Those authors concluded that "the evidence is sufficient and clear that there are no unique health risks (either qualitative or quantitative) associated with dual use of cigarettes and smokeless tobacco products, which are not anticipated or observed from single use of these products for the major health effects associated with smoking and smokeless tobacco. Some data indicate that the risks of dual use are lower than those of exclusive smoking." In this current review, the health risks among those who

switch to snus from cigarettes were lower than those observed among individuals who continued to smoke cigarettes, and were generally comparable to, or had lower point estimates than the risks estimates observed among those who quit tobacco entirely. These conclusions are also consistent with those reached by Lee (2013), who reviewed the health effects of switching among the same studies of smoking-related outcomes included in this analysis. With respect to incident IHD or MI, Lee (2013) compared risk estimates of switchers with quitters and continuing smokers quantitatively, and where appropriate, provided combined summary estimates of switching vs. continued smoking (0.55; 95% CI: 0.45-0.68) and quitting (1.02; 95% CI: 0.83-1.26). Lee (2013) concluded that “the findings consistently demonstrate that switching from cigarettes to snus is associated with a clearly lower risk of CVD and cancer than is continuing to smoke. The risk in switchers is no different than that in smokers who quit smoking.”

## 5. NON-CLINICAL TOXICOLOGICAL STUDIES WITH SNUS

Nine potentially relevant non-clinical toxicological and *in vitro* studies were identified in the July 28, 2017 literature search. Of the nine, five were identified as relevant, with four excluded for reasons including nonuse of Swedish Match snus product(s), or previous inclusion in the 2013 ENVIRON report.

### 5.1 *In Vitro* Studies of Swedish Snus

#### 5.1.1 Cardiovascular

Ljungberg et al. (2013) conducted an experiment in which the effects of nicotine and its metabolites on platelet function (platelet adhesion, aggregation and P-selectin expression), and Ettan moist snuff (Swedish Match) extract, Copenhagen snuff fine cut extract, tobacco free snuff extract (Choice apple), and Camel cigarette smoke extract on platelet adhesion were evaluated *in vitro*. The effects of tobacco extracts were evaluated both alone and with known platelet activators (ADP and adrenaline). Blood was collected from healthy human donors. A weak, but significant effect of nicotine at 10  $\mu$ M only on platelet aggregation was observed, while none of the four metabolites evaluated at 0.1 to 10  $\mu$ M affected ADP-induced platelet aggregation. Nicotine had no effect on platelet adhesion and only two of the four metabolites caused a weak inhibition: trans-3'-hydroxycotinine exclusively at 0.1  $\mu$ M (but not at higher concentrations), and nicotine-1'-N-oxide at 1 and 10  $\mu$ M.

With respect to the effects of tobacco extracts, a reduction in platelet adhesion to fibrinogen and collagen was observed for 10% Ettan snuff extract, while 10% Copenhagen moist extract reduced platelet adhesion to collagen, and reduced adhesion to fibrinogen at 3% and 10%. Camel cigarette smoke extract induced a significant decrease in adhesion to albumin and fibrinogen at all concentrations (0.001 to 10%), with adhesion to collagen decreased at 3% and 10%. 10% Choice apple extract reduced platelet adhesion to collagen, and 3% and 10% to fibrinogen. When platelets were pretreated with a nicotine-receptor inhibitor, or drugs that interfere with the nitric oxide system, the inhibitory effect of the tobacco extracts on platelet adhesion persisted. The authors concluded that because "only limited effects of nicotine and nicotine metabolites were seen, the tobacco-induced platelet inhibition are likely induced by other compounds present in tobacco and tobacco free snuff." The potential clinical significance of these results are unclear, as previous smoking studies, noted by the authors, have indicated increased platelet activity and increased risk for thrombosis. This contradicts the results of the current study. Furthermore, the authors noted that the direct effects of nicotine or tobacco products on platelet activity can be difficult to elucidate from *in vivo* studies.

#### 5.1.2 Genotoxicity, Mutagenicity, and Cytotoxicity

Merne et al. (2014) conducted an *in vitro* study in which human HPV-positive and HPV-negative oral keratinocytes and oral HPV-negative fibroblasts were exposed to Ettan snus (Swedish Match) (STE1), and US-type reference snuff extract (STE2) to investigate the potential genotoxic effects on the cells, specifically, aneuploidy (abnormal number of chromosomes). The results were as follows:

- The HPV-positive keratinocytes exposed to STE2 showed a statistically significant increase in the number of aneuploid cells from 27.4% to 80.5%, while the changes following STE1 exposure were much less (27.4% to 30.8%).

- In oral spontaneously transformed HPV-negative keratinocytes, the number of aneuploid cells at G2-M stage increased after STE1 and STE2 exposure from 3.4% to 8.5% and 7.2%, respectively.
- In HPV-negative oral fibroblasts, the number of aneuploid cells at G2-M phase increased from 11% to 21% after STE1 and 29% after STE2 exposure.
- Neither STE1 or STE2 exposure had an effect on HPV16 E6 and E7 oncogene expression.

The authors concluded that the effects of the STEs varied by cell line, but that they both increased the aneuploidy of HPV16 E6/E7-transformed oral epithelial cells. However, only STE2 led to statistically significant increases in aneuploidy cells. The authors further noted that their "*in vitro* results are in line with the epidemiological reports showing greater risk of oropharyngeal cancer with STE2, the North American snuff, than STE1, the Scandinavian type of snuff."

Song et al. (2016) evaluated and compared the chemical composition and *in vitro* toxicity of seven conventional and 12 low-TSNA moist snuff products (including Swedish Match products: Ettan Lossnus and General Mini Portion). The products were extracted with dimethyl sulfoxide (DMSO). The assays included the Ames Salmonella reverse mutation assay, the Neutral Red Uptake (NRU) Cytotoxicity assay, and the micronucleus (MN) assay. A limitation of the study, however, was that the results reported by the authors included the combined effects of Swedish products, including the two Swedish Match product(s) with a non-Swedish Match product called Skruf Stark Portion. The results of experiments on mutagenicity, cytotoxicity, and genotoxicity were as follows:

- The authors reported that "the largest increase (average 22%) in mutagenicity was observed in Swedish low-TSNA moist snuff products with the highest addition of the extracted products (1.1 mg/mL) compared to its absence ( $p=0.049$ )."
- Loss of cell viability was observed with exposure of 2.2 mg/mL of extracts in all products, with Swedish low-TSNA products showing similar low cytotoxicity to conventional moist snuff products. Statistically significantly higher cytotoxicity was observed in South Africa and US low-TSNA moist snuff products compared to conventional products ( $p=0.04$ ), with mean proportions of cell death of 56.6%, 50% and 34.8%, respectively.
- The MN genotoxicity test showed that the mean proportion of micronuclei was statistically significantly increased (122%-127%) ( $p=1.47 \times 10^{-7}$ ) with treatment of all products compared to controls, but no differences were observed among the products.

A major limitation of *in vitro* studies such as this one, as acknowledged by the authors, is that "it is difficult to apply these data to human risk because the cell culture conditions do not exist in humans."

## **5.2 Studies of Swedish snus in Experimental Animals (*In Vivo*)**

### **5.2.1 Cardiovascular & Developmental**

Folkesson et al. (2016) conducted an *in vivo* study to investigate the potential differences in developmental and cardiovascular toxicities associated with cigarette and snuff extracts (Göteborgs Rapé snuff, Swedish Match) in a zebrafish model (embryos). The authors reported that exposure to the tobacco extracts led to a variety of toxic effects including early embryonic mortality, developmental delay, cerebral hemorrhages, defects in lymphatics development and ventricular

function, and aneurysm development, with both extracts more toxic than nicotine alone. Developmental delay and aneurysm development were specifically observed in the snuff extract group, while cerebral hemorrhages were found only in the group exposed to cigarette extracts. It is important to note, however, that the differences in the route of exposure, and use (e.g., combustion) could present differences in toxicity when comparing snuff use and cigarette smoking in humans. Furthermore, aside from the potential differences between human and zebrafish embryos, the conditions for which the embryos were exposed (injection) is not necessarily representative of real-world tobacco use in humans.

### 5.2.2 Non-Cancer Soft Tissue Changes

Nilsson et al. (2016) conducted an *in vivo* study in which Wistar rats consumed a tobacco slurry in which 10 g of Ettan brand snus from Swedish Match was homogenized in 100 ml of water alone, as well as in conjunction with additives including blueberries and an extract from milk thistle that might exert protective effects against soft tissue changes in the rat forestomach. The rat forestomach was used as a model in the study of “undesirable keratotic lesions and associated epithelial abnormalities in the oral cavity” among snus users. The authors noted the reversibility of snus-induced oral lesions in humans, and that “the cancer risk from snus is extremely low.”

Following 4 weeks of treatment with Ettan snus, observed effects included dilation of blood vessels in the submucosa, and a thickening of the basal region of squamous epithelium forestomach due to a proliferation of cells in the basal layer, compared with controls. In comparison with treatment of Ettan snus only, combined administration with blueberries or extract from milk thistle decreased the number of proliferating cells significantly by 36-44%. The authors concluded that “in spite of a relatively short time of exposure, the marked inhibition by blueberries and milk thistle extract on cellular proliferation induced by Swedish snus in the rat forestomach epithelium indicates a possible approach for achieving protection against the soft tissue changes in the human oral cavity caused by smokeless tobacco.”

With respect to the effects of Ettan snus alone on the rat forestomach in this study, the results are consistent with snus’s effects on the oral mucosa in humans, and those reported in a study of Ettan snus placed in the rat lip canal described in the 2013 ENVIRON report (Schwartz et al. 2010).

## 5.3 Summary and Conclusions

Five new studies were identified since publication of the 2013 ENVIRON report. Similar to the 2013 report, some of the new studies included genotoxicity, mutagenicity, and cytotoxicity endpoints investigated *in vitro*, as well as an *in vivo* study of rats. New endpoints included *in vitro* effects on platelet function (adhesion) and aneuploidy (abnormal number of chromosomes), and an *in vivo* study of potential cardiovascular and developmental effects of Swedish snus on zebrafish embryos.

Consistent with previous findings, one study of the combined effect of three Swedish snus products (one of which was not Swedish Match brand) indicated that Swedish snus may be mutagenic (increased mutation revertants), genotoxic (increased micronuclei), and cytotoxic (lower cell viability) *in vitro*. Another *in vitro* study of the potential genotoxicity of Swedish snus did not report a statistically significant increase in aneuploid HPV-positive keratinocytes. A third *in vitro* study reported a reduction in platelet adhesion to fibrinogen and collagen for 10% Ettan snuff extract. The potential

clinical significance of these results is unclear, and it remains unknown to what extent any of the *in vitro* effects from these studies may be relevant to humans *in vivo*.

In an *in vivo* study of rats that consumed a tobacco slurry of Swedish snus, consistent with previous findings in animals as well as oral changes in humans, non-cancerous soft tissue changes in the forestomach were observed including cell proliferation, and a thickening of the basal region of squamous epithelium. In a new study of the potential cardiovascular and developmental effects of Swedish snus on zebrafish embryos, a variety of toxic effects including early embryonic mortality, developmental delay, defects in lymphatics development and ventricular function, and aneurysm development were observed following injection with Swedish snus extracts. Aside from the potential differences between human and zebrafish embryos, the conditions for which the embryos were exposed in this study (injection) is not necessarily representative of potential real-world exposure of human embryos as a result of the mother using snus.



## 6. REFERENCES

- Accortt NA, Waterbor JW, Beall C, and Howard G. 2002. Chronic disease mortality in a cohort of smokeless tobacco users. *Am J Epidemiol* 156:730-737.
- Ahlbom HE. 1937. Pradisponierende faktoren fur plattenepithelkarzinom in mund, hals, und speiserohre. Eine statistische untersuchung am material des radiumhemmets, Stockholm (Predisposing factors for squamous cell carcinoma in the mouth, throat and esophagus. A statistical study of the material of the radiumhemmet, Stockholm). *Acta Radiol* 18:63-185.
- Altman DG, Bland JM. 2003. Interaction revisited: the difference between two estimates. *Bmj* 326(7382):219.
- ACS (American Cancer Society). 2012. What are the risk factors for cancer of the esophagus? <http://www.cancer.org/cancer/esophaguscancer/detailedguide/esophagus-cancer-risk-factors>.
- ACS (American Cancer Society). 2013a. What are the risk factors for lung cancer? <http://www.cancer.org/cancer/lungcancer-non-smallcell/moreinformation/lungcancerpreventionandearlydetection/lung-cancer-prevention-and-early-detection-risk-factors>.
- ACS (American Cancer Society). 2013b. What are the risks for stomach cancer? <http://www.cancer.org/cancer/stomachcancer/detailedguide/stomach-cancer-risk-factors>.
- AHA (American Heart Association). 2012. Understand Your Risk of Heart Attack. [http://www.heart.org/HEARTORG/Conditions/HeartAttack/UnderstandYourRiskofHeartAttack/Understand-Your-Risk-of-Heart-Attack\\_UCM\\_002040\\_Article.jsp](http://www.heart.org/HEARTORG/Conditions/HeartAttack/UnderstandYourRiskofHeartAttack/Understand-Your-Risk-of-Heart-Attack_UCM_002040_Article.jsp).
- American Heart Association (AHA). 2014. Your Risk for Metabolic Syndrome. [http://www.heart.org/HEARTORG/Conditions/More/MetabolicSyndrome/Your-Risk-for-Metabolic-Syndrome\\_UCM\\_301924\\_Article.jsp](http://www.heart.org/HEARTORG/Conditions/More/MetabolicSyndrome/Your-Risk-for-Metabolic-Syndrome_UCM_301924_Article.jsp).
- Andersson G and Axell T. 1989. Clinical appearance of lesions associated with the use of loose and portion-bag packed Swedish moist snuff: A comparative study. *J Oral Pathol Med* 18:2-7.
- Andersson G and Warfvinge G. 2003. The influence of pH and nicotine concentration in oral moist snuff on mucosal changes and salivary pH in Swedish snuff users. *Swed Dent J* 27:67-75.
- Andersson G, Axell T, and Larsson A. 1989. Histologic changes associated with the use of loose and portion-bag packed Swedish moist snuff: a comparative study. *J Oral Pathol Med* 18:491-497.
- Andersson G, Axell T, and Larsson A. 1990. Impact of consumption factors on soft tissue changes in Swedish moist snuff users: a histologic study. *J Oral Pathol Med* 19:453-458.
- Andersson G, Axell T, and Larsson A. 1991. Clinical classification of Swedish snuff dippers' lesions supported by histology. *J Oral Pathol Med* 20:253-257.

- Andersson G, Bjornberg G, and Curvall M. 1994. Oral mucosal changes and nicotine disposition in users of Swedish smokeless tobacco products: a comparative study. *J Oral Pathol Med* 23:161-167.
- Andersson G, Axell T, and Curvall M. 1995. Reduction in nicotine intake and oral mucosal changes among users of Swedish oral moist snuff after switching to a low-nicotine product. *J Oral Pathol Med* 24:244-250.
- Andersson MLE, Bergman S and Söderlin MK. 2013. The effect of snuff (smokeless tobacco) on disease activity and function in rheumatoid arthritis: Experiences from the better anti-rheumatic pharmacotherapy, a longitudinal multicenter study on early rheumatoid arthritis. *Journal of Clinical Rheumatology*, 19(1): 14–18.
- Angman M and Eliasson M. 2008. [Snuff and blood pressure. Cross-sectional study of blood pressure in rest among men in the MONICA study in Northern Sweden]. *Lakartidningen* 105:3530-3535.
- Araghi M, Rosaria Galanti M, Lundberg M, Lager A, Engström G, Alfredsson L, Knutsson A, Norberg M, Sund M, Wennberg P, Trolle Lagerros Y, Belloc R, Pedersen NL, Östergren P-O and Magnusson C. 2017. Use of moist oral snuff (snus) and pancreatic cancer: Pooled analysis of nine prospective observational studies. *International Journal of Cancer*, 141(4): 687–693.
- Arefalk G, Hergens MP, Ingelsson E, Arnlov J, Michaelsson K, Lind L, Ye W, Nyren O, Lambe M, and Sundstrom J. 2011. Smokeless tobacco (snus) and risk of heart failure: results from two Swedish cohorts. *Eur J Cardiovasc Prev Rehabil* 19:1120-1127.
- Arefalk G, Hambraeus K, Lind L, Michaëlsson K, Lindahl B and Sundström J. 2014. Discontinuation of smokeless tobacco and mortality risk after myocardial infarction. *Circulation*, 130(4): 325–332.
- Aro P, Ronkainen J, Storskrubb T, Vieth M, Engstrand L, Johansson SE, Bolling-Sternevald E, Bolinder G, Alving K, Talley NJ, and Agreus L. 2010. Use of tobacco products and gastrointestinal morbidity: an endoscopic population-based study (the Kalixanda study). *Eur J Epidemiol* 10:741-750.
- Asplund K, Nasic S, Janlert U, and Stegmayr B. 2003. Smokeless tobacco as a possible risk factor for stroke in men: a nested case-control study. *Stroke* 34:1754-1759.
- Attvall S, Fowelin J, Lager I, Von SH, and Smith U. 1993. Smoking induces insulin resistance-- a potential link with the insulin resistance syndrome. *J Intern Med* 233:327-332.
- Axell T. 1976. A prevalence study of oral mucosal lesions in an adult Swedish population. *Odontol Revy* 27:1-103.
- Axell T, Mornstad H, and Sundstrom B. 1978. [Snuff and cancer of the oral cavity--a retrospective study]. *Lakartidningen* 75:2224-2226.
- Axell T. 1987. Occurrence of leukoplakia and some other oral white lesions among 20,333 adult Swedish people. *Community Dent Oral Epidemiol* 15:46-51.
- Axell TE. 1993. Oral mucosal changes related to smokeless tobacco usage: research findings in Scandinavia. *Eur J Cancer B Oral Oncol* 29B:299-302.

- Axell T and Hedin CA. 1982. Epidemiologic study of excessive oral melanin pigmentation with special reference to the influence of tobacco habits. *Scand J Dent Res* 90:434-442.
- Axell T and Henricsson V. 1985. Association between recurrent aphthous ulcers and tobacco habits. *Scand J Dent Res* 93:239-242.
- Axell T, Mornstad H, and Sundstrom B. 1976. The relation of the clinical picture to the histopathology of snuff dipper's lesions in a Swedish population. *J Oral Pathol* 5:229-236.
- Baba S, Wikstrom AK, Stephansson O, and Cnattingius S. 2012a. Changes in snuff and smoking habits in Swedish pregnant women and risk for small for gestational age births. *BJOG* 120:456-462.
- Baba S, Wikstrom AK, Stephansson O, and Cnattingius S. 2012b. Influence of smoking and snuff cessation on risk of preterm birth. *Eur J Epidemiol* 27:297-304.
- Baba S, Wikstrom A-K, Stephansson O and Cnattingius S. 2014. Influence of snuff and smoking habits in early pregnancy on risks for stillbirth and early neonatal mortality. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*, 16(1): 78-83.
- Bergstrom J, Keilani H, Lundholm C, and Radestad U. 2006. Smokeless tobacco (snuff) use and periodontal bone loss. *J Clin Periodontol* 33:549-554.
- Bertuccio P, La VC, Silverman DT, Petersen GM, Bracci PM, Negri E, Li D, Risch HA, Olson SH, Gallinger S, Miller AB, Bueno-de-Mesquita HB, Talamini R, Polesel J, Ghadirian P, Baghurst PA, Zatonski W, Fontham ET, Bamlet WR, Holly EA, Lucenteforte E, Hassan M, Yu H, Kurtz RC, Cotterchio M, Su J, Maisonneuve P, Duell EJ, Bosetti C, and Boffetta P. 2011. Cigar and pipe smoking, smokeless tobacco use and pancreatic cancer: an analysis from the International Pancreatic Cancer Case-Control Consortium (PanC4). *Ann Oncol* 22:1420-1426.
- Bjorkman F, Edin F, Mattsson CM, Larsen F, Ekblom B, Björkman F, Edin F, Mattsson CM, Larsen F and Ekblom B. 2017. Regular moist snuff dipping does not affect endurance exercise performance. *PLoS ONE*, 12(7): e0181228.
- Boffetta P, Aagnes B, Weiderpass E, and Andersen A. 2005. Smokeless tobacco use and risk of cancer of the pancreas and other organs. *Int J Cancer* 114:992-995.
- Boffetta P, Hecht S, Gray N, Gupta P, and Straif K. 2008. Smokeless tobacco and cancer. *Lancet Oncol* 9:667-675.
- Boffetta P and Straif K. 2009. Use of smokeless tobacco and risk of myocardial infarction and stroke: systematic review with meta-analysis. *BMJ* 339:502-507.
- Bolinder G. 1997. Long-term use of smokeless tobacco: Cardiovascular mortality and risk factors. Ph.D. diss. Karolinska Institutet, Stockholm.
- Bolinder GM, Ahlborg BO, and Lindell JH. 1992. Use of smokeless tobacco: blood pressure elevation and other health hazards found in a large-scale population survey. *J Intern Med* 232:327-334.

- Bolinder G, Alfredsson L, Englund A, and de Faire U. 1994. Smokeless tobacco use and increased cardiovascular mortality among Swedish construction workers. *Am J Public Health* 84:399-404.
- Bolinder G, Noren A, de Faire U, and Wahren J. 1997a. Smokeless tobacco use and atherosclerosis: An ultrasonographic investigation of carotid intima media thickness in healthy middle-aged men. *Atherosclerosis* 132:95-103.
- Bolinder G, Noren A, Wahren J, and de Faire U. 1997b. Long-term use of smokeless tobacco and physical performance in middle-aged men. *Eur J Clin Invest* 27:427-433.
- Bolinder G and de Faire U. 1998. Ambulatory 24-h blood pressure monitoring in healthy, middle-aged smokeless tobacco users, smokers, and nontobacco users. *Am J Hypertens* 11:1153-1163.
- Bombard JM, Rock VJ, Pederson LL, and Asman KJ. 2008. Monitoring polytobacco use among adolescents: Do cigarette smokers use other forms of tobacco? *Nicotine Tob Res* 10:1581-1589.
- Bombard JM, Pederson LL, Koval JJ, and O'Hegarty M. 2009. How are lifetime polytobacco users different than current cigarette-only users? Results from a Canadian young adult population. *Addict Behav* 34:1069-1072.
- Brattwall M, Warren SM, Rawal N, Segerdahl M, Houltz E, and Jakobsson J. 2010. Postoperative impact of regular tobacco use, smoking or snuffing, a prospective multi-center study. *Acta Anaesthesiol Scand* 54:321-327.
- Byhamre ML, Gustafsson PE, Jansson J-H, Wennberg M, Hammarstrom A and Wennberg P. 2017. Snus use during the life-course and risk of the metabolic syndrome and its components. *Scandinavian journal of public health*, 1403494817706631.
- Carlsson S, Andersson T, Araghi M, Galanti R, Lager A, Lundberg M, Nilsson P, Norberg M, Pedersen NL, Trolle-Lagerros Y and Magnusson C. 2017. Smokeless tobacco (snus) is associated with an increased risk of type 2 diabetes: results from five pooled cohorts. *Journal of Internal Medicine*, 281(4): 398-406.
- Carlens C, Hergens MP, Grunewald J, Ekblom A, Eklund A, Olgart HC, and Askling J. 2010. Smoking, Use of Moist Snuff and Risk of Chronic Inflammatory Diseases. *Am J Respir Crit Care Med* 181:1217-1222.
- Centers for Disease Control and Prevention (CDC). 2008. Smoking-attributable mortality, years of potential life lost, and productivity losses--United States, 2000-2004. *Morb Mortal Wkly Rep* 57:1226-1228.
- Centers for Disease Control and Prevention (CDC). 2011. 2011 National Diabetes Fact Sheet. <http://www.cdc.gov/diabetes/pubs/general11.htm>.
- Dafar A, Çevik-Aras H, Robledo-Sierra J, Mattsson U and Jontell M. 2016. Factors associated with geographic tongue and fissured tongue. *Acta Odontologica Scandinavica*, 74(3): 210-216.

Dahlin S, Gunnerbeck A, Wikström A-K, Cnattingius S and Edstedt Bonamy A-K. 2016. Maternal tobacco use and extremely premature birth – a population-based cohort study. *BJOG: An International Journal of Obstetrics and Gynaecology*, 123(12): 1938–1946.

Edwards AC, Maes HH, Pedersen NL, and Kendler KS. 2011. A population-based twin study of the genetic and environmental relationship of major depression, regular tobacco use and nicotine dependence. *Psychol Med* 41:395-405.

Ekfeldt A, Hugoson A, Bergendal T and Helkimo M. 1990. An individual tooth wear index and an analysis of factors correlated to incisal and occlusal wear in an adult Swedish population. *Acta odontologica Scandinavica*, 48(5): 343–349.

Eliasson M, Lundblad D, and Hagg E. 1991. Cardiovascular risk factors in young snuff-users and cigarette smokers. *J Intern Med* 230:17-22

Eliasson M, Asplund K, Evrin PE, and Lundblad D. 1995. Relationship of cigarette smoking and snuff dipping to plasma fibrinogen, fibrinolytic variables and serum insulin. The Northern Sweden MONICA Study. *Atherosclerosis* 113:41-53.

Eliasson M, Asplund K, Nasic S, and Rodu B. 2004. Influence of smoking and snus on the prevalence and incidence of type 2 diabetes amongst men: the northern Sweden MONICA study. *J Intern Med* 256:101-110.

England LJ, Levine RJ, Mills JL, Klebanoff MA, Yu KF, and Cnattingius S. 2003. Adverse pregnancy outcomes in snuff users. *Am J Obstet Gynecol* 189:939-943.

Engstrom K, Magnusson C, and Galanti MR. 2010. Socio-demographic, lifestyle and health characteristics among snus users and dual tobacco users in Stockholm County, Sweden. *BMC Public Health* 10:619.

ENVIRON. 2013. Review of the scientific literature on snus (Swedish moist snuff).

Eriksson M and Ng N. 2015. Changes in access to structural social capital and its influence on self-rated health over time for middle-aged men and women: A longitudinal study from northern Sweden. *Social Science and Medicine*, 130: 250–258.

Fang F, Belloc R, Hernan MA, and Ye W. 2006. Smoking, snuff dipping and the risk of amyotrophic lateral sclerosis--a prospective cohort study. *Neuroepidemiology* 27:217- 221.

Fernberg P, Odenbro A, Belloc R, Boffetta P, Pawitan Y, and Adami J. 2006. Tobacco use, body mass index and the risk of malignant lymphomas--a nationwide cohort study in Sweden. *Int J Cancer* 118:2298-2302.

Fernberg P, Odenbro A, Belloc R, Boffetta P, Pawitan Y, Zendejdel K, and Adami J. 2007. Tobacco use, body mass index, and the risk of leukemia and multiple myeloma: a nationwide cohort study in Sweden. *Cancer Res* 67:5983-5986.

Food and Drug Administration (FDA). 2016. Literature Review Methodology: An Overview. Presented at The Premarket Tobacco Product Application for Electronic Nicotine Delivery Systems (ENDS): A Public Seminar. October 17.

Friedman GD, Tekawa I, and Sidney S. 1997. Smoking and Mortality: The Kaiser Permanente Experience. In: Changes in Cigarette-Related Disease Risks and Their Implications for Prevention and Control, eds Shopland DR, Burns DM, Garfinkel L, and Samet JM, 477- 500. Vol 8. NIH Pub. No. 97-4213.

Frithiof L, Anneroth G, Lasson U, and Sederholm C. 1983. The snuff-induced lesion. A clinical and morphological study of a Swedish material. *Acta Odontol Scand* 41:53-64.

Frost-Pineda K, Appleton S, Fisher M, Fox K, and Gaworski CL. 2010. Does dual use jeopardize the potential role of smokeless tobacco in harm reduction? *Nicotine Tob Res* 12:1055-1067.

Gudnadóttir AÝ, Ólafsdóttir IS, Middelveld R, Ekerljung L, Forsberg B, Franklin K, Lindberg E and Janson C. 2017. An investigation on the use of snus and its association with respiratory and sleep-related symptoms: A cross-sectional population study. *BMJ Open*, 7(5): e015486.

Gunnerbeck A, Wikstrom AK, Bonamy AK, Wickstrom R, and Cnattingius S. 2011. Relationship of Maternal Snuff Use and Cigarette Smoking With Neonatal Apnea. *Pediatrics* 128:503-509.

Gunnerbeck A, Edstedt Bonamy A-K, Wikstrom A-K, Granath F, Wickstrom R and Cnattingius S. 2014. Maternal snuff use and smoking and the risk of oral cleft malformations--a population-based cohort study. *PloS one*, 9(1): e84715.

Gustafsson PE, Janlert U, Theorell T, Westerlund H, and Hammarstrom A. 2011a. Socioeconomic status over the life course and allostatic load in adulthood: results from the Northern Swedish Cohort. *J Epidemiol Community Health* 65:986-992.

Gustafsson PE, Persson M, and Hammarstrom A. 2011b. Life course origins of the metabolic syndrome in middle-aged women and men: the role of socioeconomic status and metabolic risk factors in adolescence and early adulthood. *Ann Epidemiol* 21:103-110.

Gustavsen MW, Page CM, Moen SM, Bjølgerud A, Berg-Hansen P, Nygaard GO, Sandvik L, Lie BA, Celius EG and Harbo HF. 2014. Environmental exposures and the risk of multiple sclerosis investigated in a Norwegian case-control study. *BMC Neurology*, 14(1): 196.

Hadi HAR, Carr CD, Suwaidi JAI. 2005. Endothelial dysfunction: cardiovascular risk factors, therapy, and outcome. *Vasc Health Risk Man*, 1(3): 183-198.

Haglund B, Stenbeck M, Rosen M, Eliasson M, Rosen M, and Haglund B. 2007. Is moist snuff use associated with excess risk of IHD or stroke? A longitudinal follow-up of snuff users in Sweden. *Scand J Public Health* 35:618-622.

Halling A and Unell L. 2007. General health and tobacco habits among middle-aged Swedes. *The European Journal of Public Health*, 17(2): 151-154.

Hansson LE, Baron J, Nyren O, Bergstrom R, Wolk A, and Adami HO. 1994. Tobacco, alcohol and the risk of gastric cancer. A population-based case-control study in Sweden. *Int J Cancer* 57:26-31.

Hansson J, Pedersen NL, Galanti MR, Andersson T, Ahlbom A, Hallqvist J, and Magnusson C. 2009. Use of snus and risk for cardiovascular disease: results from the Swedish Twin Registry. *J Intern Med* 265:717-724.

Hansson J, Galanti MR, Magnusson C, and Hergens MP. 2011. Weight gain and incident obesity among male snus users. *BMC Public Health* 11:371.

Hansson J, Galanti MR, Hergens MP, Fredlund P, Ahlbom A, Alfredsson L, Bellocco R, Eriksson M, Hallqvist J, Hedblad B, Jansson JH, Nilsson P, Pedersen N, Trolle LY, Ostergren PO, and Magnusson C. 2012. Use of snus and acute myocardial infarction: pooled analysis of eight prospective observational studies. *Eur J Epidemiol* 27:771-779.

Hansson J, Galanti MR, Hergens MP, Fredlund P, Ahlbom A, Alfredsson L, Bellocco R, Engström G, Eriksson M, Hallqvist J, Hedblad B, Jansson JH, Pedersen NL, Trolle Lagerros Y, Ostergren PO and Magnusson C. 2014. Snus (Swedish smokeless tobacco) use and risk of stroke: pooled analyses of incidence and survival. *Journal of internal medicine*, 276(1): 87–95.

Hardell L, Eriksson M and Degerman A. 1994. Exposure to phenoxyacetic acids, chlorophenols, or organic solvents in relation to histopathology, stage, and anatomical localization of non-Hodgkin's lymphoma. *Cancer research*, 54(9): 2386–2389.

Hedstrom AK, Baarnhielm M, Olsson T, and Alfredsson L. 2009. Tobacco smoking, but not Swedish snuff use, increases the risk of multiple sclerosis. *Neurology* 73:696-701.

Hedström AK, Hillert J, Olsson T, Alfredsson L, Hedstrom AK, Hillert J, Olsson T and Alfredsson L. 2013. Nicotine might have a protective effect in the etiology of multiple sclerosis. *Multiple Sclerosis Journal*, 19(8): 1009–1013.

Heir T and Eide G. 1997. Injury proneness in infantry conscripts undergoing a physical training programme: smokeless tobacco use, higher age, and low levels of physical fitness are risk factors. *Scand J Med Sci Sports* 7:304-311.

Hellqvist L, Bostrom A, Lingstrom P, Hugoson A, Rolandsson M and Birkhed D. 2012. Effect of nicotine-free and nicotine-containing snus on plaque pH in vivo. *Swedish dental journal*, 36(4): 187–194.

Hellqvist L, Margot R, Hucoson A, Lingstrom P, Birkhed D, Hellqvist L, Rolandsson M, Hugoson A, Lingstrom P and Birkhed D. 2015. Dental caries and associated factors in a group of Swedish snus users. *Swedish Dental Journal*, 39(1): 47–54.

Hemberg A, Holmberg H, Norberg M and Nordin P. 2017. Tobacco use is not associated with groin hernia repair, a population-based study. *Hernia*, 21(4): 517–523.

Henley SJ, Connell CJ, Richter P, Husten C, Pechacek T, Calle EE, and Thun MJ. 2007. Tobacco-related disease mortality among men who switched from cigarettes to spit tobacco. *Tob Control* 16:22-28.

Hergens MP, Ahlbom A, Andersson T, and Pershagen G. 2005. Swedish moist snuff and myocardial infarction among men. *Epidemiology* 16:12-16.

Hergens MP, Alfredsson L, Bolinder G, Lambe M, Pershagen G, and Ye W. 2007. Long-term use of Swedish moist snuff and the risk of myocardial infarction amongst men. *J Intern Med* 262:351-359.

Hergens MP, Lambe M, Pershagen G, Terent A, and Ye W. 2008a. Smokeless tobacco and the risk of stroke. *Epidemiology* 19:794-799.

Hergens MP, Lambe M, Pershagen G, and Ye W. 2008b. Risk of hypertension amongst Swedish male snuff users: a prospective study. *J Intern Med* 26:187-194.

Hergens M-P, Galanti R, Hansson J, Fredhmd P, Ahlbom A, Son LA, Bellocco R, Eriksson M, Son EIF, Hallqvist J, Jansson J-H, Knutsson A, Pedersen N, Lagerros YT, Östergren P-O, Magnusson C, Fredlund P, Ahlbom A, Alfredsson L, Bellocco R, Eriksson M, Fransson EI, Hallqvist J, Jansson J-H, Knutsson A, Pedersen N, Lagerros YT, Östergren P-O and Magnusson C. 2014. Use of scandinavian moist smokeless tobacco (snus) and the risk of atrial fibrillation. *Epidemiology*, 25(6): 872-876.

Heuch I, Kvale G, Jacobsen BK, and Bjelke E. 1983. Use of alcohol, tobacco and coffee, and risk of pancreatic cancer. *Br J Cancer* 48:637-643.

Hilding A, Grill V, Efendic S, and Östenson C-G. 2005. High consumption of oral moist snuff ("snus") increases the risk of type 2 diabetes in a prospective study of middle-aged Swedish men. *Diabetologica* 48:A136.

Hirsch JM, Heyden G, and Thilander H. 1982. A clinical, histomorphological and histochemical study on snuff-induced lesions of varying severity. *J Oral Pathol* 11:387-398.

Hirsch JM, Livian G, Edward S and Noren JG. 1991. Tobacco habits among teenagers in the city of Goteborg, Sweden, and possible association with dental caries. *Swedish dental journal*, 15(3): 117-123.

Hirsch JM, Hedner J, Wernstedt L, Lundberg J, and Hedner T. 1992. Hemodynamic effects of the use of oral snuff. *Clin Pharmacol Ther* 52:394-401.

Hirsch JM, Wallström M, Carlsson A-P and Sand L. 2012. Oral cancer in Swedish snuff dippers. *Anticancer Research*, 32(8): 3327-3330.

Holmberg SA and Thelin AG. 2006. Primary care consultation, hospital admission, sick leave and disability pension owing to neck and low back pain: a 12-year prospective cohort study in a rural population. *BMC Musculoskelet Disord* 7:66.

Hughes JR, Adams EH, Franzon MA, Maguire MK, and Guary J. 2005. A prospective study of off-label use of, abuse of, and dependence on nicotine inhaler. *Tob Control* 14:49-54.

Hugoson A, Hellqvist L, Rolandsson M, and Birkhed D. 2012. Dental caries in relation to smoking and the use of Swedish snus: epidemiological studies covering 20 years (1983- 2003). *Acta Odontol Scand* 70:289-296.



- Hugoson A and Rolandsson M. 2011. Periodontal disease in relation to smoking and the use of Swedish snus: epidemiological studies covering 20 years (1983-2003). *J Clin Periodontol* 38:809-816.
- Huhtasaari F, Asplund K, Lundberg V, Stegmayr B, and Wester PO. 1992. Tobacco and myocardial infarction: is snuff less dangerous than cigarettes? *BMJ* 305:1252-1256.
- Huhtasaari F, Lundberg V, Eliasson M, Janlert U, and Asplund K. 1999. Smokeless tobacco as a possible risk factor for myocardial infarction: a population-based study in middle-aged men. *J Am Coll Cardiol* 34:1784-1790.
- Hvitfeldt T and Gripe I. 2009. Drug trends in Sweden – 2009. Swedish Council for Information on Alcohol and Other Drugs (CAN). 118.
- Ibrahim SO, Johannessen AC, Idris AM, Hirsch JM, Vasstrand EN, Magnusson B, and Nilsen R. 1996. Immunohistochemical detection of p53 in non-malignant and malignant oral lesions associated with snuff dipping in the Sudan and Sweden. *Int J Cancer* 68:749-753.
- Institute of Medicine (IOM). 2003. Gulf War and Health: Volume 2. Insecticides and Solvents. National Academies Press. Washington, DC.
- Iodice S, Gandini S, Maisonneuve P, and Lowenfels AB. 2008. Tobacco and the risk of pancreatic cancer: a review and meta-analysis. *Langenbecks Arch Surg* 393:535-545.
- Jakobsson U. 2008. Tobacco use in relation to chronic pain: results from a Swedish population survey. *Pain Med* 9:1091-1097.
- Jakobsson U and Larsson C. 2014. Smoking and Chronic Pain Among People Aged 65 Years and Older. *Pain Practice*, 14(3): 237–244.
- Janzon E and Hedblad B. 2009. Swedish snuff and incidence of cardiovascular disease. A population-based cohort study. *BMC Cardiovasc Disord* 9:21-27.
- Jiang X, Alfredsson L, Klareskog L and Bengtsson C. 2014. Smokeless tobacco (moist snuff) use and the risk of developing rheumatoid arthritis: results from a case-control study. *Arthritis care & research*, 66(10): 1582–1586.
- Johansson SE, Sundquist K, Qvist J, and Sundquist J. 2005. Smokeless tobacco and coronary heart disease: a 12-year follow-up study. *Eur J Cardiovasc Prev Rehabil* 12:387-392.
- Juárez SP and Merlo J. 2013. The Effect of Swedish Snuff (Snus) on Offspring Birthweight: A Sibling Analysis. *PLoS ONE*, 8(6): e65611.
- Juliñ A, Barr AM, and Modeer T. 2008. Risk factors and risk indicators in relation to incipient alveolar bone loss in Swedish 19-year-olds. *Acta Odontol Scand* 66:139-147.
- Kallestål C and Uhlin S. 1992. Buccal attachment loss in Swedish adolescents. *J Clin Periodontol* 19:485-491.

- Katsika D, Tuvblad C, Einarsson C, Lichtenstein P and Marschall H-U. 2007. Body mass index, alcohol, tobacco and symptomatic gallstone disease: a Swedish twin study. *Journal of internal medicine*, 262(5): 581–587.
- Klesges RC, Ebbert JO, Morgan GD, Sherrill-Mittleman D, Asfar T, Talcott WG, and Debon M. 2011. Impact of differing definitions of dual tobacco use: implications for studying dual use and a call for operational definitions. *Nicotine Tob Res* 13:523-531.
- Koskinen LO and Blomstedt PC. 2006. Smoking and non-smoking tobacco as risk factors in subarachnoid haemorrhage. *Acta Neurol Scand* 114:33-37.
- Lagergren J, Bergstrom R, Lindgren A, and Nyren O. 2000. The role of tobacco, snuff and alcohol use in the aetiology of cancer of the oesophagus and gastric cardia. *Int J Cancer* 85:340-346.
- Larsson A, Axell T, and Andersson G. 1991. Reversibility of snuff dippers' lesion in Swedish moist snuff users: a clinical and histologic follow-up study. *J Oral Pathol Med* 20:258-264.
- Lee PN. 2007. Circulatory disease and smokeless tobacco in Western populations: a review of the evidence. *Int J Epidemiol* 36:789-804.
- Lee PN. 2011. Summary of the epidemiological evidence relating snus to health. *Regul Toxicol Pharmacol* 59:197-214.
- Lee PN. 2013. The effect on health of switching from cigarettes to snus – A review. *Regul Toxicol Pharmacol* 66:1-5.
- Lee PN. 2014. Health risks related to dual use of cigarettes and snus - a systematic review. *Regulatory toxicology and pharmacology : RTP*, 69(1): 125–134.
- Lee PN and Hamling J. 2009a. The relation between smokeless tobacco and cancer in Northern Europe and North America. A commentary on differences between the conclusions reached by two recent reviews. *BMC Cancer* 9:256.
- Lee PN and Hamling JS. 2009b. Systematic review of the relation between smokeless tobacco and cancer in Europe and North America. *BMC Med* 7:36.
- Lewin F, Norell SE, Johansson H, Gustavsson P, Wennerberg J, Biorklund A, and Rutqvist LE. 1998. Smoking tobacco, oral snuff, and alcohol in the etiology of squamous cell carcinoma of the head and neck: A population-based case: Referent study in Sweden. *Cancer* 82:1367-1375.
- Lie TM, Bomme M, Hveem K, Hansen JM and Ness-Jensen E. 2017. Snus and risk of gastroesophageal reflux. A population-based case-control study: the HUNT study. *Scandinavian Journal of Gastroenterology*, 52(2): 193–198.
- Lindstrom D, Sadr AO, Bellocco R, Wladis A, Linder S, and Adami J. 2007. The effect of tobacco consumption and body mass index on complications and hospital stay after inguinal hernia surgery. *Hernia* 11:117-123.

Liu Z, Roosaar A, Axéll T and Ye W. 2017. Tobacco use, oral health, and risk of Parkinson's disease. *American Journal of Epidemiology*, 185(7): 538–545.

Ljungberg LU, Persson K, Eriksson AC, Green H and Whiss PA. 2013. Effects of nicotine, its metabolites and tobacco extracts on human platelet function in vitro. *Toxicology in Vitro*, 27(2): 932–938.

Ludvigsson JF, Nordenvall C and Järholm B. 2014. Smoking, use of moist snuff and risk of celiac disease: A prospective study. *BMC Gastroenterology*, 14(1).

Lunell E and Curvall M. 2011. Nicotine Delivery and Subjective Effects of Swedish Portion Snus Compared With 4 mg Nicotine Polacrilex Chewing Gum. *Nicotine Tob Res* 13:573- 578.

Luo J, Ye W, Zendehdel K, Adami J, Adami HO, Boffetta P, and Nyren O. 2007. Oral use of Swedish moist snuff (snus) and risk for cancer of the mouth, lung, and pancreas in male construction workers: a retrospective cohort study. *Lancet* 369:2015-2020.

Martensson G. 1978. [Snuff and chewing tobacco as a cause of pathological changes in the oral mucosa]. *Tandteknikern* 47:121, 4.

Mattila VM, Sahi T, Jormanainen V, and Pihlajamäki H. 2008. Low back pain and its risk indicators: a survey of 7,040 Finnish male conscripts. *Eur Spine J* 17:64-69.

McLaughlin JK, Hrubec Z, Blot WJ, and Fraumeni JF, Jr. 1995. Smoking and cancer mortality among U.S. veterans: a 26-year follow-up. *Int J Cancer* 60:190-193.

Merne M, Heinäro I, Lahteenoja H, and Syrjänen S. 2002. Proliferation and differentiation markers in snuff-induced oral mucosal lesions. *J Oral Pathol Med* 31:259-266.

Merne M, Rautava J, Ruutu M and Syrjänen S. 2014. Smokeless tobacco increases aneuploidy in oral HPV16 E6/E7-transformed keratinocytes in vitro. *Journal of oral pathology & medicine : official publication of the International Association of Oral Pathologists and the American Academy of Oral Pathology*, 43(9): 685–690.

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(6): e1000097.

Modeer T, Lavstedt S, and Ahlund C. 1980. Relation between tobacco consumption and oral health in Swedish schoolchildren. *Acta Odontol Scand* 38:223-227.

Monten U, Wennström JL, and Ramberg P. 2006. Periodontal conditions in male adolescents using smokeless tobacco (moist snuff). *J Clin Periodontol* 33:863-868.

Mørnstad H, Axell T, and Sundström B. 1989. Clinical picture of snuff dipper's lesion in Swedes. *Community Dent Oral Epidemiol* 17:97-101.

Morente-Sánchez J, Zandonai T, Mateo-March M, Sanabria D, Sánchez-Muñoz C, Chiamulera C, Zabala Díaz M, Morente-Sánchez J, Zandonai T, Mateo-March M, Sanabria D, Sanchez-Munoz C, Chiamulera C

and Zabala Diaz M. 2015. Acute effect of Snus on physical performance and perceived cognitive load on amateur footballers. *Scandinavian Journal of Medicine and Science in Sports*, 25(4): e423–e431.

Munafo MR, Larsson Lonn S, Sundquist J, Sundquist K, Kendler K, Munafo MR, Larsson Lönn S, Sundquist J, Sundquist K and Kendler K. 2016. Snus use and risk of schizophrenia and non-affective psychosis. *Drug and Alcohol Dependence*, 164: 179–182.

National Cancer Institute (NCI). 2009a. What You Need To Know About Oral Cancer: Risk Factors. <http://www.cancer.gov/cancertopics/wyntk/oral/page4>.

National Cancer Institute (NCI). 2009b. What You Need To Know About Stomach Cancer: Risk Factors. <http://www.cancer.gov/cancertopics/wyntk/stomach/page4>.

National Cancer Institute (NCI). 2010. What You Need to Know About Cancer of the Pancreas: Risk Factors. <http://www.cancer.gov/cancertopics/wyntk/pancreas/page4>.

Neumann A, Norberg M, Schoffer O, Norström F, Johansson I, Klug SJ and Lindholm L. 2013. Risk equations for the development of worsened glucose status and type 2 diabetes mellitus in a Swedish intervention program. *BMC public health*, 13: 1014.

Nilsson R, Micic M, Filipovic J, Sobot AV, Drakulic D, Stanojlovic M and Joksic G. 2016. Inhibition by blueberries (bilberries) and extract from milk thistle of rat forestomach hyperplasia induced by oral smokeless tobacco (Swedish snus). *Regulatory toxicology and pharmacology : RTP*, 76: 94–101.

Norberg M, Stenlund H, Lindahl B, Boman K, and Weinehall L. 2006. Contribution of Swedish moist snuff to the metabolic syndrome: a wolf in sheep's clothing? *Scand J Public Health* 34:576-583.

Nordenstam F, Lundell B, Cohen G, Tessma MK, Raaschou P and Wickstrom R. 2017. Prenatal Exposure to Snus Alters Heart Rate Variability in the Infant. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*, 19(7): 797–803.

Nordenvall C, Nilsson PJ, Ye W, and Nyren O. 2010. Smoking, snus use and risk of right- and left-sided colon, rectal, and anal cancer, a 37-year follow-up study. *Int J Cancer* 128:157- 165.

Nordenvall C, Nilsson PJ, Ye W, Andersson TM, and NYREN O. 2013. Tobacco use and cancer survival: A cohort study of 40,230 Swedish male construction workers with incident cancer. *Int J Cancer* 132:155-161.

Nordgren P and Ramstrom L. 1990. Moist snuff in Sweden--tradition and evolution. *British journal of addiction*, 85(9): 1107–1112.

Oberg J, Jorde R, Almas B, Emaus N, Grimnes G, Öberg J, Jorde R, Grimnes G, Almås B and Emaus N. 2014. Vitamin D deficiency and lifestyle risk factors in a Norwegian adolescent population. *Scandinavian Journal of Public Health*, 42(7): 593–602.

Odenbro A, Bellocco R, Boffetta P, Lindelof B, and Adami J. 2005. Tobacco smoking, snuff dipping and the risk of cutaneous squamous cell carcinoma: a nationwide cohort study in Sweden. *Br J Cancer* 92:1326-1328.

Odenbro A, Gillgren P, Bellocco R, Boffetta P, Hakansson N, and Adami J. 2007. The risk for cutaneous malignant melanoma, melanoma in situ and intraocular malignant melanoma in relation to tobacco use and body mass index. *Br J Dermatol* 156:99-105.

Ostenson CG, Hilding A, Grill V, and Efendic S. 2012. High consumption of smokeless tobacco ("snus") predicts increased risk of type 2 diabetes in a 10-year prospective study of middle-aged Swedish men. *Scand J Public Health* 40:730-737.

Overland S, Skogen JC, Lissner L, Bjerkeset O, Tjora T and Stewart R. 2013. Snus use and cardiovascular risk factors in the general population: The HUNT3 study. *Addiction*, 108(11): 2019–2028.

Ozga JE, Felicione NJ, Elswick D and Blank MD. 2016. Acute effects of snus in never-tobacco users: a pilot study. *American Journal of Drug and Alcohol Abuse*. Department of Psychology, West Virginia University, Morgantown, WV, USA: Taylor and Francis Ltd.

Palmisano S, Schwartzbaum J, Prochazka M, Pettersson D, Bergenheim T, Florentzon R, Harder H, Mathiesen T, Nyberg G, Siesjö P and Feychting M. 2012. Role of tobacco use in the etiology of acoustic neuroma. *American Journal of Epidemiology*, 175(12): 1243–1251.

Parn T, Grau Ruiz R, Kunovac Kallak T, Ruiz JR, Davey E, Hreinsson J, Wanggren K, Salumets A, Sjöström M, Stavreus-Evers A, Ortega FB, Altnäe S, Pärn T, Grau Ruiz R, Kunovac Kallak T, Ruiz JR, Davey E, Hreinsson J, Wångren K, Salumets A, Sjöström M, Stavreus-Evers A, Ortega FB and Altnäe S. 2015. Physical activity, fatness, educational level and snuff consumption as determinants of semen quality: findings of the ActiART study. *Reproductive BioMedicine Online*, 31(1): 108–119.

Pedersen W and von Soest T. 2014. Tobacco use among Norwegian adolescents: From cigarettes to snus. *Addiction*, 109(7): 1154–1162.

Persson PG, Carlsson S, Svanström L, Ostenson CG, Efendic S, and Grill V. 2000. Cigarette smoking, oral moist snuff use and glucose intolerance. *J Intern Med* 248:103-110.

Persson PG, Hellers G, and Ahlbom A. 1993. Use of oral moist snuff and inflammatory bowel disease. *Int J Epi*. 22(6): 1101-1103.

Pettersson K, Saers J, Lindberg E and Janson C. 2016. Sleep disturbances among Swedish soldiers after military service abroad. *Uppsala Journal of Medical Sciences*, 121(1): 65–69.

Rasouli B, Andersson T, Carlsson P-O, Grill V, Groop L, Martinell M, Midthjell K, Storm P, Tuomi T and Carlsson S. 2017. Use of Swedish smokeless tobacco (snus) and the risk of Type 2 diabetes and latent autoimmune diabetes of adulthood (LADA). *Diabetic Medicine*, 34(4): 514–521.

Richthoff J, Elzanaty S, Rylander L, Hagmar L, and Giwercman A. 2008. Association between tobacco exposure and reproductive parameters in adolescent males. *Int J Androl* 31:31- 39.

Rodu B. 2011. The scientific foundation for tobacco harm reduction, 2006-2011. *Harm Reduct J*. 8(1):19.

- Rodu B, Phillips C V. 2015. Letter by Rodu and Phillips Regarding Article, "Discontinuation of Smokeless Tobacco and Mortality Risk After Myocardial Infarction." *Circulation*. 131(17):e422.
- Rodu B and Jansson C. 2004. Smokeless tobacco and oral cancer: a review of the risks and determinants. *Crit Rev Oral Biol Med* 15:252-263.
- Rodu B, Stegmayr B, Nasic S, Cole P, and Asplund K. 2004. The influence of smoking and smokeless tobacco use on weight amongst men. *J Intern Med* 255:102-107.
- Rohani M and Agewall S. 2004. Oral snuff impairs endothelial function in healthy snuff users. *J Intern Med* 255:379-383
- Rolandsson M, Hellqvist L, Lindqvist L, and Hugoson A. 2005. Effects of snuff on the oral health status of adolescent males: a comparative study. *Oral Health Prev Dent* 3:77-85.
- Roosaar A, Johansson AL, Sandborgh-Englund G, Nyren O, and Axell T. 2006. A long-term follow-up study on the natural course of snus-induced lesions among Swedish snus users. *Int J Cancer* 119:392-397.
- Roosaar A, Johansson AL, Sandborgh-Englund G, Axell T, and Nyren O. 2008. Cancer and mortality among users and nonusers of snus. *Int J Cancer* 123:168-173.
- Rosenquist K, Wennerberg J, Schildt EB, Bladstrom A, Hansson BG, and Andersson G. 2005. Use of Swedish moist snuff, smoking and alcohol consumption in the aetiology of oral and oropharyngeal squamous cell carcinoma. A population-based case-control study in southern Sweden. *Acta Otolaryngol* 125:991-998.
- Rostron B. 2012. Smoking-Attributable Mortality by Cause in the United States: Revising the CDC's Data and Estimates. *Nicotine Tob Res* 15(1):238-246.
- Rygh E, Gallefoss F and Reiso H. 2016. Use of snus and smoking tobacco among pregnant women in the Agder counties. *Tidsskrift for den Norske Laegeforening*, 136(16): 1351–1355.
- Salonen L, Axell T, and Hellden L. 1990. Occurrence of oral mucosal lesions, the influence of tobacco habits and an estimate of treatment time in an adult Swedish population. *J Oral Pathol Med* 19:170-176.
- SAMMEC. 2013. Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC). Centers for Disease Control and Prevention (CDC). <http://apps.nccd.cdc.gov/sammec/>.
- Schildt EB, Eriksson M, Hardell L, and Magnuson A. 1998a. Oral infections and dental factors in relation to oral cancer: a Swedish case--control study. *Eur J Cancer Prev* 7:201-206.
- Schildt EB, Eriksson M, Hardell L, and Magnuson A. 1998b. Oral snuff, smoking habits and alcohol consumption in relation to oral cancer in a Swedish case-control study. *Int J Cancer* 77:341-346.

Schildt EB, Nylander K, Eriksson M, Hardell L, Magnusson A, and Roos G. 2003. Expression of p53, PCNA, Ki-67 and bcl-2 in relation to risk factors in oral cancer - a molecular epidemiological study. *Int J Oncol* 22:861-868.

Schwartz JL, Brunnemann KD, Adami AJ, Panda S, Gordon SC, Hoffmann D, and Adami GR. 2010. Brand specific responses to smokeless tobacco in a rat lip canal model. *J Oral Pathol Med* 39:453-459.

Shinton R and Beevers G. 1989. Meta-analysis of relation between cigarette smoking and stroke. *BMJ* 298:789-794.

Skaug E-AE-A, Nes B, Aspenes ST and Ellingsen O. 2016. Non-Smoking tobacco affects endothelial function in healthy men in one of the largest health studies ever performed; the nord-trøndelag health study in Norway; HUNT3. *PLoS ONE*, 11(8): e0160205.

Song M-A, Marian C, Brasky TM, Reisinger S, Djordjevic M and Shields PG. 2016. Chemical and toxicological characteristics of conventional and low-TSNA moist snuff tobacco products. *Toxicology letters*, 245: 68–77.

Sponsiello-Wang Z, Weitkunat R, and Lee PN. 2008. Systematic review of the relation between smokeless tobacco and cancer of the pancreas in Europe and North America. *BMC Cancer* 8:356.

Stratton K, Shetty P, Wallace R, and Bondurant S. 2001. *Clearing the Smoke: The Science Base for Tobacco Harm Reduction*. Washington, D.C.: Institute of Medicine, National Academy Press.

Sundbeck M, Grahn M, Lonngren V, Mansson NO, Rastam L, and Lindblad U. 2009. Snuff use associated with abdominal obesity in former smokers. *Scand J Public Health* 37:487-493.

Sundstrom D, Waldenborg M, and Emilsson K. 2012. Acute effects on the ventricular function in Swedish snuffers: an echocardiographic study. *Clin Physiol Funct Imaging* 32:106- 113.

Swedish Match. June 6, 2014. Modified Risk Tobacco Product Application for Swedish Match North America Snus Products.

Teo KK, Ounpuu S, Hawken S, Pandey MR, Valentin V, Hunt D, Diaz R, Rashed W, Freeman R, Jiang L, Zhang X, and Yusuf S. 2006. Tobacco use and risk of myocardial infarction in 52 countries in the INTERHEART study: a case-control study. *Lancet* 368:647-658.

U.S. Department of Health and Human Services (USDHHS). 1989. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the surgeon General*. 89-8411.

U.S. Department of Health and Human Services (USDHHS). 2004. 2004 Surgeon General's Report-The Health Consequences of Smoking, 35-360. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

U.S. Department of Health and Human Services (USDHHS). 2010. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*. Atlanta,GA: U.S. Department of Health and Human Services, Centers for Disease Control and

Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Varga T V, Hallmans G, Hu FB, Renström F and Franks PW. 2013. Smoking status, snus use, and variation at the CHRNA5-CHRNA3-CHRNA4 locus in relation to obesity: The GLACIER study. *American Journal of Epidemiology*, 178(1): 31–37.

Vidyasagaran AL, Siddiqi K and Kanaan M. 2016. Use of smokeless tobacco and risk of cardiovascular disease: A systematic review and meta-analysis. *European journal of preventive cardiology*, 23(18): 1970–1981.

W-Dahl A and Toksvig-Larsen S. 2007. No delayed bone healing in Swedish male oral snuffers operated on by the hemicallosis technique: a cohort study of 175 patients. *Acta Orthop* 78:791-794.

Wallenfeldt K, Hulthe J, Bokemark L, Wikstrand J, and Fagerberg B. 2001. Carotid and femoral atherosclerosis, cardiovascular risk factors and C-reactive protein in relation to smokeless tobacco use or smoking in 58-year-old men. *J Intern Med* 250:492-501.

Wallstrom M, Kjelsberg M, Johannessen AC, and Hirsch JM. 2011. The Reversibility of Snuff-Induced Lesions: A Clinical and Histomorphological Study. *International Journal of Oral and Maxillofacial Pathology* 2:4-10.

Wandell PE, Bolinder G, de Faire U, and Hellenius ML. 2008. Association between metabolic effects and tobacco use in 60-year-old Swedish men. *Eur J Epidemiol* 23:431-434.

Wedenberg C, Jonsson A, and Hirsch JM. 1996. Assessment of p53 and Ki-67 expression in snuff-induced lesions. *Br J Oral Maxillofac Surg* 34:409-413.

Wennberg P, Eliasson M, Hallmans G, Johansson L, Boman K, and Jansson JH. 2007. The risk of myocardial infarction and sudden cardiac death amongst snuff users with or without a previous history of smoking. *J Intern Med* 262:360-367.

Wennmalm A, Benthin G, Granstrom EF, Persson L, Petersson A-S, and Winell S. 1991. Relation between tobacco use and urinary excretion of thromboxane A2 and prostacyclin metabolites in young men. *Circulation* 83:1698-1704.

Wickholm S, Soder PO, Galanti MR, Soder B, and Klinge B. 2004. Periodontal disease in a group of Swedish adult snuff and cigarette users. *Acta Odontol Scand* 62:333-338.

Wikstrom AK, Cnattingius S, Galanti MR, Kieler H, and Stephansson O. 2010a. Effect of Swedish snuff (snus) on preterm birth. *BJOG* 117:1005-1010.

Wikstrom AK, Cnattingius S, and Stephansson O. 2010b. Maternal use of Swedish snuff (snus) and risk of stillbirth. *Epidemiology* 21:772-778.

Wikstrom AK, Stephansson O, and Cnattingius S. 2010c. Tobacco Use During Pregnancy and Preeclampsia Risk. Effects of Cigarette Smoking and Snuff. *Hypertension* 55:1254-1259.



Willi C, Bodenmann P, Ghali WA, Faris PD, and Cornuz J. 2007. Active smoking and the risk of type 2 diabetes: a systematic review and meta-analysis. *Jama* 298:2654-2664.

Wilson KM, Markt SC, Fang F, Nordenvall C, Rider JR, Ye W, Adami H-O, Stattin P, Nyren O and Mucci LA. 2016. Snus use, smoking and survival among prostate cancer patients. *International journal of cancer*, 139(12): 2753–2759.

Wolk K, Mallbris L, Larsson P, Rosenblad A, Vingard E, and Stahle M. 2009. Excessive body weight and smoking associates with a high risk of onset of plaque psoriasis. *Acta Derm Venereol* 89:492-497.

Wong MC, Lao XQ, Ho KF, Goggins WB, Shelly LA. 2017. Incidence and mortality of lung cancer: global trends and association with socioeconomic status. *Scientific reports*. 7(1):14300.

Wood MW, Medina JE, Thompson GC, Houck JR, and Min KW. 1994. Accumulation of the p53 tumor-suppressor gene product in oral leukoplakia. *Otolaryngol Head Neck Surg* 111:758-763.

Wrangsjö K, Alderling M, Lindahl G, Meding B, Wrangsjö K, Alderling M, Lindahl G and Meding B. 2015. Hand eczema and use of snus (Moist snuff) – A population-based study. *Acta Dermato-Venereologica*, 95(3): 298–302.

Yang F, Pedersen NL, Ye W, Liu Z, Norberg M, Forsgren L, Trolle Lagerros Y, Bellocco R, Alfredsson L, Knutsson A, Jansson J-H, Wennberg P, Galanti MR, Lager ACJ, Araghi M, Lundberg M, Magnusson C and Wirdefeldt K. 2016. Moist smokeless tobacco (Snus) use and risk of Parkinson's disease. *International journal of epidemiology*.

Ye W, Ekstrom AM, Hansson LE, Bergstrom R, and Nyren O. 1999. Tobacco, alcohol and the risk of gastric cancer by sub-site and histologic type. *Int J Cancer* 83:223-229.

Zandonai T, Tam E, Bruseghini P, Pizzolato F, Franceschi L, Baraldo M, Capelli C, Cesari P and Chiamulera C. 2016. The effects of oral smokeless tobacco administration on endurance performance. *Journal of Sport and Health Science*. Neuropsychopharmacology Laboratory, Department of Diagnostic and Public Health, University of Verona, Verona 37134, Italy: Elsevier B.V.

Zendejdel K, Nyren O, Luo J, Dickman PW, Boffetta P, Englund A, and Ye W. 2008. Risk of gastroesophageal cancer among smokers and users of Scandinavian moist snuff. *Int J Cancer* 122:1095-1099.

## Appendix A: The PRISMA Checklist

Section/topic	#	Checklist item	Reported on page #
<b>TITLE</b>			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	26, 108
<b>ABSTRACT</b>			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	Not applicable
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known.	15-16, 108-111
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	15-16, 108-111
<b>METHODS</b>			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	16-25, 111-115
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	16-19
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	17
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	17-18, Appendix B
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	17-20, 111-112
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	17-21
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	Appendix E, Appendix G
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	21-23

Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	114-115
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., $I^2$ ) for each meta-analysis.	23-25, 112-115
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	21-25
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	113-115
<b>RESULTS</b>			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	19-21, Appendix C, Appendix D
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Appendix F, Appendix G
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Within each respective endpoint section
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	Within each respective endpoint section
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	Within each respective endpoint section
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	Within each respective endpoint section
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	Within each respective endpoint section
<b>DISCUSSION</b>			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	Within each respective endpoint section
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	Within each respective endpoint section
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	Within each respective endpoint

			section
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	15

*From:* Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097.

For more information, visit: [www.prisma-statement.org](http://www.prisma-statement.org).

## Appendix B: Search Results Tracking Table

The following search terms seek to be as inclusive as possible, and consequently focus on the exposure of interest for Research Topics 1-4 (Table B1). Table B2 presents the search terms and results that were used in the retrospective literature search of the health effects studies on Swedish snus through December 1, 2012. Given the relatively unique scope of Research Topic 5, different search terms were used to identify literature for this research question (Table B3).

<b>Table B1: Update Literature Searches</b>				
<b>Search No.</b>	<b>Source</b>	<b>Date</b>	<b>Search terms</b>	<b>Results (#)</b>
1	PubMed	7/28/2017	snus OR snuff  Filter: December 1, 2012 to present	1,194
2	Scopus	7/28/2017	TITLE-ABS-KEY(snus OR snuff) AND PUBYEAR > 2011  Filter: January 1, 2012 to Present	578
4	Clinicaltrials.gov	7/28/2017	snus OR snuff  Filter: Limited to studies that have been "completed" and "with results." Terms entered into the "other terms" field. No year limits available.	26 total results (includes studies from all years)  0 relevant studies conducted after 2012.
5	<a href="http://www.scb.se/">http://www.scb.se/</a>	7/28/2017	snus, snuff, tobacco	<b>Snus:</b> 249 "pages and documents," 1 "statistical database" <b>Snuff:</b> 17 "pages and documents," 2 "statistical databases" <b>Tobacco:</b> 548 "pages and documents," 2 "statistical databases"
6	<a href="http://www.socialstyrelsen.se">www.socialstyrelsen.se</a>	7/28/2017	snus, snuff, tobacco	<b>Snus:</b> 8 <b>Snuff:</b> 3 <b>Tobacco:</b> 28
7	<a href="http://www.folkhalsomyndigheten.se">www.folkhalsomyndigheten.se</a>	7/28/2017	snus, snuff, tobacco	<b>Snus:</b> 103 <b>Snuff:</b> 18 <b>Tobacco:</b> 122
8	<a href="http://www.helsedirektoratet.no">www.helsedirektoratet.no</a>	7/28/2017	snus, snuff, tobacco	<b>Snus:</b> 70 <b>Snuff:</b> 1

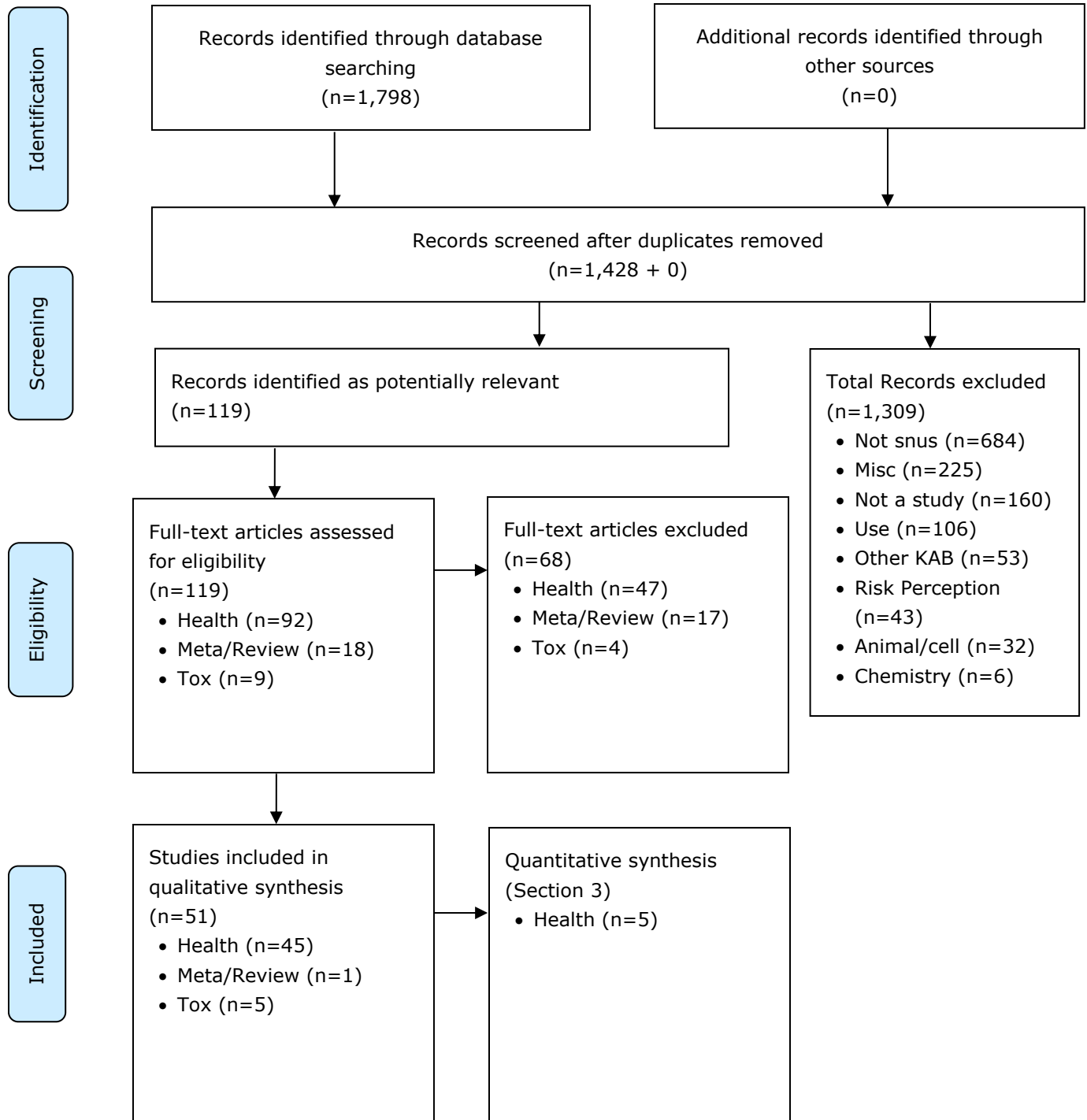
				<b>Tobacco:</b> 40
9	<a href="http://www.fhi.no">www.fhi.no</a>	7/28/2017	snus, snuff, tobacco	<b>Snus:</b> 78 <b>Snuff:</b> 4 <b>Tobacco:</b> 30

<b>Table B2: Retrospective literature search on the health effects of Swedish snus through December 1, 2012</b>				
	<b>Source</b>	<b>Date</b>	<b>Search terms</b>	<b>Results (#)</b>
1	PubMed	7/28/2017	snus OR snuff  Filter: All time to December 1, 2012	3,541
2	Scopus	7/28/2017	TITLE-ABS-KEY(snus OR snuff) AND PUBYEAR < 2013  Filter: All time to December 31, 2012	1,579
3	Clinicaltrials.gov	7/28/2017	snus OR snuff Filter: Limited to studies that have been "completed" and "with results." Terms entered into the "other terms" field. No year limits available.	26 total results (includes studies from all years)  3 potentially relevant studies conducted prior to 2012: 1 was a duplicate, 1 wasn't Swedish snus, and the last was previously reviewed and determined to be non-relevant

<b>Table B3: Databases and Proposed Search Queries for Topic #5</b>		
<b>Database</b>	<b>Search Query</b>	<b>Notes</b>
PubMed	((("chew" AND "tobacco") OR ("alternative" AND ("nicotine" OR "tobacco"))) OR "potential reduced exposure products" OR ("spit" AND "tobacco") OR "non-cigarette tobacco" OR ("chewing" AND "tobacco") OR "dissolvable tobacco" OR (dissolvable AND tobacco) OR "dry snuff" OR "non-combustible PREPs" OR ("smokeless tobacco") OR snuff OR snus OR ("personal" and "vaporizers") OR "non-cigarette tobacco" OR e-cig OR e-cigarette OR "electronic cigarette" OR "electronic nicotine delivery" OR vape OR vaping OR hookah OR shisha OR "modified risk tobacco product") AND (flavor OR flavors OR flavoring OR flavoured OR flavored OR attractiveness OR attract OR preferences OR preference OR prefer OR appeal OR reason OR reasons OR susceptibility OR receptivity)	1,358 results (10/10/18)
Scopus	TITLE-ABS-KEY (((("chew" AND "tobacco") OR	1,317 results (10/10/18)

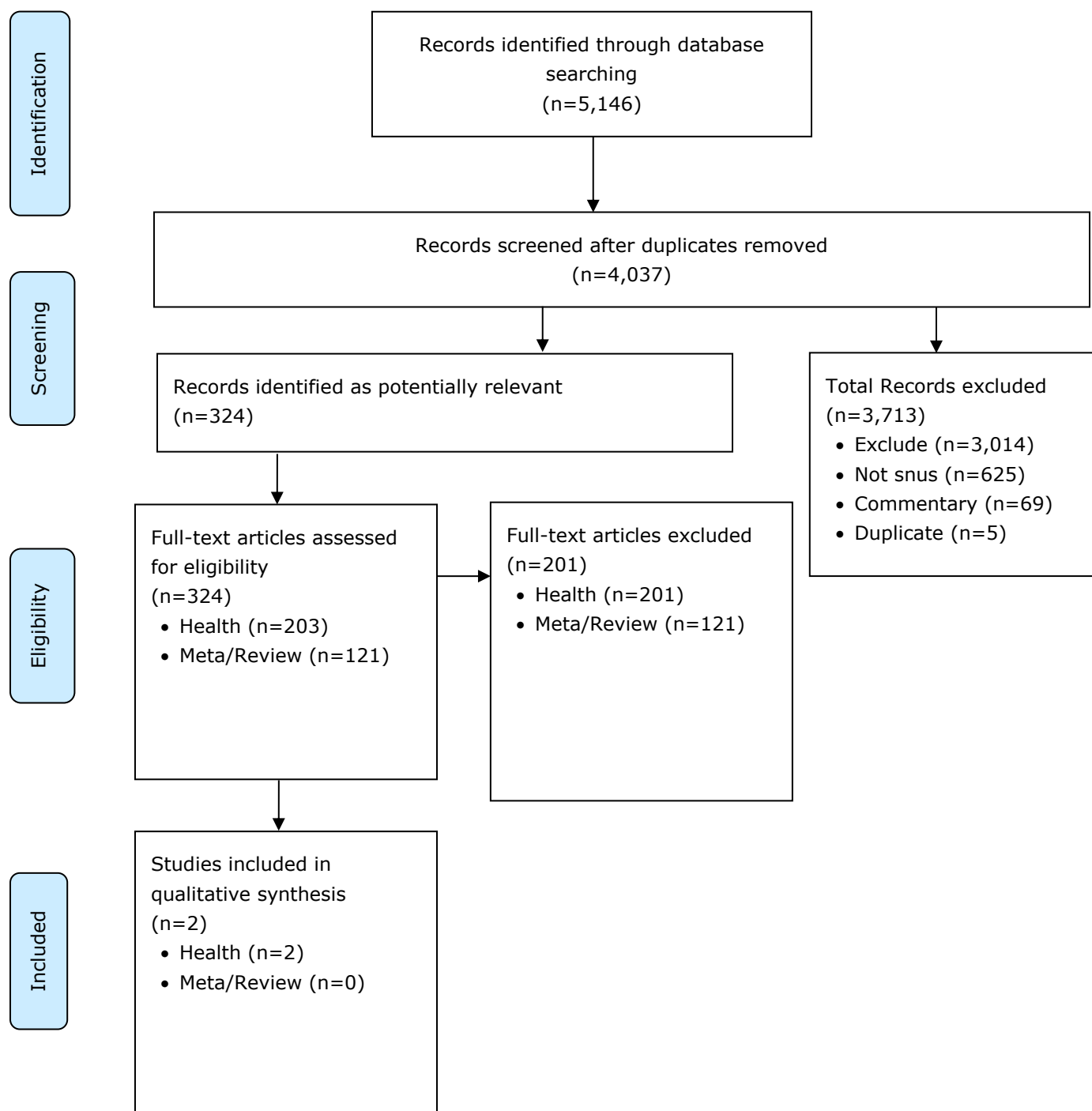
	<p>("alternative" AND ("nicotine" OR "tobacco")) OR "potential reduced exposure products" OR ("spit" AND "tobacco") OR "non-cigarette tobacco" OR ("chewing" AND "tobacco") OR "dissolvable tobacco" OR (dissolvable AND tobacco) OR "dry snuff" OR "non-combustible PREPs" OR ("smokeless tobacco") OR snuff OR snus OR ("personal" and "vaporizers") OR "non-cigarette tobacco" OR e-cig OR e-cigarette OR "electronic cigarette" OR "electronic nicotine delivery" OR vape OR vaping OR hookah OR shisha OR "modified risk tobacco product") AND (flavor OR flavors OR flavoring OR flavoured OR flavored OR attractiveness OR attract OR preferences OR preference OR prefer OR appeal OR reason OR reasons OR susceptibility OR receptivity))</p> <p>Limit to articles and articles in press, and English only</p>	
--	---	--

## Appendix C: Adapted PRISMA Literature Inclusion/Exclusion Diagram for the Updated Search





## Appendix D: Adapted PRISMA Literature Inclusion/Exclusion Diagram for Retrospective Health Effects Literature Search Prior to December 1, 2012



## Appendix E: Literature Abstraction Templates

Health-Related Literature (Update to Section 5 of the 2013 ENVIRON Report)

**Note:** If a study provides information for multiple endpoints, the results for each endpoint will be recorded as separate line items.

<b><u>TABLE HEADER</u></b>	<b><u>DETAILS</u></b>
<b>First Author</b>	Last name of first author
<b>Year</b>	Year of publication
<b>Overall Evidence Quality</b>	Overall quality determination for this line of evidence: Strong, Moderate, Weak
<b>Limitations and Potential Biases</b>	Study limitations potentially influencing the reported findings.
<b>Product Description</b>	Brand and type of snus, as applicable, author description
<b>Study Design</b>	Examples: cohort, case-control, clinical trial, focus group, etc.
<b>Population (total)</b>	Population/cohort description and total number of participants, prior to any screening/exclusion
<b>No. case/controls or equivalent</b>	Numbers used in specific analysis, and number of exposed cases
<b>Study Period</b>	--
<b>Endpoint Category</b>	Non-cancer Oral, Dental, Cancer, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, Repro, Other
<b>Endpoint</b>	Health endpoint evaluated (as described in the study)
<b>Covariates</b>	Examples: age, sex, race, education status, etc.
<b>Exposed Group</b>	Description of tobacco use (e.g. exclusive, duration, intensity, etc.)
<b>Referent Group</b>	Examples: never-users of tobacco, non-users of tobacco
<b>Risk Estimate Description</b>	Examples: Odds ratio, relative risk, etc.
<b>Risk Estimate</b>	--
<b>LCL</b>	Lower confidence limit
<b>UCL</b>	Upper confidence limit
<b>p-value (if applicable)</b>	--
<b>Statistically Significant?</b>	Yes/No
<b>Funding Source</b>	--
<b>Author Conclusion + Comments</b>	Author conclusion in quotes, and any additional comments regarding the study.

# Appendix F: Literature Abstraction Table: Health-Related Literature (Update to Section 5 of the 2013 ENVIRON Report)

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Andersson MLE, Bergman S and Söderlin MK. 2013. The effect of snuff (smokeless tobacco) on disease activity and function in rheumatoid arthritis: Experiences from the better anti-rheumatic pharmacotherapy, a longitudinal multicenter study on early rheumatoid arthritis. Journal of Clinical Rheumatology, 19(1): 14–18.	Weak	Snuff use assessed retrospectively (potential misclassification and recall bias), snuff users may have smoked previously, small sample size	Swedish "Snuff (moist smokeless tobacco)"	Cohort	2,800 patients older than 18 years enrolled in the BARFOTstudy, which included patients with early rheumatoid arthritis (RA) in southern Sweden	51 snuff users / 49 never-smoking controls	Enrolled in 1992-2005, followed through September 2010	Other	Rheumatoid Arthritis disease activity: Disease Activity Score 28 joints (DAS28)	socioeconomic class, disease duration, number of previous disease-modifying antirheumatic drugs and biologics (grouped together)	Snuff users (prior to start of, and after inclusion into the BARFOT study)	Never-smokers	Difference in mean DAS28 score				0.001	Yes (for 3 months and 6 months, but not 1, 2, and 5 years)	Swedish Society of Medicine, the Swedish Rheumatism Association, the Research Department of the County Council of Halland, the Gothenburg District Rheumatology Foundation, and the Crafoord Foundation	"No significant differences in DAS28 values at inclusion, at 3, 6, and 12 months, and at 1, 2, and 5 years of follow-up between snuff users and never smokers (P = 0.35, P = 0.81, P = 0.17, P = 0.89, P = 0.77, and P = 0.74, respectively)."  Following adjustments, "snuff users had significantly lower DAS28 scores at 3 months of follow-up (mean DAS28, 2.0 in snuff users vs. 3.7 in never smokers; P = 0.001) and at 6 months (mean DAS28, 2.1 in snuff users vs. 3.2 in never smokers, P = 0.003)."  "patients with RA using snuff generally had lower DAS28 values than those who had never smoked at up to 6 months of follow-up, and as compared with previous smokers at up to 2 years of follow-up, but no effect of snuff use was seen on HAQ or EULAR response."
Araghi M, Rosaria Galanti M, Lundberg M, Lager A, Engström G, Alfredsson L, Knutsson A, Norberg M, Sund M, Wennberg P, Trolle Lagerros Y, Bellocco R, Pedersen NL, Östergren P-O and Magnusson C. 2017. Use of moist oral snuff (snus) and pancreatic cancer: Pooled analysis of nine prospective observational studies. International Journal of Cancer, 141(4): 687–693.	Strong	Possible misclassification of exposure with long follow up	Swedish "moist oral snuff (snus)"	Pooled cohort	418,448 male participants from nine cohort studies. Data came from the Swedish Collaboration on Health Effects of Snus Use, and participants were followed up through linkage to health registries.	30% of participants had ever used snus at time of entry.	1978-2013	Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	Ever users	Never users of snus	HR (95% CI)	0.93	0.82	1.06	No	No stated		Cohorts included: Construction Worker Cohort, Malmo diet and Cancer Study, Multinational Monitoring of Cardiovascular disease (MONICA), National March Cohort, Scania Public Health Cohort, Stockholm Public Health Cohort, Vasterbotten intervention Programme (VIP), Work Lipids, and Fibrinogen Study.
	Strong					321 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	Former users	Never users of snus	HR (95% CI)	0.88	0.71	1.1	No			"Our findings, from the largest sample to date, do not support a role of snus use in the development of pancreatic cancer in men. They, furthermore, point to tobacco smoke constituents other than nicotine or its metabolites, i.e. carcinogens associated with combustion, as the causal agent explaining the increased risk of pancreatic cancer in smokers."
	Strong					93 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	Current users	Never users of snus	HR (95% CI)	0.96	0.83	1.11	No			
	Strong					227 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	<4 cans/week	Never users of snus	HR (95% CI)	0.87	0.7	1.08	No			"We had the opportunity to control for alcohol consumption, the level of physical activity as well as diabetes and again the main findings did not change."
	Strong					91 exposed cases 30% of participants had ever		Cancer	Pancreatic cancer	attained age, smoking	4-6 cans/week	Never users of snus	HR (95% CI)	1.16	0.93	1.46	No			Sensitivity analyses (Table 3) for cases from cancer register only, excluding the Construction Worker Cohort,

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						used snus at time of entry.				(never, former, current), and BMI										and excluding cohorts with no information on former snus use were all nonsignificant.
	Strong					83 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	≥ 7 cans/week	Never users of snus	HR (95% CI)	0.87	0.65	1.17		No		
	Strong					48 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	<5 years	Never users of snus	HR (95% CI)	0.82	0.56	1.21		No		
	Strong					27 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	5-<10 years	Never users of snus	HR (95% CI)	1	0.72	1.39		No		
	Strong					38 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	10-<15 years	Never users of snus	HR (95% CI)	0.99	0.72	1.36		No		
	Strong					41 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	15-<20 years	Never users of snus	HR (95% CI)	0.98	0.67	1.44		No		
	Strong					27 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), and BMI	≥ 20 years	Never users of snus	HR (95% CI)	0.95	0.75	1.19		No		
	Strong					78 exposed cases 30% of participants had ever used snus at time of entry.		Cancer	Pancreatic cancer	attained age, smoking (never, former, current), BMI, alcohol consumption, physical activity, and interaction between alcohol consumption and smoking among	Ever users	Never users of snus	HR (95% CI)	1.12	0.76	1.63		No		
						92 exposed cases														

288

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Lind L, Michaëlsson K, Lindahl B and Sundström J. 2014. Discontinuation of smokeless tobacco and mortality risk after myocardial infarction. Circulation, 130(4): 325–332.		never-smoking snus users (no analysis among exclusive users). No comparison with never-users of snus.			were admitted to a coronary care unit in Sweden between 2005–2009, then followed using a secondary prevention database (SEPHIA).	users / 675 post-MI snus quitters	followed until death or December 31, 2009			smoking exposure, diabetes mellitus, hypertension, blood pressure, BMI, waist circumference, LDL/HDL ratio, type of MI, occupation status, physical activity (4 levels), participation in cardiac rehabilitation program, treatment with aspirin, treatment with any other platelet inhibitor (primarily clopidogrel), β-blockers, statins, and renin-angiotensin-aldosterone system inhibitors (angiotensin-converting enzyme inhibitor or angiotensin 2 receptor blocker)	quitters	users							Foundation, the Swedish Research Council, and the Swedish Geriatric Fund	use after an MI was associated with a nearly halved mortality risk, similar to that associated with smoking cessation. These observations suggest that the use of snus after an MI should be discouraged."
	Moderate					1,799 post-MI snus users / 675 post-MI snus quitters		Other	Mortality	Model C: age, sex, past and present smoking and sun exposure, respectively, occupation status, participation in cardiac rehabilitation program	Post-MI snus quitters	Post-MI snus users	HR (95% CI)	0.57	0.32	1.02		No		
	Moderate					1,799 post-MI snus users / 675 post-MI snus quitters		Other	Noncardiovascular mortality	Model C: age, sex, past and present smoking and sun exposure, respectively, occupation status, participation in cardiac rehabilitation program	Post-MI snus quitters	Post-MI snus users	HR (95% CI)	0.43	0.15	1.27		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					1,799 post-MI snus users / 675 post-MI snus quitters		Heart/IHD	CV events	Model C: age, sex, past and present smoking and sun exposure, respectively, occupation status, participation in cardiac rehabilitation program	Post-MI snus quitters	Post-MI snus users	HR (95% CI)	0.38	0.11	1.32		No		
	Moderate					1,799 post-MI snus users / 675 post-MI snus quitters		Heart/IHD	Mortality from CV events	Model C: age, sex, past and present smoking and sun exposure, respectively, occupation status, participation in cardiac rehabilitation program	Post-MI snus quitters	Post-MI snus users	HR (95% CI)	0.56	0.16	2		No		
Baba S, Wikstrom A-K, Stephansson O and Cnattingius S. 2014. Influence of snuff and smoking habits in early pregnancy on risks for stillbirth and early neonatal mortality. Nicotine & tobacco research; official journal of the Society for Research on Nicotine and Tobacco, 16(1): 78-83.	Strong	Limitations: small number of exposed cases; self-reported tobacco use during pregnancy might lead to underreporting	"Swedish snuff"	Cohort	948,137 women born in Sweden, Denmark, Norway, Iceland, or Finland who were in the Swedish Medical Birth Register with single births during 1999-2010	9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco 27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users	1999-2010	Reproductive	Stillbirths (in pregnancies with gestational age ≥28 weeks)	maternal age, parity, early pregnancy BMI, education	Current snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	1.56	1.12	2.17	NA	Yes	Swedish Council for Working Life and Social Research; Karolinska Institutet; Uehara Memorial Foundation Scholarship for Overseas Postdoctoral Researcher	The authors concluded that there was no effect of current snuff use or snuff cessation on early neonatal mortality, though the findings on early neonatal mortality had low statistical power due to a small number of cases. Snuff use in early pregnancy was associated with stillbirth, but cessation of snuff use before pregnancy or in early pregnancy reduced risk.  Definition of "former" use: former snuff users reported using snuff 3 months before pregnancy, but had stopped using snuff at their first prenatal care visit.
	Strong					9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco 27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths		Reproductive	Stillbirths (in pregnancies with gestational age ≥28 weeks)		Current snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	1.43	1.02	1.99	NA	Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					among current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco		Reproductive	Stillbirths (in pregnancies with gestational age ≥28 weeks)	crude (no covariates)	Former snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	0.76	0.52	1.1	NA	No		
	Strong				27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco			Reproductive	Stillbirths (in pregnancies with gestational age ≥28 weeks)	maternal age, parity, early pregnancy BMI, education	Former snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	0.73	0.5	1.06	NA	No		
	Strong				27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco			Reproductive	Early neonatal deaths (among live born infants at ≥22 weeks)	crude (no covariates)	Current snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	0.8	0.38	1.7	NA	No		



Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases / controls or exposed / unexposed #  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco 27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users		Reproductive	Early neonatal deaths (among live born infants at ≥22 weeks)	maternal age, parity, early pregnancy BMI, education	Current snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	0.75	0.35	1.58	NA	No		
	Strong					current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco 27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users		Reproductive	Early neonatal deaths (among live born infants at ≥22 weeks)	maternal age, parity, early pregnancy BMI, education, gestational age	Current snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	0.64	0.3	1.37	NA	No		
	Strong					current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco 27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users		Reproductive	Early neonatal deaths (among live born infants at ≥22 weeks)	crude (no covariates)	Former snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	1.12	0.67	1.86	NA	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco		Reproductive	Early neonatal deaths (among live born infants at ≥22 weeks)	maternal age, parity, early pregnancy BMI, education	Former snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	1.06	0.64	1.78	NA	No		
	Strong					27 stillbirths and 15 early neonatal deaths among former snuff users; 37 stillbirths and 7 early neonatal deaths among current snuff users 9,198 current snuff users; 14,162 former snuff users; 667,301 nonusers of tobacco		Reproductive	Early neonatal deaths (among live born infants at ≥22 weeks)	maternal age, parity, early pregnancy BMI, education, gestational age	Former snuff user	Nonusers of snuff and cigarettes	OR (95% CI)	1.15	0.68	1.93	NA	No		
Bjorkman F, Edin F, Mattsson CM, Larsen F, Ekblom B, Bjorkman F, Edin F, Mattsson CM, Larsen F and Ekblom B. 2017. Regular moist snuff dipping does not affect endurance exercise performance. PLoS ONE, 12(7): e0181228.	Strong	Participants may have modified other behaviors during follow-up; cotinine test for snuff abstinence done only at the end of cessation, not during cessation period	"Swedish snuff (i.e. oral moist snuff, 'snus')"	Clinical trial	24 regular snuff users (>2 years daily use), no illnesses or medications, regular exercise >3 times/week	24 participants who stopped using snuff for >6 weeks; 11 snuff users who continued their usual daily use	Not stated	CV Effects	Resting systolic BP (mmHg)  Resting diastolic BP (mmHg)  Resting mean BP  Resting heart rate (beats min-1)  blood lactate (mM L-1)  total cholesterol (mM L-1)	NA	Snuff cessation group	Usual snuff use group	arithmetic mean ± SD	NA	NA	NA	Not reported  no significant difference between groups in any of these measures	No	The Public Health Agency of Sweden; the Swedish School of Sport and Health Sciences	Regular daily snuff use does not affect endurance exercise performance. Effects of snuff on cardiovascular risk factors are mixed; heart rate and blood pressure improved after cessation, but total cholesterol, LDL, and body mass showed negative effects after cessation.

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					24 participants who stopped using snuff for >6 weeks; 11 snuff users who continued their usual daily use		CV Effects	LDL (mM L-1) HDL (mM L-1) free fatty acids (FFA) (mM L-1) C-reactive protein (mg L-1) Peak values during maximal running tests: VO2 max (L min-1) Time to exhaustion (sec) HR peak (beats min-1) VE (L min-1) RER blood lactate (mM L-1) RPE (breathing) RPE (legs)	NA	Snuff cessation group	Usual snuff use group	arithmetic mean ± SD	NA	NA	NA	<0.000 (time to exhaustion) 0.02 (blood lactate) no significant difference between groups in any of these measures except time to exhaustion (p<0.000) and blood lactate (p=0.02)	No		
	Strong				42 regular snuff users (>2 years daily use), no illnesses or medications, regular exercise >3 times/week	24 participants who stopped using snuff for >6 weeks; 11 snuff users who continued their usual daily use		Diabetes/MetSy	Resting blood glucose (mM L-1) Resting insulin (mIU L-1)	NA	Snuff cessation group (for insulin, n=11)	Usual snuff use group (for insulin, n=10)	arithmetic mean ± SD	NA	NA	NA	0.093 no significant difference for blood glucose insulin group effect p=0.093	No		
	Strong					24 participants who stopped using snuff for >6 weeks; 11 snuff users who continued their usual daily use		Diabetes/MetSy	Peak values during maximal running tests: Blood glucose (mM L-1)	NA	Snuff cessation group	Usual snuff use group	arithmetic mean ± SD	NA	NA	NA	0.02 group effect is significantly different, p=0.02	No		
	Strong					24		Body Weight	Body	NA	Snuff	Usual	arithmetic	NA	NA	NA	Not	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases / controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments		
						participants who stopped using snuff for >6 weeks; 11 snuff users who continued their usual daily use			mass BMI		cessation group	snuff use group	c mean ± SD				report ed  no significant differences between groups for these measures					
Byhamre ML, Gustafsson PE, Jansson J-H, Wennberg M, Hammarstrom A and Wennberg P. 2017. Snus use during the life-course and risk of the metabolic syndrome and its components. Scandinavian Journal of public health, 1403494817706631.	Moderate	Small numbers, especially of exclusive snus users; participants only followed until age 43, and metabolic risk factors may take longer to develop; possible residual confounding from changes in other variables (like SES) over time; cumulative snus analysis included smokers	Swedish Snus	Cohort	All students in Swedish municipality of Lulea who attained 9th grade in 1981 (n=1083); at follow-up in 2008, the 94% of baseline still alive participated (n=1001)	Never tobacco users, age 43: n=308; current snus users who never smoked, age 43: n=37 (smokers and dual users are also evaluated)	1981-2008	Diabetes/Met Sy	Metabolic syndrome age 16 (n=81)	in adjusted models: sex, cumulative smoking, BMI at 16 years, SES at 16 years, family history of diabetes, alcohol consumption n at 43 years, physical activity at 43 years	Snus users who never smoked, at different ages	Never-users of tobacco	OR (95% CI)	0.95	0.54	1.65		No	County Council of Vasterbotten, County Council of Vasternorrland, Swedish Society of Medicine, VISARE NORR Fund (Northern County Councils Regional Federation)	Snus exposure in different life periods and cumulative snus exposure from age 16 to 43 were not associated with developing metabolic syndrome or its components at age 43.  Note that models in Table 2 among never-smokers were adjusted for cumulative smoking.		
								Metabolic syndrome age 21 (n=53)			1.15	0.60	2.21									
								Metabolic syndrome age 30 (n=57)			1.01	0.52	1.99									
								Metabolic syndrome age 43 (n=37)			1.15	0.52	2.51									
	Moderate								Body Weight	central obesity age 16 (n=81)	in adjusted models: sex, cumulative smoking, BMI at 16 years, SES at 16 years, family history of diabetes, alcohol consumption n at 43 years, physical activity at 43 years	Snus users who never smoked, at different ages	Never-users of tobacco	OR (95% CI)	1.40	0.83	2.35				No	
										central obesity age 21 (n=53)			1.24	0.65	2.34							
										central obesity age 30 (n=57)			1.15	0.61	2.15							
										central obesity age 43 (n=37)			1.65	0.76	3.58							
	Moderate								CV Effects	Raised triglycerides age 16 (n=81)	in adjusted models: sex, cumulative smoking, BMI at 16 years, SES at 16 years, family history of diabetes, alcohol consumption n at 43 years, physical activity at 43 years	Snus users who never smoked, at different ages	Never-users of tobacco	OR (95% CI)	1.38	0.81	2.37				No	
										Raised triglycerides age 21 (n=53)			1.27	0.66	2.45							
										Raised triglycerides age 30 (n=57)			1.37	0.71	2.63							
										Raised triglycerides age 43 (n=37)			1.10	0.49	2.45							
Moderate			CV Effects	Low HDL-C age16 (n=81)	in adjusted models: sex, cumulative smoking, BMI at 16 years, SES	Snus users who never smoked, at different ages	Never-users of tobacco	OR (95% CI)	1.23	0.72	2.12		No									
				Low HDL-C age 21 (n=53)				0.84	0.41	1.70												
								0.53	0.25	1.12												
								0.69	0.29	1.66												

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						smoked, age 43: n=37 (smokers and dual users are also evaluated)			Low HDL-C age 30 (n=57)  Low HDL-C age 43 (n=37)	at 16 years, family history of diabetes, alcohol consumption at 43 years, physical activity at 43 years										
	Moderate					Never tobacco users, age 43: n=308; current snus users who never smoked, age 43: n=37 (smokers and dual users are also evaluated)		Diabetes/Met Sy	Impaired fasting glucose or T2DM age 16 (n=81)  Impaired fasting glucose or T2DM age 21 (n=53)  Impaired fasting glucose or T2DM 30 (n=57)  Impaired fasting glucose or T2DM 43 (n=37)	in adjusted models: sex, cumulative smoking, BMI at 16 years, SES at 16 years, family history of diabetes, alcohol consumption at 43 years	Snus users who never smoked, at different ages	Never-users of tobacco	OR (95% CI)	1.08  1.28  1.01  0.38	0.59  0.63  0.48  0.12	1.97  2.62  2.11  1.16		No		
	Moderate					Never tobacco users, age 43: n=308; current snus users who never smoked, age 43: n=37 (smokers and dual users are also evaluated)		CV Effects	High blood pressure age 16 (n=81)  High blood pressure age 21 (n=53)  High blood pressure age 30 (n=57)  High blood pressure age 43 (n=37)	in adjusted models: sex, cumulative smoking, BMI at 16 years, SES at 16 years, family history of diabetes, alcohol consumption at 43 years	Snus users who never smoked, at different ages	Never-users of tobacco	OR (95% CI)	1.08  1.31  1.61  1.41	0.66  0.71  0.88  0.69	1.77  2.42  2.96  2.89		No		
	Moderate					Never tobacco users, age 43: n=308; current snus users who never smoked, age 43: n=37 (smokers and dual users are also evaluated)		Diabetes/Met Sy	Metabolic syndrome	in adjusted models: sex, smoking, BMI at 16 years, SES at 16 years, family history of diabetes, alcohol consumption at 43 years	Snus use 1 period (n=122)  Snus use 2 periods (n=97)  Snus use 3 periods (n=64)  Snus use 4 periods (n=47)	Never-users of tobacco	OR (95% CI)	1.08  1.11  1.01  0.91	0.59  0.57  0.50  0.40	1.96  2.17  2.06  2.05	p for trend= 0.660	No		
										(period= time between follow-up ages 16, 21, 30, and 43 years; includes smokers)										

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Carlsson S, Andersson T, Araghi M, Galanti R, Lager A, Lundberg M, Nilsson P, Norberg M, Pedersen NL, Trolle-Lagerros Y and Magnusson C. 2017. Smokeless tobacco (snus) is associated with an increased risk of type 2 diabetes: results from five pooled cohorts. Journal of Internal Medicine, 281(4): 398–406.	Strong	Incidence of diabetes was not assessed uniformly across the pooled studies, with some cases being self-reported. This might lead to underreporting and undiagnosed cases.	Swedish Snus	pooled Cohort	Male never smokers from 5 Swedish cohorts: the Vasterbotten Intervention Programme, the Stockholm Public Health Cohort, the Malmo Diet and Cancer Study, the National March Cohort, and the SALT study (n=54,531).	248 cases among current snus users; 118 cases among former users. Number of unexposed was reported as percentage of each cohort and number of person-years, not number of participants	1991–2013	Diabetes/Met Sy	Incident type 2 diabetes ICD-10, E11 type 2, E14 unspecified	age, calendar time, BMI, physical activity, education, alcohol consumption	Current snus users  Former snus users	Never smoking, never snus users	HR (95% CI)	1.15  0.86	1.00  0.71	1.32  1.05		No	Not stated	The authors concluded that high snus consumption increases the risk of developing type 2 diabetes.
	Strong					248 cases among current snus users; 118 cases among former users. Number of unexposed was reported as percentage of each cohort and number of person-years, not number of participants		Diabetes/Met Sy	Incident type 2 diabetes ICD-10, E11 type 2, E14 unspecified	age, calendar time, BMI, physical activity, education, alcohol consumption	Number of boxes/week (current)  1-2 (n=54 exposed case)  3-4 (n=83 exposed case)  5-6 (n=54 exposed case)  7+ (n=31 exposed case)  1-4 (n=137 exposed case)  4+ (n=85 exposed case)	Never smoking, never snus users	HR (95% CI)	1.14  1.03  1.42  1.68  1.08  1.43	0.86  0.82  1.07  1.17  0.90  1.15	1.50  1.29  1.87  2.41  1.29  1.79		Yes, at 5-6, 7+ boxes/week, and 4+ boxes/week		
	Strong					248 cases among current snus users; 118 cases among former users. Number of unexposed was reported as percentage of each cohort and number of person-years, not number of participants		Diabetes/Met Sy	Incident type 2 diabetes ICD-10, E11 type 2, E14 unspecified	age, calendar time, BMI, physical activity, education, alcohol consumption	Duration of snus use (current users)  <30 years (n=66 exposed case)  30+ years (n=152 exposed case)	Never smoking, never snus users	HR (95% CI)	  1.34  1.17	  1.03  0.98	  1.73  1.39		Yes, for <30 years		
Dafar A, Cevik-Aras H, Robledo-Sierra J, Mattsson U and Jontell M. 2016. Factors associated	Weak	Methods/study design unclear (referent group is unclear in model); authors do	Swedish snus	Case-control (authors describe as "retrospective	6448 patients examined by dentists in Boras, Sweden from 2004-2006	Nonreferred GT patients (n=130) and FT patients (n=62); referred GT patients	2004-2006	Non-cancer oral	Geographic tongue or fissured tongue	age, gender	Answered "yes" to snus use (may include smokers--not stated)	Referent group is unclear, but is described as a random sample of	OR (95% CI)	2.1	1.1	4.35	0.025	Yes	Saudi Arabian Ministry of Higher Education; Cultural Bureau, Berlin,	"In conclusion, the present study demonstrates that hypertension or hypertensive medications and the use of snus are factors associated with GT." Snus use was significantly

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments	
with geographic tongue and fissured tongue. Acta Odontologica Scandinavica, 74(3): 210–216. Dahlin S, Gunnerbeck A, Wikström A-K, Cnattingius S and Edstedt Bonamy A-K. 2016. Maternal tobacco use and extremely premature birth – a population-based cohort study. BJOG: An International Journal of Obstetrics and Gynaecology, 123(12): 1938–1946.	Strong	not state whether snus users are also smokers, and don't control for smoking in the analysis Tobacco use was self-reported (possible misclassification); more than 20% of women who had extremely preterm deliveries had missing tobacco information (information bias)	Swedish snuff	Cohort	All live singleton births in the Swedish Medical Birth Register 1999-2012	(n=166) and FT patients (n=15), and 1029 controls with no oral mucosal lesions 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users	1999-2012	Reproductive	Extremely preterm births (<28 weeks gestation)	maternal age, parity, cohabitant with father, country of birth, education, BMI	Snuff user in early pregnancy	Non-tobacco users	OR (95% CI)	1.58	1.14	2.21		Yes	Germany  Swedish Research Council for Health, Working Life, and Welfare	more prevalent among those with geographic tongue vs. controls (10.1% vs. 3.8%, P<0.01). No significant difference was observed in prevalence of use among those with fissured tongue.  The authors concluded that the use of Swedish snuff in pregnancy was associated with risk of extremely preterm birth, and that the risk was similar to that observed in women who smoked during pregnancy. Cessation of snuff or smoking reduced risks.  Further results are available (Table 4) which break down the three categories of preterm births by spontaneous vs. medically indicated.	
	Strong							Reproductive	Very preterm (28-31 weeks)	maternal age, parity, cohabitant with father, country of birth, education, BMI	Snuff user in early pregnancy	Non-tobacco users	OR (95% CI)	1.25	0.98	1.59		No			
	Strong								Reproductive	Moderately preterm (32-36 weeks)	maternal age, parity, cohabitant with father, country of birth, education, BMI	Snuff user in early pregnancy	Non-tobacco users	OR (95% CI)	1.21	1.11	1.31		Yes		
	Strong								Reproductive	Extremely preterm births (<28 weeks)	maternal age, parity, cohabitant with father, country of birth, education, BMI	Kept using snuff in pregnancy	Non-tobacco users	OR (95% CI)	1.69 0.78	1.17 0.52	2.45 1.16		Yes for kept using snuff		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users		Reproductive	Very preterm (28-31 weeks)	maternal age, parity, cohabitant with father, country of birth, education, BMI	Ceased snuff before early pregnancy	Non-tobacco users	OR (95% CI)	1.26 0.90	0.95 0.71	1.66 1.15		No		
	Strong					14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users 14,671 snuff users 1,117,464 nonusers of tobacco 37 extremely preterm births among snuff users 72 very preterm births among snuff users 712 moderately preterm births among snuff users		Reproductive	Moderately preterm (32-36 weeks)	maternal age, parity, cohabitant with father, country of birth, education, BMI	Ceased snuff before early pregnancy	Non-tobacco users	OR (95% CI)	1.26 0.95	1.15 0.88	1.38 1.02		Yes for kept using snuff		
Eriksson M and Ng N. 2015. Changes in access to structural social capital and its influence on self-rated health over time for middle-aged men and women: A longitudinal study from	Weak	Snuff was included as a covariate, not as an exposure. Results not shown for association of snuff with self-reported health, and reported association is based on a cross-sectional analysis.	Swedish "snuff"	Cohort (analysis of snuff use is cross sectional)	96,475 men and women aged 40, 50, and 60 at baseline who participated in the Vasterbotten Intervention Program (VIP) study. This study included 21,139 people who were 40 or 50 at baseline, who had complete data at follow-	Men: 8611 never snuff users 2679 former users 4137 current users Women: 16,129 never snuff users 499 former users 705 current	1990-2013	Other	Self-reported health	not reported for snuff analysis	Current snuff users	People who did not smoke or use snuff at baseline	Data not shown	Data not shown	Data not shown	Data not shown	Data not shown	FORTE, the Swedish Research Council for Health, Working Life, and Welfare	"Men and women who were current snuff users and only women who were current smokers had higher odds of reporting poor SRH than those who did not smoke or use snuff at baseline. However, these associations were not observed in the follow-up data (data not shown)."  Associations were only observed at baseline.	



Reference	Evidence Quality	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
northern Sweden. Social Science and Medicine, 130: 250–258.					up.	users														
Gudnadottir AY, Olafsdottir IS, Middelveld R, Ekerljung L, Forsberg B, Franklin K, Lindberg E, Janson C, Gudnadottir AY, Olafsdottir IS, Middelveld R, Ekerljung L, Forsberg B, Franklin K, Lindberg E and Janson C. 2017. An investigation on the use of snus and its association with respiratory and sleep-related symptoms: A cross-sectional population study. BMJ Open, 7(5): e015486.	Weak	Sample size is large, but study is limited by cross-sectional design. Tobacco-free comparison group for some analyses includes nearly 27% former smokers, and so is not truly tobacco-free.	Swedish "Snus"	Cross-sectional	45,000 subjects randomly selected for a postal questionnaire in the Global Allergy and Asthma European Network survey in 2008. In this study, 26,697 respondents from four Swedish cities, aged 16-75 years	20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1	2008	Other	Asthma	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.51	1.28	1.77	<0.05	Yes	EU Sixth Framework Programme for Research, Swedish Heart and Lung Foundation, Swedish Asthma and Allergy Foundation, Swedish Association against Heart and Lung Diseases, Centre for Allergy Research at the Karolinska Institutet, Karolinska Institutet and AstraZeneca Translational Science Centre Collaboration Research Program, Science for Life Laboratory Stockholm and AstraZeneca Collaboration Research Program, VBG Group Centre for Asthma and Allergy Research	The authors reported an association between risk of asthma and current snus use; no increased risk was observed among smokers or dual users. Snus users, smokers, and dual users all showed increased risk of asthmatic and other respiratory symptoms. Snus users had an increased risk of some sleep problems (snoring, difficulty initiating sleep, excessive daytime sleepiness) but decreased risk of difficulty maintaining sleep.
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Asthma	gender, age, BMI, study center, educational level, physical activity	Dual users (current snus users who have used snus every day for 6+ months who have also smoked in the past month, and have smoked at least one cigarette a day for at least 1 year)	Currently tobacco-free (includes former smokers)	OR (95% CI)	0.93	0.65	1.33	>0.05	No		Table 4 has results for former and current snus users among never smokers, but does not report the referent group (see Table 4 for these results, which are not abstracted here).
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Asthmatic symptoms :  Wheezing  Wheezing and breathlessness  Wheezing without having a cold  Night-time chest tightness  Night-time attacks of breathlessness  Night-time coughing	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.50 1.42 1.50 1.21 1.02 1.10	1.33 1.23 1.30 1.05 0.83 0.99	1.69 1.65 1.73 1.40 1.24 1.23	All but night-time attacks of breathlessness and night-time coughing  Yes, all but night-time attacks of breathlessness and night-time coughing  <0.05			
	Weak					20,699 tobacco		Other	Asthmatic symptoms	gender, age, BMI,	Dual users	Currently tobacco-	OR (95% CI)				<0.05	Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1			:	study center, educational level, physical activity	(current snus users who have used snus every day for 6+ months who have also smoked in the past month, and have smoked at least one cigarette a day for at least 1 year)	free (includes former smokers)		2.09	1.71	2.55				
									Wheezing					1.46	1.12	1.90				
									Wheezing and breathlessness					2.17	1.73	2.73				
														1.43	1.12	1.82				
														1.58	1.16	2.13				
									Wheezing without having a cold					1.79	1.49	2.15				
									Night-time chest tightness											
									Night-time attacks of breathlessness											
									Night-time coughing											
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Chronic bronchitis	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.19	1.03	1.37	<0.05	Yes		
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Chronic bronchitis	gender, age, BMI, study center, educational level, physical activity	Dual users (current snus users who have used snus every day for 6+ months who have also smoked in the past month, and have smoked at least one cigarette a day for at least 1 year)	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.85	1.48	2.31	<0.05	Yes		
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of		Other	Allergic rhinitis	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.17	1.05	1.3	<0.05	Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					exposed cases not given, but percentages are in Table 1 20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Allergic rhinitis	gender, age, BMI, study center, educational level, physical activity	Dual users (current snus users who have used snus every day for 6+ months who have also smoked in the past month, and have smoked at least one cigarette a day for at least 1 year)	Currently tobacco-free (includes former smokers)	OR (95% CI)	0.92	0.75	1.13	>0.05	No		
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Chronic rhinosinusitis	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.28	1.09	1.5	<0.05	Yes		
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)  # of exposed cases not given, but percentages are in Table 1		Other	Chronic rhinosinusitis	gender, age, BMI, study center, educational level, physical activity	Dual users (current snus users who have used snus every day for 6+ months who have also smoked in the past month, and have smoked at least one cigarette a day for at least 1 year)	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.78	1.38	2.29	<0.05	Yes		
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users		Other	Sleeping problems: Snoring Difficulty initiating sleep Difficulty	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months	Currently tobacco-free (includes former smokers)	OR (95% CI)	1.41 1.76 0.74 1.18	1.25 1.56 0.66 1.07	1.58 1.99 0.83 1.31	For all but early morning awakening, p<0.05	Yes, for all but early morning awakening		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistical Significance? (Yes/No)	Funding Source	Author Conclusion + Comments
						(current)			maintaining sleep					0.87	0.76	1.00				
						# of exposed cases not given, but percentages are in Table 1			Excessive daytime sleepiness					1.33	1.07	1.65				
									Early morning awakening											
									Use of medication for sleeping problems											
	Weak					20,699 tobacco free 2265 exclusive snus users (current) 597 snus/smoker dual users (current)		Other	Sleeping problems: Snoring	gender, age, BMI, study center, educational level, physical activity	Dual users (current snus users who have used snus every day for 6+ months who have also smoked in the past month, and have smoked at least one cigarette a day for at least 1 year)	Currently tobacco-free (includes former smokers)	OR (95% CI)	2.16	1.77	2.63	For all but difficulty maintaining sleep and early morning awakening	Yes, for all but difficulty maintaining sleep and early morning awakening		
									Difficulty initiating sleep					2.95	2.43	3.58				
									Difficulty maintaining sleep					0.91	0.75	1.12				
									Excessive daytime sleepiness					1.38	1.16	1.65				
									Early morning awakening					0.91	0.70	1.17				
									Use of medication for sleeping problems					2.77	2.05	3.74				
	Weak					14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked		Other	Asthma	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months, never smokers	Tobacco-free, never smoked	OR (95% CI)	1.49	1.2	1.85	<0.001	Yes		
						# of exposed cases not given, but percentages are in Table 3														
	Weak					14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked		Other	Asthma	gender, age, BMI, study center, educational level, physical activity	Ex-smokers, never smokers	Not stated	OR (95% CI)	1.06	0.79	1.4		No		
						# of exposed cases not given, but percentages are in Table 3														

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					3 14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked  # of exposed cases not given, but percentages are in Table 3		Other	Asthmatic symptoms :  Wheezing  Wheezing and breathlessness  Wheezing without having a cold  Night-time chest tightness  Night-time attacks of breathlessness  Night-time coughing	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months, never smokers	Tobacco-free, never smoked	OR (95% CI)	1.56  1.38  1.48  1.41  1.39  1.27	1.32  1.12  1.21  1.16  1.07  1.09	1.84  1.69  1.80  1.71  1.82  1.47	<0.001  0.002  <0.001  0.004  0.045  0.987	Yes. Unclear why the p-value for night time coughing is 0.987 if the CI does not include 1.		
	Weak					14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked  # of exposed cases not given, but percentages are in Table 3		Other	Asthmatic symptoms :  Wheezing  Wheezing and breathlessness  Wheezing without having a cold  Night-time chest tightness  Night-time attacks of breathlessness  Night-time coughing	gender, age, BMI, study center, educational level, physical activity	Ex-snus users, never smokers	Not stated	OR (95% CI)	1.10  1.00  1.24  1.01  1.27  1.14	0.89  0.76  0.97  0.78  0.92  0.96	1.36  1.31  1.59  1.30  1.76  1.37		No		
	Weak					14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked  # of exposed cases not given, but percentages are in Table 3		Other	Night-time coughing Chronic bronchitis	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months, never smokers	Tobacco-free, never smoked	OR (95% CI)	1.47	1.21	1.78	<0.001	Yes		
	Weak					14,914 tobacco free, never smoked 1168		Other	Chronic bronchitis	gender, age, BMI, study center, educational	Ex-snus users, never smokers	Not stated	OR (95% CI)	0.91	0.7	1.19		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed cases  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistical Significance? (Yes/No)	Funding Source	Author Conclusion + Comments
						exclusive snus users (current), never smoked				level, physical activity										
	Weak					# of exposed cases not given, but percentages are in Table 3 14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked		Other	Allergic rhinitis	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months, never smokers	Tobacco-free, never smoked	OR (95% CI)	1.14	0.99	1.31	0.012	No (again, unclear why p-value is so low if CI includes 1; the p-values might be for some measure other than the OR, but the table is unclear)		
	Weak					# of exposed cases not given, but percentages are in Table 3 14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked		Other	Allergic rhinitis	gender, age, BMI, study center, educational level, physical activity	Ex-snus users, never smokers	Not stated	OR (95% CI)	0.95	0.8	1.12		No		
	Weak					# of exposed cases not given, but percentages are in Table 3 14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked		Other	Chronic rhinosinusitis	gender, age, BMI, study center, educational level, physical activity	Nonsmoking current snus users who have used snus every day for 6+ months, never smokers	Tobacco-free, never smoked	OR (95% CI)	1.37	1.11	1.7	0.005	Yes		
	Weak					# of exposed cases not given, but percentages are in Table 3 14,914 tobacco free, never smoked 1168 exclusive snus users (current), never smoked		Other	Chronic rhinosinusitis	gender, age, BMI, study center, educational level, physical activity	Ex-snus users, never smokers	Not stated	OR (95% CI)	0.95	0.71	1.28		No		

306

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
population-based cohort study. PloS one, 9(1): e84715.	Moderate	exposure due to self-report of tobacco use; also, no information on consumption patterns of snuff (duration, intensity of use). Exact timing of cessation of exposure among women who quit was also not available (whether it was during or before pregnancy).			tobacco users, 11,461 snuff users, 746 dual users  Exposed cases: 31 cases among snuff users in early pregnancy, 2 among dual users in early pregnancy. Before pregnancy: 773,625 non tobacco users, 21,994 snuff users, 2,895 dual users  Early pregnancy (<15 weeks gestation): 917,900 non-tobacco users, 11,461 snuff users, 746 dual users  Exposed cases: 31 cases among snuff users in early pregnancy, 2 among dual users in early pregnancy. Before pregnancy: 773,625 non tobacco users, 21,994 snuff users, 2,895 dual users  Early pregnancy (<15 weeks gestation): 917,900 non-tobacco users, 11,461 snuff users, 746 dual users  Exposed cases: 31 cases among			Reproductive	Cleft lip, with or without cleft palate (ICD-10 codes Q36 & Q37)	maternal age, parity, education, living with father-to-be or not, hypertension, diabetes, preeclampsia, sex of newborn, birth (singleton or multiple), variation of diagnosis frequency, mother's country of birth	Current snuff user in pregnancy (n=17 exposed cases)  Stopped using snuff before or in early pregnancy (n=12 exposed cases)	Non-tobacco users	OR (95% CI)	1.61  0.77	1.00  0.44	2.61  1.37		No (borderline for current users)		
	Moderate							Reproductive	Isolated cleft palate	maternal age, parity, education, living with father-to-be or not, hypertension, diabetes, preeclampsia, sex of newborn, birth (singleton or multiple), variation of diagnosis frequency, mother's country of birth	Current snuff user in pregnancy (n=8 exposed cases)  Stopped using snuff before or in early pregnancy (n=5 exposed cases)	Non-tobacco users	OR (95% CI)	1.26  0.59	0.63  0.24	2.55  1.43		No		



Reference	Evidence Quality	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					snuff users in early pregnancy, 2 among dual users in early pregnancy. Before pregnancy: 773,625 non tobacco users, 21,994 snuff users, 2,895 dual users			Reproductive	Other malformations among infants with oral clefts	maternal age, parity, education, living with father-to-be or not, hypertension, diabetes, preeclampsia, sex of newborn, birth (singleton or multiple), variation of diagnosis frequency, mother's country of birth	Current snuff user in pregnancy	Non-tobacco users	Chi^2 (Difference between groups)			0.4	No		
Gustavsen MW, Page CM, Moen SM, Bjelgerud A, Berg-Hansen P, Nygaard GO, Sandvik L, Lie BA, Cellius EG and Harbo HF. 2014. Environmental exposures and the risk of multiple sclerosis investigated in a Norwegian case-control study. BMC Neurology, 14(1): 196.	Moderate	Exposure assessment was limited to ever/never use, and snuff users included smokers (analysis adjusted for smoking). Possible selection bias, as controls selected from a bone marrow donor registry might be healthier than the general population.	Swedish "snuff"	Case-control	cases, 756 MS patients from the Oslo MS Registry controls, 1090 randomly selected healthy people from the Norwegian Bone Marrow Donor Registry	530 cases, 918 controls  60 exposed cases, 141 exposed controls	2011-2012	Other	Multiple sclerosis	age, gender, smoking status, mononucleosis	Ever snuff users, carrier of HLA-DRB1*15:01 gene  Ever snuff users, NOT carrier of HLA-DRB1*15:01 gene	Not stated; likely never snuff users within gene carrier category	OR (95% CI)  0.60  0.88	0.60  0.88	0.27  0.39	1.32  2.0	0.20  0.76	No	The Research Council of Norway; Oslo MS Society; Odd Fellow Norway	A smaller percentage of MS patients (11.4%) reported ever using snuff than controls (15.6%).  The authors reported a significant association (decreased risk) of MS among snuff users who were carriers of the HLA-DRB1*15:01 gene (OR, 95% CI 0.41, 0.22-0.77), but this association was only seen in the unadjusted analysis. (See Table 4 for complete stratified unadjusted and adjusted results.)
Hansson J, Galanti MR, Hergens MP, Fredlund P, Ahlbom A, Alfreðsson L, Bellocchio R, Engström G, Eriksson M, Hallqvist J, Hedblad B, Jansson JH,	Strong	Large pooled analysis, restricted to never smokers. Possible misclassification of exposure, as snus exposure was	Swedish Snus	pooled Cohort	291,309 participants in eight prospective cohort studies which have been pooled into the Swedish Collaboration on Health Effects of Snus Use	130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases,	Recruitment from 1978-2004, follow-up ranged from 5-29 years	Stroke	First ever stroke, all types: ICD-10: I60-I61, I63, I64 ICD-9: 430-431, 434, 436 "corresponding codes in	age, BMI	Current snus users (n=291 exposed cases)  Former snus users (n=39 exposed	Never tobacco users	HR (95% CI)  1.01  0.88	1.01  0.88	0.89  0.64	1.14  1.22		No	Stockholm County Council, Swedish Research Council, National Institute of Public Health, Swedish Council for	The authors reported no association between snus use and incident stroke. Snus users showed increased case fatality, especially in the first weeks after diagnosis, but the authors could not rule out confounding as an explanation.

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Pedersen NL, Trolle Lagerros Y, Ostergren PO and Magnusson C. 2014. Snus (Swedish smokeless tobacco) use and risk of stroke: pooled analyses of incidence and survival. Journal of Internal Medicine, 276(1): 87-95.	Strong	measured at baseline and may have changed over time. Also, most analyses included former snus users in the referent group.				former snus users = 2630 # of cases, current snus users = 304		Stroke	the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death First ever stroke, all types: ICD-10: I60-I61, I63, I64 ICD-9: 430-431, 434, 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI, education	Current snus users (exposed cases not provided)	Never tobacco users	HR (95% CI)	1.1	0.78	1.57		No		Working Life and Social Research
	Moderate					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304			First ever stroke, all types: ICD-10: I60-I61, I63, I64 ICD-9: 430-431, 434, 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death											
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304			First ever stroke, all types: ICD-10: I60-I61, I63, I64 ICD-9: 430-431, 434, 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death											

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	cause of death Ischaemic stroke ICD-10 I63 ICD-9 434 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	Current snus users (exposed cases not provided)	"Noncurrent snus users"	HR (95% CI)	1.06	0.91	1.23		No		
	Moderate					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	Ischaemic stroke mortality ICD-10 I63 ICD-9 434 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI, year of diagnosis	Current snus users (exposed cases not provided)	"Noncurrent snus users"	HR (95% CI)	1.29	1	1.67		No		
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	Haemorrhagic stroke ICD-10 I60-I61 ICD-9 430-431 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	Current snus users (exposed cases not provided)	"Noncurrent snus users"	HR (95% CI)	0.94	0.73	1.22		No		
	Moderate					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	Haemorrhagic stroke mortality ICD-10 I60-I61 ICD-9 430-431 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI, year of diagnosis	Current snus users (exposed cases not provided)	"Noncurrent snus users"	HR (95% CI)	1.76	1.16	2.67		Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						snus users = 304			diagnoses and underlying cause of death											
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	Unspecified stroke ICD-10 I64 ICD-9 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	Current snus users (exposed cases not provided)	"Noncurrent snus users"	HR (95% CI)	1.1	0.78	1.54		No		
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	28-day case fatality for overall stroke	age, BMI, year of diagnosis	Current snus users (n=41 exposed cases)	Never tobacco users	HR (95% CI)	1.42	0.99	2.04		No		The authors reported no association between snus use and incident stroke. Snus users showed increased case fatality, especially in the first weeks after diagnosis, but the authors could not rule out confounding as an explanation. OR was much lower following exclusion of construction worker cohort (OR was 1.43 (95% CI 0.52–3.92))
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	First ever stroke, all types: ICD-10: I60-I61, I63, I64 ICD-9: 430-431, 434, 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	Snus use at baseline:  <4 cans/week (235 cases)  4-6 cans/week (26 cases)  7+ cans/week (14 cases)	"Noncurrent snus users"	HR (95% CI)	1.05 1.00 0.72	0.92 0.67 0.42	1.20 1.47 1.22		No		The authors reported no association between snus use and incident stroke. Snus users showed increased case fatality, especially in the first weeks after diagnosis, but the authors could not rule out confounding as an explanation.
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus		Stroke	Ischaemic stroke ICD-10 I63 ICD-9 434 "corresponding codes in the 8th and 7th edition" Included main and	age, BMI	Snus use at baseline:  <4 cans/week (151 cases)  4-6 cans/week (16 cases)	"Noncurrent snus users"	HR (95% CI)	1.06 1.02 0.54	0.89 0.62 0.24	1.26 1.68 1.26		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed cases  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					users = 2630 # of cases, current snus users = 304 130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	secondary diagnoses and underlying cause of death Haemorrhagic stroke ICD-10 I60-I61 ICD-9 430-431 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	7+ cans/week (6 cases)  Snus use at baseline:  <4 cans/week (151 cases)  4-6 cans/week (16 cases)  7+ cans/week (6 cases)	"Noncurrent snus users"	HR (95% CI)	0.95  1.02  0.78	0.71  0.51  0.32	1.27  2.07  1.90		No		
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	Unspecified stroke ICD-10 I64 ICD-9 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	Snus use at baseline:  <4 cans/week (151 cases)  4-6 cans/week (16 cases)  7+ cans/week (6 cases)	"Noncurrent snus users"	HR (95% CI)	1.16  0.75  1.52	0.81  0.19  0.49	1.68  3.01  4.79		No		
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	First ever stroke, all types: ICD-10: I60-I61, I63, I64 ICD-9: 430-431, 434, 436 "corresponding codes in the 8th and 7th edition" Included main and secondary diagnoses and underlying cause of death	age, BMI	Duration of snus use at baseline:  <20 years  20+ years	"Noncurrent snus users"	HR (95% CI)	0.98  1.05	0.81  0.89	1.18  1.23		No		
	Strong					130,485 men with no history of smoking or stroke included in analyses # of cases in all snus users= 2934 # of cases, former snus users = 2630 # of cases, current snus users = 304		Stroke	Ischaemic stroke ICD-10 I63 ICD-9 434 "corresponding codes in the 8th and 7th edition"	age, BMI	Duration of snus use at baseline:  <20 years  20+ years	"Noncurrent snus users"	HR (95% CI)	1.01  1.05	0.79  0.85	1.29  1.28		No		

313

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed # exposed cases	Study period	Endpoint Category (Not-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Olsson T and Alfredsson L. 2013. Nicotine might have a protective effect in the etiology of multiple sclerosis. Multiple Sclerosis Journal, 19(8): 1009–1013.	Moderate	unmatched analyses are presented in this report since these were significant and in close agreement with those from the matched analyses but had wider CIs (around 2000 more controls in unconditional analysis). This suggests that the matched analysis produced statistically non-significant values, though it is somewhat mitigated by the fact that the estimates were “in close agreement” and the matched factors were controlled for in the presented analyses. Given the likely negative attitude toward snus use, it is unlikely that information bias, a typical weakness in case-control studies, led to an inverse association between snus use and decreased odds of MS.				7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	5-10 packet-years	Snuff non-users	OR (95% CI)	0.77	0.63	0.95	0.01	Yes	Working Life and Social Research, FP6 EU Program Neuropromisse, Bibbi and Niels Jensens Foundation, Knut and Alice Wallenberg Foundation, Söderberg Foundation, and Swedish Association for Persons with Neurological Disabilities.	between cumulative dose of snuff use and the risk of developing the disease. Those who combined smoking and snuff use had a significantly lower risk for MS than smokers who had never used moist snuff.
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	>10 packet-years	Snuff non-users	OR (95% CI)	0.57	0.44	0.74	<0.0001	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	<5 packet-years, females only	Snuff non-users, females only	OR (95% CI)	0.83	0.68	1.04	0.1	No		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	5-10 packet-years, females only	Snuff non-users, females only	OR (95% CI)	0.65	0.41	1.05	0.08	No		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	>10 packet-years, females only	Snuff non-users, females only	OR (95% CI)	0.35	0.13	0.96	0.04	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	<5 packet-years, males only	Snuff non-users, males only	OR (95% CI)	0.83	0.71	0.98	0.03	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	5-10 packet-years, males only	Snuff non-users, males only	OR (95% CI)	0.78	0.62	0.99	0.04	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	>10 packet-years, males only	Snuff non-users, males only	OR (95% CI)	0.59	0.45	0.78	0.0004	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	<5 packet-years, never smokers	Never smoking snuff non-users	OR (95% CI)	0.96	0.68	1.35	0.9	No		
Moderate				7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level, ancestry, smoking	5-10 packet-years, never smokers	Never smoking snuff non-users	OR (95% CI)	0.87	0.68	1.1	0.6	No				

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistical Significance? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry Age, gender, residential area, educational level,	>10 packet-years, never smokers	Never smoking snuff non-users	OR (95% CI)	0.45	0.28	0.68	0.001	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry Age, gender, residential area, educational level,	Snus use and ever smoking	Never smoking snuff non-users	OR (95% CI)	1.19	1.06	1.34	<0.001	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level,	Snus use and current smoking	Never smoking snuff non-users	OR (95% CI)	1.42	1.21	1.65	<0.001	Yes		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level,	Snus use and past smoking	Never smoking snuff non-users	OR (95% CI)	1.03	0.88	1.2	0.7	No		
	Moderate					7883 cases 9437 controls		Other	Multiple Sclerosis	ancestry, smoking Age, gender, residential area, educational level,	Exclusive snus use	Never smoking snuff non-users	OR (95% CI)	0.75	0.63	0.9	0.002	Yes		
Hellqvist L, Boström A, Lingström P, Hugoson A, Rolandsson M and Birkhed O. 2012. Effect of nicotine-free and nicotine-Containing snus on plaque pH in vivo. Swedish Dental Journal, 36(4): 187-194.	Weak	The biological relevance of short term snus-related changes in plaque pH to dental caries is unknown. Small number of participants.	Swedish Match - General Original Portion	Clinical trial (cross-over)	10 Swedish adults	NA	11 weeks, 45 minute sessions/ week	Dental	plaque pH	NA	Swedish Match - General Original Portion	Sucrose control	Increased				<0.001	Yes	Karlstad University	Intraoral pH for nicotine-containing products increased in contrast to three of the six nicotine-free products, which lowered the plaque pH considerably, though all 10 products induced statistically significant pH changes compared to sucrose control. Overall, there appears to be a relationship between the content of fermentable carbohydrates in the snus and the pH fall in dental plaque after the application of the product intraorally.
	Weak		FLSnus - Granit White			NA		Dental	plaque pH	NA	FLSnus - Granit White	Sucrose control	Increased				<0.001	Yes		
	Weak		Swedish-snus - Gustavus Original Portion			NA		Dental	plaque pH	NA	Swedish-snus - Gustavus Original Portion	Sucrose control	Increased				<0.001	Yes		
	Weak		Skruf Snus AB - Skruf Original Portion			NA		Dental	plaque pH	NA	Skruf Snus AB - Skruf Original Portion	Sucrose control	Increased				<0.001	Yes		
	Weak		Gotlandssnus - Jakobsson Classic Nicofree AB - Choice Original			NA		Dental	plaque pH	NA	Gotlandssnus - Jakobsson Classic Nicofree AB - Choice Original	Sucrose control	Decreased				<0.001	Yes		
	Weak		Pepper Rebel Tobacco AB - Energy			NA		Dental	plaque pH	NA	Pepper Rebel Tobacco AB - Energy	Sucrose control	Decreased				<0.001	Yes		
	Weak		Swedish Match - Onico (old recipe)			NA		Dental	plaque pH	NA	Swedish Match - Onico (old recipe)	Sucrose control	Decreased				<0.001	Yes		
	Weak		Swedish Match - Onico Svenska			NA		Dental	plaque pH	NA	Swedish Match - Onico Svenska	Sucrose control	Decreased				<0.001	Yes		
	Weak					NA		Dental	plaque pH	NA		Sucrose control	Decreased				<0.001	Yes		
	Weak					NA		Dental	plaque pH	NA		Sucrose control	Decreased				<0.001	Yes		



316

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					non-users for >= 10 years 101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Number of decayed and filled tooth surfaces (upper front)	NA	Non-smoking daily snus users	Tobacco non-users	Mean Difference	0.1			0.762	No		
	Weak					101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Lactobacilli in saliva	NA	Non-smoking daily snus users	Tobacco non-users	Mean Difference	-0.3 log CFU/ml			0.054	No		
	Weak					101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Salivary secretion rate	NA	Non-smoking daily snus users	Tobacco non-users	Mean Difference	0.3 ml/min			0.005	Yes		
	Weak					101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Buffer capacity	NA	Non-smoking daily snus users	Tobacco non-users	Mean Difference				0.566	No		
	Weak					101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Cariogram value	NA	Non-smoking daily snus users	Tobacco non-users	Mean Difference	0.009			>0.05	No		
	Weak					101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Plaque pH	NA	Non-smoking daily snus users	Tobacco non-users	Mean Difference				>0.05	No		
	Weak					101 non-smoking daily snus users for >= 10 years 100 tobacco non-users for >= 10 years		Dental	Plaque pH fall	NA	Placing snus under the lip	No snus	Mean Difference	Smaller			0.001	Yes		
Hernberg A, Holmberg H, Norberg M and Nordin P. 2017. Tobacco use	Moderate	Methodology details are lacking, including details regarding	Swedish "snus"	Cohort	102,857 adults from Vasterbotten, Sweden	71169 snus never users 10647 former snus users 11679	2001-2013	Other	Groin hernia repairs	age, BMI, education	Former snus users, males	Never snus users, males	HR (95% CI)	1.1	0.96	1.25	0.17	No	Swedish government	"Tobacco use is not a risk factor for requiring a groin hernia repair."

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
is not associated with groin hernia repair, a population-based study. Hernia, 21(4): 517-523.	Moderate	the relative timings of exposure and outcome assessments . There are no assessments of exclusive snus users nor were the snus results adjusted for smoking and age, both of which are associated with risk of groin hernia repair. However, this is all somewhat mitigated by the fact that the observed associations were inverse, not positive, which still supports the statement that there were no increased risk of groin hernia repair associated with tobacco use.				current snus users who use <4 boxes per week 4170 current snus users who use 4+ boxes of snus per week 71169 snus never users 10647 former snus users 11679 current snus users who use <4 boxes per week 4170 current snus users who use 4+ boxes of snus per week 71169 snus never users 10647 former snus users 11679 current snus users who use <4 boxes per week 4170 current snus users who use 4+ boxes of snus per week 71169 snus never users 10647 former snus users 11679 current snus users who use <4 boxes per week 4170 current snus users who use 4+ boxes of snus per week		Other	Groin hernia repairs	age, BMI, education	<4 boxes of snus per week, males	Never snus users, males	HR (95% CI)	0.93	0.82	1.07	0.31	No		
	Moderate																			
	Moderate																			
	Moderate																			

Reference	Evidence Quality	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					snus users who use 4+ boxes of snus per week 71169 snus never users 10647 former snus users 11679 current snus users who use <4 boxes per week 4170 current snus users who use 4+ boxes of snus per week														
Hergens M-P, Galanti R, Hansson J, Fredhmd P, Ahlbom A, Son LA, Bellocco R, Eriksson M, Son EIF, Hallqvist J, Jansson J-H, Knutsson A, Pedersen N, Lagerros YT, Ostergren P-O, Magnusson C, Fredlund P, Ahlbom A, Alfredsson L, Bellocco R, Eriksson M, Fransson EI, Hallqvist J, Jansson J-H, Knutsson A, Pedersen N, Lagerros YT, Ostergren P-O and Magnusson C. 2014. Use of scandinavian moist smokeless tobacco (snus) and the risk of atrial fibrillation. Epidemiology, 25(6): 872–876.	Strong	The nature of the reference group does not exclude never smoking former snus users and may have biased the results toward null. The exposure assessment is likely done at a single timepoint for all cohorts, which likely means non-differential misclassification of exposure and thus likely a bias towards the null.	Swedish "Moist smokeless tobacco (snus)"	Pooled Cohort	127,907 Swedish males from 7 prospective cohort studies	425 current exclusive snus user cases observed 3069 snus nonuser cases observed	Baseline: 1978–2004, follow-up date not provided	Heart/IHD	Atrial Fibrillation	Age, BMI. Education was assessed and made no appreciable difference to the results.	Never smoker, current snus users	Never smoker, non-current snus	HR (95% CI)	1.07	0.97	1.19		No	Swedish Institute of Public Health and the Swedish Council for Working Life and Social Research	"Findings from this large national pooling project indicate that snus use is unlikely to confer any important increase in risk of atrial fibrillation."
Hirsch J-M, Wallström M, Carlsson A-P and Sand L. 2012. Oral cancer in Swedish snuff dippers. Anticancer Research, 32(8): 3327–3330.	Weak	The interpretation of the results depend on study participant selection. It is unknown whether the 16 participants were selected at	"Swedish snuff"	Case Series	16 patients with neoplastic oral lesions in the vestibular mucosa	16 exposed	NA	Cancer	Oral Cancer (oral squamous cell carcinoma)	NA	NA	NA	NA	NA	NA	NA			Thuréus Foundation	All 16 examined cases developed oral squamous cell carcinoma at the same location where snus "quid" was placed daily

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Jakobsson U and Larsson C. 2014. Smoking and Chronic Pain Among People Aged 65 Years and Older. Pain Practice, 14(3): 237-244.	Weak	random or if they were selected because their tumor location and snus quid placement location coincided. Temporality may be a concern as it is possible that those with snus-associated chronic pain may have quit prior to the study. It is possible that selection and information biases, two common features in cross sectional studies, may have been present and biased the results toward the null, but it is difficult to gauge the likelihood. Similarly, it is possible that non-differential misclassification of exposure or outcome biased the results toward the null, but its effects would have been minor	Swedish "moist snuff"	Cross-sectional	2000 Swedes 65 or older	90.1% never snus users (n=1028) 5.6% former snus users (n=64) 0.7% occasional snus users (n=8) 3.5% daily snus users (n=40) 90.1% never snus users (n=1028) 5.6% former snus users (n=64) 0.7% occasional snus users (n=8) 3.5% daily snus users (n=40) 90.1% never snus users (n=1028) 5.6% former snus users (n=64) 0.7% occasional snus users (n=8) 3.5% daily snus users (n=40) 90.1% never snus users (n=1028) 5.6% former snus users (n=64) 0.7% occasional snus users (n=8) 3.5% daily snus users (n=40) 90.1% never snus users (n=1028) 5.6% former snus users (n=64) 0.7%	2011	Other	Pain Intensity	Age, smoking	Former snus users, males	Never snus users, males	$\beta$	0.421	-0.072	0.914	0.094	No	King Gustav V and Queen Victoria's Foundation of Freemasons, the Gyllenstierna Krapperrup Foundation, and the Ragnhild and Einar Lundströms Foundation	No relationship was found between chronic pain and using moist snuff (snus).
	Weak							Other	Pain Intensity	Age, smoking	Occasional snus users, males	Never snus users, males	$\beta$	0.722	-0.426	1.87	0.284	No		
	Weak							Other	Pain Intensity	Age, smoking	Daily snus users, males	Never snus users, males	$\beta$	0.408	-0.095	0.911	0.112	No		
	Weak							Other	Pain Intensity	Age, smoking	Former snus users, females	Never snus users, females	$\beta$	0.447	-0.056	0.839	0.583	No		
	Weak							Other	Pain Intensity	Age, smoking	Daily snus users, females	Never snus users, females	$\beta$	-0.255	-1.541	1.032	0.697	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Jiang X, Alfredsson L, Klareskog L and Bengtsson C. 2014. Smokeless tobacco (moist snuff) use and the risk of developing rheumatoid arthritis: results from a case-control study. Arthritis care & research, 66(10): 1582–1586.	Moderate	It is possible that selection and information biases, two common features in case-control studies, may have been present and biased the results toward the null, but it is difficult to gauge the likelihood. Similarly, it is possible that non-differential misclassification of exposure or outcome biased the results toward the null, but its effects would have been minor	"Swedish moist snuff"	Case-control	2451 Swedes	occasional snus users (n=8) 3.5% daily snus users (n=40) 1998 cases 2252 controls	1996–2006	Other	Rheumatoid Arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Ever snus users  n=254 exposed cases	Snus non-users	OR (95% CI)	1	0.8	1.2	No	Swedish Research Council for Health, Working Life and Welfare; the Swedish Research Council; Vinnova; the AFA Insurance Company; King Gustaf V's 80-Year Foundation; the Swedish Rheumatism Foundation; and the European Union-funded Innovative Medicines Initiative (BTCure).	The use of moist snuff was not associated with the risk of either anti-citrullinated protein/peptide antibody-positive or anti-citrullinated protein/peptide antibody-negative rheumatoid arthritis. Other inhaled constituents of tobacco smoke than nicotine are more likely to be involved in the pathogenesis of anti-citrullinated protein/peptide antibody-positive RA.	
Moderate	1998 cases 2252 controls					Other		Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Ever snus users  n=172 exposed cases	Snus non-users	OR (95% CI)	1	0.8	1.3	No				
Moderate	1998 cases 2252 controls					Other		Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Ever snus users  n=82 exposed cases	Snus non-users	OR (95% CI)	0.9	0.7	1.2	No				
Moderate	1998 cases 2252 controls					Other		Rheumatoid Arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Current snus users  n=164 exposed cases	Snus non-users	OR (95% CI)	1.1	0.8	1.4	No				
Moderate	1998 cases 2252 controls					Other		Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Current snus users  n=109 exposed cases	Snus non-users	OR (95% CI)	1	0.8	1.4	No				
Moderate	1998 cases 2252 controls					Other		Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Current snus users  n=55 exposed cases	Snus non-users	OR (95% CI)	1	0.7	1.4	No				
Moderate	1998 cases 2252 controls					Other		Rheumatoid Arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Former snus users  n=90 exposed cases	Snus non-users	OR (95% CI)	0.9	0.6	1.2	No				
Moderate	1998 cases 2252 controls					Other		Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Former snus users  n=63 exposed cases	Snus non-users	OR (95% CI)	1	0.7	1.4	No				
Moderate	1998 cases 2252 controls					Other		Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption n.	Former snus users	Snus non-users	OR (95% CI)	0.8	0.5	1.2	No				

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					1998 cases 2252 controls		Other	ptide antibody negative rheumatoid arthritis	smoking, and alcohol consumption.	n=27 exposed cases	Never smoking ever snus users	Never smoking snus non-users	OR (95% CI)	1	0.6	1.7	No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=27 exposed cases	Never smoking ever snus users	Never smoking snus non-users	OR (95% CI)	1	0.5	1.9	No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=16 exposed cases	Never smoking ever snus users	Never smoking snus non-users	OR (95% CI)	1	0.5	2	No		
	Moderate					1998 cases 2252 controls		Other	Rheumatoid Arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=11 exposed cases	Never smoking current snus users	Never smoking snus non-users	OR (95% CI)	1.2	0.7	2.2	No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=22 exposed cases	Never smoking current snus users	Never smoking snus non-users	OR (95% CI)	1	0.5	2.2	No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=11 exposed cases	Never smoking current snus users	Never smoking snus non-users	OR (95% CI)	1.5	0.7	3.3	No		
	Moderate					1998 cases 2252 controls		Other	Rheumatoid Arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=11 exposed cases	Never smoking former snus users	Never smoking snus non-users	OR (95% CI)	0.5	0.2	1.5	No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption	n=5 exposed cases	Never smoking former snus users	Never smoking snus non-users	OR (95% CI)	1	0.3	2.8	No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-	n=5 exposed cases	Never smoking former	Never smoking snus non-	OR (95% CI)	NA	NA	NA	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistical Significance? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					1998 cases 2252 controls		Other	protein/peptide antibody negative rheumatoid arthritis	years of smoking, and alcohol consumption.	snus users n=0 exposed cases Ever smoking ever snus users	users Ever smoking snus non-users	OR (95% CI)	1	0.8	1.3		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=227 exposed cases Ever smoking ever snus users	Ever smoking snus non-users	OR (95% CI)	1	0.8	1.4		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=156 exposed cases Ever smoking ever snus users	Ever smoking snus non-users	OR (95% CI)	0.9	0.6	1.2		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=71 exposed cases Ever smoking current snus users	Ever smoking snus non-users	OR (95% CI)	1	0.8	1.4		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=142 exposed cases Ever smoking current snus users	Ever smoking snus non-users	OR (95% CI)	1.1	0.8	1.5		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=98 exposed cases Ever smoking current snus users	Ever smoking snus non-users	OR (95% CI)	0.9	0.6	1.3		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=44 exposed cases Ever smoking former snus users	Ever smoking snus non-users	OR (95% CI)	1	0.7	1.4		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, pack-years of smoking, and alcohol consumption.	n=85 exposed cases Ever smoking former snus users	Ever smoking snus non-users	OR (95% CI)	1	0.7	1.4		No		
	Moderate					1998 cases 2252		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential	n=58 exposed cases Ever smoking	Ever smoking	OR (95% CI)	0.9	0.5	1.5		No		



Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						controls			d protein/peptide antibody negative rheumatoid arthritis	area, pack-years of smoking, and alcohol consumption n.	former snus users  n=27 exposed cases	snus non-users								
	Moderate					1998 cases 2252 controls		Other	Rheumatoid Arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking ever snus users	Light, former, or never smoking snus non-users	OR (95% CI)	0.9	0.7	1.3		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking ever snus users	Light, former, or never smoking snus non-users	OR (95% CI)	0.9	0.6	1.4		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking ever snus users	Light, former, or never smoking snus non-users	OR (95% CI)	1	0.7	1.6		No		
	Moderate					1998 cases 2252 controls		Other	Rheumatoid Arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking current snus users	Light, former, or never smoking snus non-users	OR (95% CI)	1	0.7	1.5		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking current snus users	Light, former, or never smoking snus non-users	OR (95% CI)	0.9	0.5	1.4		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking current snus users	Light, former, or never smoking snus non-users	OR (95% CI)	1.3	0.8	2.1		No		
	Moderate					1998 cases 2252 controls		Other	Rheumatoid Arthritis	Age, sex, residential area, and alcohol consumption n.	Light, former, or never smoking former snus users  n=22	Light, former, or never smoking snus non-users	OR (95% CI)	0.8	0.5	1.4		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistical Significance? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody positive rheumatoid arthritis	Age, sex, residential area, and alcohol consumption.	exposed cases Light, former, or never smoking former snus users  n=15 exposed cases Light, former, or never smoking former snus users	Light, former, or never smoking snus non-users	OR (95% CI)	1	0.5	1.8		No		
	Moderate					1998 cases 2252 controls		Other	Anti-citrullinated protein/peptide antibody negative rheumatoid arthritis	Age, sex, residential area, and alcohol consumption.	n=7 exposed cases Light, former, or never smoking former snus users	Light, former, or never smoking snus non-users	OR (95% CI)	0.6	0.3	1.4		No		
Juarez SP, Merlo J, Juárez SP and Merlo J. 2013. The Effect of Swedish Snuff (Snus) on Offspring Birthweight: A Sibling Analysis. PLoS ONE, 8(6): e65611.	Strong	Possible survivor bias due to the use of liveborns.	"Swedish snuff (snus)"	Cohort	938,932 Swedish pregnancies/newborns	591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester	2002-2010	Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Use of snus in the first and/or third trimester	No use of snus during pregnancy	β	-19	-27	-11		Yes	Swedish Council for Working Life and Social Research, the Swedish Research Council	"Snus use during pregnancy was associated with a slight reduction in offspring birthweight." However, "the adverse effect of smoking during pregnancy on offspring birthweight may be explained by the combustion or other products of smoking rather than by nicotine."
	Strong					591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Use of snus throughout pregnancy	No use of snus during pregnancy	β	-47	-63	-47		Yes		
	Strong					591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Use of snus only in first trimester, quit before third trimester	No use of snus during pregnancy	β	-6	-17	4		No		
	Strong					591,690 non-users during pregnancy 2298 continuous snus users		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Took up snus between first and third trimester	No use of snus during pregnancy	β	-4	-27	19		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester 591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Sibling who experienced snus exposure during pregnancy	Sibling with no snus exposure during pregnancy	$\beta$	-12	-25	2		No		
	Strong					4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester 591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Sibling who experienced snus exposure in throughout pregnancy	Sibling with no snus exposure during pregnancy	$\beta$	-20	-52	12		No		
	Strong					4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester 591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Sibling who experienced snus exposure only in first trimester	Sibling with no snus exposure during pregnancy	$\beta$	-14	-31	3		No		
	Strong					4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester 591,690 non-users during pregnancy 2298 continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital status	Sibling who experienced snus exposure starting between first and third trimester	Sibling with no snus exposure during pregnancy	$\beta$	-14	-46	18		No		
	Strong					4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester 591,690 non-users during pregnancy 2298 continuous snus users		Reproductive	Birthweight	gestational age, birth order, sex, mother's age, and marital	Use of snus at any time point in the first pregnancy	First pregnancy among those who did not use	$\beta$	4	-21	30				

327

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Katsika D, Tuvblad C, Einarsson C, Lichtenstein P, Marschall HU. 2007. Body mass index, alcohol, tobacco and symptomatic gallstone disease: a Swedish twin study. Journal of internal medicine. 262(5):581-7.	Weak  Weak	Limited data on tobacco habits. Data missing on over half of cases, and approx. half of controls, thus limiting statistical power, few exposed cases, lack of control for potential confounders	Swedish "Smoke-free tobacco (snuff)"		Swedish Twin Registry with 58,402 twins born 1886-1958  27,692 male 30,710 female	continuous snus users 4934 snus users who quit by 3rd trimester 1107 snus users who relapsed by 3rd trimester  1666 cases (twins with gallstone disease)  n=7 exposed cases	1886-1958	Other	Gallstone disease	None	Twins with gallstone disease who reported current smoke-free tobacco use	Twins who reported never using smoke-free tobacco	OR (95% CI)	1.05	0.49	2.23		No	Department of Higher Education, Swedish Scientific Council, AstraZeneca, grants from Swedish Medical Society and Karolinska Institutet	"Smoking or use of smoke-free tobacco did not have a significant impact on symptomatic gallstone disease."
						1666 cases (twins with gallstone disease)  n=20 exposed cases		Other	Gallstone disease	None	Twins with gallstone disease who reported previous smoke-free tobacco use	Twins who reported never using smoke-free tobacco	OR (95% CI)	0.62	0.37	1.04		No		
Lie TM, Bomme M, Hveem K, Hansen JM and Ness-Jensen E. 2017. Snus and risk of gastroesophageal reflux. A population-based case-control study: the HUNT study. Scandinavian Journal of Gastroenterology, 52(2): 193-198.	Weak  Weak  Weak  Weak  Weak	The reduced risk among daily current snus users may indicate survivor bias given the increased risk observed in former users. The study focused on severe GERS cases and eliminated those who may have mild cases. It is possible that there was information and selection bias, both of which could have biased the results away from the null. The comparison groups were unclear at times.	Swedish "snus"	Cross sectional	58,634 Norwegians from the Nord-Trendelag county	24373 snus never-users 1342 former snus users 983 occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983 occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983 occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983 occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983	2006-2008	GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Former snus users	Snus never-users	OR (95% CI)	1.2	1	1.46		No	Not stated	Daily snus users had a reduced risk of GERS. However, previous snus users and subgroups of snus users had an increased risk of GERS indicating that snus use could increase the risk of GERS.
								GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Occasional snus users	Snus never-users	OR (95% CI)	1.21	0.96	1.52		No		
								GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Daily snus users	Snus never-users	OR (95% CI)	0.77	0.64	0.93		Yes		
								GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	<2 boxes/month	Snus never-users	OR (95% CI)	1.41	1.02	1.96		Yes		
								GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	2-8 boxes/month	Snus never-users	OR (95% CI)	0.93	0.78	1.1		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983		GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	>8 boxes/month	Snus never-users	OR (95% CI)	1.16	0.88	1.54		No		
	Weak					occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983		GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Never smoking ever snus users	Never smoking snus-never users	OR (95% CI)	0.75	0.54	1.03		No		
	Weak					occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983		GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Former smoking ever snus users	Former smoking snus-never users	OR (95% CI)	0.62	0.48	0.79		Yes		
	Weak					occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983		GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Occasional smoking ever snus users	Occasional smoking snus-never users	OR (95% CI)	1.39	0.94	2.04		No		
	Weak					occasional snus users 2104 daily snus users 24373 snus never-users 1342 former snus users 983		GI Effects	Severe gastroesophageal reflux disease	Age, sex, smoking status, BMI, and physical exercise	Daily smoking ever snus users	Daily smoking snus-never users	OR (95% CI)	1.12	0.78	1.61		No		
Liu Z, Roosaar A, Axéll T and Ye W. 2017. Tobacco use, oral health, and risk of Parkinson's disease. American Journal of Epidemiology, 185(7): 538–545.	Strong	Minor misclassification of exposure	"Swedish moist snuff (snus)"	Cohort	20,333 Uppsala County residents 15 years or older	occasional snus users 2104 daily snus users 3103 never daily user of any tobacco 5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user	1973–2012	Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive ever smoker	Never daily users of any tobacco	HR (95% CI)	0.68	0.49	0.93		Yes	Swedish Research Council for Health, Working Life and Welfare	Scandinavian moist snuff was associated with a reduced risk of Parkinson's Disease in males.
	Strong					3103 never daily user of any tobacco		Other	Parkinson's Disease	Age, area of residence, marital	Exclusive former smoker	Never daily users of any	HR (95% CI)	0.73	0.49	1.09		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user 3103 never daily user of any tobacco		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive current smoker	Never daily users of any tobacco	HR (95% CI)	0.64	0.44	0.93		Yes		
	Strong					5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user 3103 never daily user of any tobacco		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive snus user n=11 exposed cases	Never daily users of any tobacco	HR (95% CI)	0.51	0.27	0.95		Yes		
	Strong					5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user 3103 never daily user of any tobacco		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Dual user n=3 exposed cases	Never daily users of any tobacco	HR (95% CI)	0.21	0.07	0.67		Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Strong					user 3103 never daily user of any tobacco 5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive snus user of <=10 years	Never daily users of any tobacco	HR (95% CI)	0.54	0.2	1.49		No		
	Strong					3103 never daily user of any tobacco 5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive snus user of >10 years	Never daily users of any tobacco	HR (95% CI)	0.5	0.23	1.1		No		
	Strong					3103 never daily user of any tobacco 5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker 865 exclusive snus user 690 dual user		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive snus user of <=10 g/day	Never daily users of any tobacco	HR (95% CI)	0.33	0.12	0.91		No		
	Strong					3103 never daily user of any tobacco 5298 exclusive ever smoker 1635 exclusive former smoker 3663 exclusive current smoker		Other	Parkinson's Disease	Age, area of residence, marital status, and alcohol consumption	Exclusive snus user of >10 g/day	Never daily users of any tobacco	HR (95% CI)	0.76	0.35	1.66		No		



Reference	Evidence Quality	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Ludvigsson JF, Nordenvall C and Järnholm B. 2014. Smoking, use of moist snuff and risk of celiac disease: A prospective study. BMC Gastroenterology, 14(1).	Strong	Possible misclassification (long follow-up period without reevaluation), no exclusive snus group, although smoking was not associated with Celiac disease	Swedish "moist snuff"		199,185 men and women from the Swedish Construction Worker cohort	smoker 865 exclusive snus user 690 dual user 82,572 ever / 116,613 never users  597 men and 59 women with biopsy verified celiac disease (310 with data on moist snuff) 82,572 ever / 116,613 never users  597 men and 59 women with biopsy verified celiac disease (310 with data on moist snuff) 82,572 ever / 116,613 never users  597 men and 59 women with biopsy verified celiac disease (310 with data on moist snuff)	Baseline: 1971-1973. Follow-up: 2008	GI Effects	Celiac disease	Person-years stratified for age (10-year age-classes), decennium, sex and tobacco smoking	Ever users	Never tobacco users	RR (95% CI)	1	0.78	1.28		No	Swedish Society of Medicine, the Swedish Research Council, and the Swedish Celiac Society, Swedish Society for Medical Research, Swedish Research council for Health, Working Life and Welfare	"The most likely explanation for RRs around 1 in both smokers and moist snuff users are that these factors do not play a major role in the aetiology of CD in a Swedish setting." "In conclusion, we found no association between smoking, moist snuff use and CD."
	Strong																			
	Strong																			
Morente-Sánchez J, Zandonai T, Mateo-March M, Sanabria D, Sánchez-Muñoz C, Chiamulera C, Zabala Diaz M, Morente-Sanchez J, Zandonai T, Mateo-March M, Sanabria D, Sanchez-Munoz C, Chiamulera C and Zabala Diaz M. 2015. Acute effect of Snus on physical performance and perceived cognitive load on amateur footballers. Scandinavian Journal of Medicine and Science in	Moderate	Small number of participants	1.0-g portion of Snus (Catch White Eucalyptus)	Clinical trial (double-blind randomized crossover with 5 day washouts)	18 nonsmoking, non-snus-using male amateur football players in Spain	Half of participants received snus, and half received placebo during two experiments	2014	CV Effects	Acute decrease in heart rate variability (HRV): mean R-R interval (RRi)	NA	1-g portion of snus (8 mg nicotine) at baseline	1-g portion of snus (8 mg nicotine) at 35 minutes following acute intake	Mean difference				<0.001	Yes	Spanish "Ministerio de Educación," Spanish Ministerio de Economía y Competitividad," and Spanish "Junta de Andalucía"	"Regarding HRV, in line with Karakaya et al. (2007) findings, results showed a decrease after Snus administration even before the beginning of the fitness test battery. Results appear to confirm that nicotine leads to a reduced vagal tone."
	Moderate																			
	Moderate																			
						Half of participants received snus, and half received placebo		CV Effects	Acute decrease in heart rate variability (HRV): geometric	NA	1-g portion of snus (8 mg nicotine)	1-g portion of snus (8 mg nicotine) at 35 minutes	Mean difference				<0.04	Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Sports, 25(4): e423–e431.						during two experiments			Poincare Plot index (SD1) (instantaneous beat-to-beat variability Schizophrenia)			following acute intake								
Munafo MR, Larsson Lonn S, Sundquist J, Sundquist K, Kendler K, Munafo MR, Larsson Lonn S, Sundquist J, Sundquist K and Kendler K. 2016. Snus use and risk of schizophrenia and non-affective psychosis. Drug and Alcohol Dependence, 164: 179–182.	Moderate	Somewhat limited number of exposed cases, reference group not defined, potential for reverse causality, time period between exposure assessment and follow-up not described	"Swedish snuff ("snus")"	Cohort	227,117 Swedish men not diagnosed with non-affective psychosis (including schizophrenia) identified from various national registers, age 18-25 at time of military conscription	60,804 snus users / 166,313 non-users  36 exposed cases	Follow up through 2010 for most registries	Other		smoking, neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user (adjusted for smoking)	Not stated	HR (95% CI)	1.03	0.7	1.54		No	Not stated	"In conclusion, our data provide some evidence that snus use is associated with the subsequent development of non-affective psychosis. The evidence for an association with schizophrenia is weaker, but broadly consistent."
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Schizophrenia	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Exclusive snus user	Not stated	HR (95% CI)	1.23	0.77	1.98		No		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Schizophrenia	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user + Light smoker	Not stated	HR (95% CI)	0.42	0.16	1.07		No		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Schizophrenia	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user + Moderate smoker	Not stated	HR (95% CI)	0.75	0.19	2.92		No		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Schizophrenia	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user + Heavy smoker	Not stated	HR (95% CI)	1.43	0.29	2.08		No		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Non-affective psychosis	smoking, neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user (adjusted for smoking)	Not stated	HR (95% CI)	1.22	1	1.48		No		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Non-affective psychosis	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Exclusive snus user	Not stated	HR (95% CI)	1.38	1.09	1.75		Yes		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Non-affective psychosis	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user + Light smoker	Not stated	HR (95% CI)	0.69	0.45	1.05		No		
	Moderate					60,804 snus users / 166,313 non-users  36 exposed cases		Other	Non-affective psychosis	neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user + Moderate smoker	Not stated	HR (95% CI)	0.97	0.5	1.87		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					cases 60,804 snus users / 166,313 non-users		Other	Non-affective psychosis	prior to diagnosis neighborhood deprivation, parental education, drug abuse prior to diagnosis	Snus user + Heavy smoker	Not stated	HR (95% CI)	0.63	0.19	2.06		No		
Neumann A, Norberg M, Schoffer O, Norström F, Johansson I, Klug SJ and Lindholm L. 2013. Risk equations for the development of worsened glucose status and type 2 diabetes mellitus in a Swedish intervention program. BMC public health, 13: 1014.	Moderate	Number of exposed cases not provided, long follow up with exposures assessed only at first exam (possible misclassification), no exclusive snus group	Swedish "Snus"		29,937 adults aged 30, 40, or 50 at first exam living in the Swedish county of Vasterbotten, and followed up 10 years later for a second exam as part of the Vasterbotten Intervention Program (VIP)	No current use: 24,927 ≤4 cans/week: 3,293 >4 cans/week: 973 missing: 744	First exam: 1990-1999 Second exam: 10 years later	Diabetes/Met Sy	Progression of normal glucose tolerance to impaired fasting glucose	sex, age, education, triglyceride, blood pressure, BMI, smoking, physical activity, portions of fruits and vegetables, marital status, family history	Current use of snus	No current use of snus	OR (95% CI)	0.92	0.82	1.03		No		"The odds ratios of snus, "five a day" and marital status were all not significant."
	Moderate					No current use: 24,927 ≤4 cans/week: 3,293 >4 cans/week: 973 missing: 744		Diabetes/Met Sy	Progression of normal glucose tolerance to impaired fasting glucose and impaired glucose tolerance	sex, age, education, triglyceride, blood pressure, BMI, smoking, physical activity, portions of fruits and vegetables, marital status, family history	Current use of snus	No current use of snus	OR (95% CI)	0.79	0.59	1.05		No		
Nordenstam F, Lundell B, Cohen G, Tessa MK, Raaschou P and Wickstrom R. 2017. Prenatal Exposure to Snus Alters Heart Rate Variability in the Infant. Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco, 19(7): 797-803.	Weak	Small number of participants, lack of control for potential confounders	"Swedish snus"	Cohort	56 infants of women who used snus exclusively (n=23) or cigarettes exclusively (n=13) during pregnancy versus tobacco- and nicotine-free controls (n=19). Infants studied 1-2 months after birth.	23 infants of women who used snus, and 19 infants of nicotine-free controls	Not stated	Reproductive	Heart rate variability: max, min, and mean RR, SD RR, VLF, LF, HF, total power, LF/HF ratio	None	Infants of women who used snus exclusively	Nicotine-free controls						Yes	Swedish Medical Research Council, Swedish Council for Working Life and Social research, the Samaritan Foundation, Order of Odd Fellows and Swedish Freemasons Foundation	"We did not observe statistically significant differences between controls, snus or smoke groups in R-R intervals (min, max or mean)."  "Infants in the two tobacco exposed groups had a comparable LF/HF ratio, which was significantly higher than that of the control group. The main differences for infants in the snus group (mean difference = 1.16, 95% CI = 0.29-2.02, p = .006)... were statistically significant higher compared to controls."  "There were occasional extra beats found in all groups, mostly supraventricular extra systoles and occasionally ventricular extra systoles, but no other arrhythmias were detected."  "There was no difference between infants exposed to smokeless versus smoked tobacco, suggesting a common constituent (nicotine) altering autonomic cardiac regulation."
See table 2 for details																				

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Oberge J, Jorde R, Almas B, Emaus N, Grimnes G, Oberge J, Jorde R, Grimnes G, Almås B and Emaus N. 2014. Vitamin D deficiency and lifestyle risk factors in a Norwegian adolescent population. Scandinavian Journal of Public Health, 42(7): 593-602.	Weak	Cross-sectional design, lack of control for potential confounders	Swedish "Snuff"	Cross-sectional	890 Norwegian adolescents (475 boys and 415 girls) from the Tromsø Study	Boys: Never snuff users: n=279 Sometimes: n=58 Daily: n=131	2010-2011	Other	25(OH)D (Vitamin D level)	Univariate analysis	Boys snuff use: Sometimes Daily	Boys: Never use of snuff	Trend serum levels				0.01	Yes	The North Norway Regional Health Authority and UiT The Arctic University of Norway	"Whether snuff affects serum 25(OH)D levels by biological mechanisms or is a marker of an unhealthy lifestyle cannot be settled by this study, as there could be residual confounding factors not included in the model."
	Weak					Girls: Never snuff users: n=279 Sometimes: n=58 Daily: n=74		Other	25(OH)D (Vitamin D level)	Univariate analysis	Girls snuff use: Sometimes Daily	Girls: Never use of snuff	Trend serum levels				0.1	No		Serum Vitamin D levels were slightly lower in the "Sometimes" compared to "Daily" group, and both of these groups were lower than the "Never" group (see Table II in study for details). "Whether snuff affects serum 25(OH)D levels by biological mechanisms or is a marker of an unhealthy lifestyle cannot be settled by this study, as there could be residual confounding factors not included in the model."
Overland S, Skogen JC, Lissner L, Bjerkset O, Tjora T and Stewart R. 2013. Snus use and cardiovascular risk factors in the general population: The HUNT3 study. Addiction, 108(11): 2019-2028.	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias), adjusted for smoking	Swedish "Snus"	Cross-sectional	50,797 participants in the 3rd wave of the Nord-Trøndelag Health Surveys (HUNT3) in the county of Nord-Trøndelag, Norway	849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users	2006-2008	Body Weight	Waist circumference	age, smoking, gender, education, physical exercise, frequency of alcohol use	Previous snus use	Never snus use	b	0.78	0.13	1.43		Yes	HUNT Research Centre, Nord-Trøndelag County Council, Central Norway Health Authority and the Norwegian Institute of Public Health	"After adjusting statistically for major confounding variables, Norwegians who use snus extensively have a mixed profile in terms of cardiovascular risk: slightly higher waist circumference and systolic blood pressure but also higher high-density lipoprotein-cholesterol."
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		Body Weight	Waist circumference	age, smoking, gender, education, physical exercise, frequency of alcohol use	Sometimes snus use	Never snus use	b	-0.29	-	1.04	0.45	No		"The significant associations between snus use and the cardiovascular risk factors were found were generally quite weak, and not particularly consistent."
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias)	Swedish "Snus"	Cross-sectional	50,797 participants in the 3rd wave of the Nord-Trøndelag Health Surveys (HUNT3) in the county of Nord-Trøndelag, Norway	849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users	2006-2008	Body Weight	Waist circumference	age, smoking, gender, education, physical exercise, frequency of alcohol use	Daily snus use	Never snus use	b	-0.32	-	0.98	0.35	No	HUNT Research Centre, Nord-Trøndelag County Council, Central Norway Health Authority and the Norwegian Institute of Public Health	Stratified results by gender provided in Table 3
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		Body Weight	Waist circumference	age, smoking, gender, education, physical exercise, frequency of alcohol use	Extensive snus use	Never snus use	b	1.38	0.59	2.17		Yes		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		Body Weight	Waist circumference	age, gender, education, physical exercise, frequency of alcohol use	No previous current tobacco use	Current snus only	b	-0.41	-	0.97	0.15	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetS, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		Body Weight	Waist circumference	age, gender, education, physical exercise, frequency of alcohol use	Current smoking and snus use	Current snus only	b	0.1	-0.73	0.93		No		
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias), adjusted for smoking				849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		CV Effects	HDL-cholesterol	age, smoking, gender, education, physical exercise, frequency of alcohol use	Previous snus use	Never snus use	b	0.19	-0.52	0.9		No		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		CV Effects	HDL-cholesterol	age, smoking, gender, education, physical exercise, frequency of alcohol use	Sometimes snus use	Never snus use	b	0.95	0.14	1.76		Yes		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		CV Effects	HDL-cholesterol	age, smoking, gender, education, physical exercise, frequency of alcohol use	Daily snus use	Never snus use	b	0.92	0.2	1.64		Yes		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		CV Effects	HDL-cholesterol	age, smoking, gender, education, physical exercise, frequency of alcohol use	Extensive snus use	Never snus use	b	1.03	0.17	1.89		Yes		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		CV Effects	HDL-cholesterol	age, gender, education, physical exercise, frequency of alcohol use	No previous current tobacco use	Current snus only	b	-0.81	-1.41	-0.21		Yes		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users		CV Effects	HDL-cholesterol	age, gender, education, physical exercise, frequency of alcohol use	Current smoking and snus use	Current snus only	b	-1.57	-2.46	-0.69		Yes		
	Weak	Cross-sectional				849 Extensive snus users		CV Effects	Triglycerides	age, smoking,	Previous snus use	Never snus use	b	5.86	0.96	10.76		Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak	study design, 53% participation rate-lower among younger (selection bias), adjusted for smoking				snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Triglycerides	age, smoking, gender, education, physical exercise, frequency of alcohol use	Sometimes snus use	Never snus use	b	6.87	1.26	12.47		Yes		
	Weak					snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Triglycerides	age, smoking, gender, education, physical exercise, frequency of alcohol use	Daily snus use	Never snus use	b	-2.78	-7.77	2.21		No		
	Weak					snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Triglycerides	age, smoking, gender, education, physical exercise, frequency of alcohol use	Extensive snus use	Never snus use	b	3.24	-2.7	9.19		No		
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias)				snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Triglycerides	age, gender, education, physical exercise, frequency of alcohol use	No previous current tobacco use	Current snus only	b	-2.82	-7.05	1.41		No		
	Weak					snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Triglycerides	age, gender, education, physical exercise, frequency of alcohol use	Current smoking and snus use	Current snus only	b	9.75	3.5	15.99		Yes		
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias), adjusted for smoking				snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Systolic blood pressure (SBP)	age, smoking, gender, education, physical exercise, frequency of alcohol use	Previous snus use	Never snus use	b	-0.89	-1.8	0.03		No		
	Weak					snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849		CV Effects	Systolic blood pressure (SBP)	age, smoking, gender, education, physical exercise, frequency of alcohol use	Sometimes snus use	Never snus use	b	0.94	-0.1	1.99		No		

338

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					sometimes snus users, 1,265 previous snus users 849		CV Effects	Diastolic blood pressure (DBP)	age, smoking, gender, education, physical exercise, frequency of alcohol use	Extensive snus use	Never snus use	b	0.32	-0.4	1.05		No		
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias)			Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849			CV Effects	Diastolic blood pressure (DBP)	age, gender, education, physical exercise, frequency of alcohol use	No previous current tobacco use	Current snus only	b	-0.5	-1.01	0.01		No		
	Weak				Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849			CV Effects	Diastolic blood pressure (DBP)	age, gender, education, physical exercise, frequency of alcohol use	Current smoking and snus use	Current snus only	b	-1.67	-2.42	-0.91		Yes		
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias), adjusted for smoking			Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849			Diabetes/Met Sy	Non-fasting glucose	age, smoking, gender, education, physical exercise, frequency of alcohol use	Previous snus use	Never snus use	b	0.7	-0.44	1.85		No		
	Weak				Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849			Diabetes/Met Sy	Non-fasting glucose	age, smoking, gender, education, physical exercise, frequency of alcohol use	Sometimes snus use	Never snus use	b	1.01	-0.3	2.32		No		
	Weak				Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849			Diabetes/Met Sy	Non-fasting glucose	age, smoking, gender, education, physical exercise, frequency of alcohol use	Daily snus use	Never snus use	b	-0.51	-1.68	0.66		No		
	Weak				Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849			Diabetes/Met Sy	Non-fasting glucose	age, smoking, gender, education, physical exercise, frequency of alcohol use	Extensive snus use	Never snus use	b	-1.31	-2.7	0.08		No		



Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak	Cross-sectional study design, 53% participation rate-lower among younger (selection bias)				1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users 849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users				use			b	0.13	-0.83	1.1		No		
	Weak					849 Extensive snus users, 1,214 daily snus users, 941 sometimes snus users, 1,265 previous snus users							b	0.48	-0.95	1.91		No		
Ozga JE, Felicione NJ, Elswick D and Blank MD. 2016. Acute effects of snus in never-tobacco users: a pilot study. American Journal of Drug and Alcohol Abuse. Department of Psychology, West Virginia University, Morgantown, WV, USA: Taylor and Francis Ltd.	Moderate	Participants may have experienced "carryover effects" from previously consumed pouches, small sample size	Swedish snus (General White Large)	Clinical trial	6 men and five women, aged 19-26, who reported fewer than 100 lifetime uses of tobacco, and no tobacco in the past 3 months.	6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session	Not stated	CV Effects	Heart rate	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.012 0.001 0.018	Yes	West Virginia University Department of Psychology	"A significant Dose X Time interaction was observed for HR. As shown in Figure 1A, HR levels generally decreased from pre- to post-dose for the initial snus doses, but then increased toward the end of session. Increases in HR from pre- to post-pouch were significant only for the sixth and final dose (8.0 mg nicotine) (Tukey's HSD; p < .05)."
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		CV Effects	Systolic blood pressure (SBP)	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				<0.001 0.003 0.014	Yes		"Significant increases in physiological response at some doses suggest that users were exposed to pharmacologically active doses of nicotine. The lack of reliable subjective effects may be the product of the dosing regimen or the relatively small sample size." "A significant Dose X Time interaction was also observed for SBP. Figure 1B shows that SBP increased from pre- to post-pouch at nearly every active dose. Collapsed across dose, average SBP was 116.9 mmHg (SEM = 1.8) at pre-pouch and 120.1 mmHg (SEM = 1.9) post-pouch. Still, these increases were reliable only for the sixth and final dose (8.0 mg nicotine) (Tukey's HSD; p < .05)."
	Moderate					6 men and five women consumed six doses: 0.0, 1.6,		CV Effects	Diastolic blood pressure (DBP)	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in	Differences examined across dose	Dose Time Dose x Time				0.021 0.204 0.634	Yes		"Significant increases in physiological response at some doses suggest that users were exposed to pharmacologically active doses of nicotine. The lack of reliable subjective effects may be the product of the dosing regimen or the relatively small sample size." "For DBP, a significant main effect of Dose was observed (see Figure 1C). Collapsed across time, average DBP was 62.6 mmHg (SEM = 1.6) for

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						3.2, 4.8, 6.4, and 8.0 mg nicotine in one session					one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	groups								0.0 mg nicotine, 59.2 mmHg (SEM = 1.7) for 1.6 mg nicotine, 62.8 mmHg (SEM = 1.6) for 3.2 mg nicotine, 61.7 mmHg (SEM = 1.4) for 4.8 mg nicotine, 63.1 mmHg (SEM = 1.5) for 6.4 mg nicotine, and 66.9 mmHg (SEM = 1.5) for 8.0 mg nicotine. Average DBP for the 8.0 mg nicotine dose was significantly higher than that for all other doses (Tukey's HSD; p < .05)."
	Moderate				6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session			Other	Nauseous	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.157 0.082 0.113	No		"Significant increases in physiological response at some doses suggest that users were exposed to pharmacologically active doses of nicotine. The lack of reliable subjective effects may be the product of the dosing regimen or the relatively small sample size."
	Moderate				6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session			Other	Dizzy	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.0284 0.112 0.734	No		"Significant increases in physiological response at some doses suggest that users were exposed to pharmacologically active doses of nicotine. The lack of reliable subjective effects may be the product of the dosing regimen or the relatively small sample size."
	Moderate				6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session			Other	Lightheaded	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session.	Differences examined across dose groups	Dose Time Dose x Time				0.308 0.061 0.820	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistical Significance? (Yes/No)	Funding Source	Author Conclusion + Comments
						6.4, and 8.0 mg nicotine in one session					session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.									
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Nervous	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.349 0.337 0.254	No		
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Sweaty	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.316 0.331 0.331	No		
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Headache	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20-25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.170 0.116 0.505	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Excessive salivation	None	session, with ~20–25 minutes separating the end of a pouch and the start of the next pouch. 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20–25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.751 0.035 0.174	Yes		
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Heart Pounding	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20–25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.264 0.397 0.474	No		
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Confused	None	0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20–25 minutes separating the end of a pouch	Differences examined across dose groups	Dose Time Dose x Time				0.325 0.245 0.323	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases / controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					6 men and five women consumed six doses: 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session		Other	Weak	None	and the start of the next pouch. 0.0, 1.6, 3.2, 4.8, 6.4, and 8.0 mg nicotine in one session. 24 mg nicotine over the last 4 hours of the 5 hour session, with ~20–25 minutes separating the end of a pouch and the start of the next pouch.	Differences examined across dose groups	Dose Time Dose x Time				0.331 0.361 0.558	No		
Palmisano S, Schwartzbaum J, Prochazka M, Pettersson D, Bergenheim T, Florentzson R, Harder H, Mathiesen T, Nyberg G, Siesjö P and Feychting M. 2012. Role of tobacco use in the etiology of acoustic neuroma. American Journal of Epidemiology, 175(12): 1243–1251.	Moderate	Potential selection bias (controls less likely to participate: 65% vs. 84%). Nonparticipants were likely to be of lower SES, which is associated with snuff use, and is probably independently associated with acoustic neuroma, no exclusive snuff group	Swedish "Snuff"	Case-control	451 patients diagnosed with acoustic neuroma and 710 population-based controls	Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers	2002–2007	Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Ever snuff user	Never-user of snuff	OR (95% CI)	0.99	0.65	1.51	No		Swedish Council for Working Life and Social Research	"We observed no evidence of a role for snuff tobacco consumption in acoustic neuroma etiology."
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Former snuff user	Never-user of snuff	OR (95% CI)	1.22	0.71	2.1	No			
	Moderate					37 exposed cases  Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Current snuff user	Never-user of snuff	OR (95% CI)	0.94	0.57	1.55	No			
	Moderate					40 exposed cases  Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Age started using snuff: <15	Never-user of snuff	OR (95% CI)	1.21	0.36	4.07	No			
						10 exposed cases				Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking										

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  28 exposed cases		Other	Acoustic neuroma	status Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Age started using snuff: 15-19	Never-user of snuff	OR (95% CI)	0.95	0.53	1.68		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  40 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Age started using snuff: ≥20	Never-user of snuff	OR (95% CI)	1.01	0.6	1.68	0.98 (trend)	No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  7 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Years since starting: <10	Never-user of snuff	OR (95% CI)	0.8	0.31	2.06		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  15 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Years since starting: 10-19	Never-user of snuff	OR (95% CI)	1	0.45	2.19		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  26 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Years since starting: 20-29	Never-user of snuff	OR (95% CI)	1.6	0.77	3.28		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  30 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Years since starting: ≥30	Never-user of snuff	OR (95% CI)	0.86	0.51	1.65	.63 (trend)	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  19 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Total years: <10	Never-user of snuff	OR (95% CI)	0.913	0.41	1.77		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  21 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Total years: 10-19	Never-user of snuff	OR (95% CI)	1.2	0.6	2.42		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  16 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Total years: 20-29	Never-user of snuff	OR (95% CI)	0.96	0.45	2.06		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  16 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Total years: ≥30	Never-user of snuff	OR (95% CI)	0.91	0.46	1.82	.97 (trend)	No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  12 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Years since stopped: ≥20	Never-user of snuff	OR (95% CI)	1.29	0.53	3.13		No		
	Moderate					Cases: 78 snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  7 exposed cases		Other	Acoustic neuroma	Controls matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	Years since stopped: 10-19	Never-user of snuff	OR (95% CI)	0.64	0.24	1.68		No		
	Moderate					Cases: 78		Other	Acoustic	Controls	Years	Never-	OR (95%	1.56	0.68	3.59	.57	No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						snuff users, 152 nonusers  Controls: 119 users, 239 nonusers  16 exposed cases			neuroma	matched on gender, region, and age within 5 years. Adjusted for highest level of education and smoking status	since stopped: >1-9	user of snuff	CI)				(trend)			
Parn T, Grau Ruiz R, Kunovac Kallak T, Ruiz JR, Davey E, Hreinsson J, Wanggren K, Salumets A, Sjostrom M, Stavreus-Evers A, Ortega FB, Altmäe S, Pärn T, Grau Ruiz R, Kunovac Kallak T, Ruiz JR, Davey E, Hreinsson J, Wanggren K, Salumets A, Sjostrom M, Stavreus-Evers A, Ortega FB and Altmäe S. 2015. Physical activity, fatness, educational level and snuff consumption as determinants of semen quality: findings of the ActiART study. Reproductive BioMedicine Online, 31(1): 108–119.	Weak	Cross-sectional design, includes smokers, lack of control for potential confounders, small number of participants, generalizability a concern with IVF population, recall bias possible, unknown response rate	62 male non azoospermic partner from couples visiting IVF clinic for the first time in Uppsala University Hospital, Sweden	Cross-sectional	43 non-snuff users 17 snuff users	2011-2014	Reproductive	Semen volume	None	Snuff consumption	No snuff consumption	Pearson Correlation	-0.048		1.47		No	Karolinska Institutet Foundation grants, Estonian National Kristjan Jaak scholarship program, Spanish Ministry of Economy and Competitive ness, European Research Council, Marie Curie Actions, Intra-European Fellowships, Uppsala University, the Family Planning Foundation, Uppsala, Estonian Ministry of Education and Research	"In our study, snuff users had significantly lower sperm concentration, motile sperm concentration and motile sperm percentage."	
	Weak						Reproductive	Sperm concentration	None	Snuff consumption	No snuff consumption	Pearson Correlation	-0.314			0.006	Yes			
	Weak						Reproductive	Total sperm	None	Snuff consumption	No snuff consumption	Pearson Correlation	-0.299			0.002	Yes			
	Weak						Reproductive	Motile concentration	None	Snuff consumption	No snuff consumption	Pearson Correlation	-0.375			0.003	Yes			
	Weak						Reproductive	Total motile sperm	None	Snuff consumption	No snuff consumption	Pearson Correlation	-0.349			0.006	Yes			
	Weak						Reproductive	Total motility	None	Snuff consumption	No snuff consumption	Pearson Correlation	-0.299			0.02	Yes			
	Weak						Reproductive	Semen volume	None	Snuff consumption	No snuff consumption	ANOVA		~3.1 (2.6-3.55)	~3.0 (2.3-3.6)		No			
	Weak						Reproductive	Sperm concentration	None	Snuff consumption	No snuff consumption	ANOVA		~7 (6-8)	~4.5 (3-6.5)	0.02	Yes			
	Weak						Reproductive	Total sperm	None	Snuff consumption	No snuff consumption	ANOVA		~175 (125-225)	~100 (25-210)		No			
	Weak						Reproductive	Motile concentration	None	Snuff consumption	No snuff consumption	ANOVA		~5.2 (4.5-6.1)	~3 (1.7-5-4.75)	0.07	Yes			
	Weak				43 non-snuff users 17 snuff users		Reproductive	Total motile sperm	None	Snuff consumption	No snuff consumption	ANOVA		~4 (3.5-4.5)	~2.5 (1.6-3.6)	0.008	Yes			
	Weak				43 non-snuff users 17 snuff users		Reproductive	Total motility	None	Snuff consumption	No snuff consumption	ANOVA		~58 (53-65)	~45 (35-55)	0.009	Yes			
Pedersen W and von Soest T. 2014. Tobacco use among Norwegian adolescents: From cigarettes to snus. Addiction, 109(7): 1154–1162.	Weak	Cross-sectional design	Swedish "Snus"		6,217 Norwegian adolescents (aged 16-17) (population-based)	2010	Other	Depressive symptoms	gender, age, country of birth, alcohol intoxication, use of cannabis, conduct problems	gender, age, country of birth,	Daily snus use	No daily tobacco use	OR (95% CI)	1.19	0.98	1.44		No	Not stated	Not addressed by authors
	Weak						Other	Depressive symptoms	gender, age, country of birth,	gender, age, country of birth,	Daily snus use	No daily tobacco use	OR (95% CI)	1.27	1.06	1.51		Yes		See Table 3 in study for covariates in additional categories.



Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Pettersson K, Saers J, Lindberg E and Janson C. 2016. Sleep disturbances among Swedish soldiers after military service abroad. Upsala Journal of Medical Sciences, 121(1): 65-69.	Weak	Cross-sectional design, potential confounding (lack of information on combat experience, depression, anxiety, PTSD), number of exposed cases not provided	Swedish "Moist snuff"		1,080 Swedish soldiers and officers who had completed at least one period of military service abroad were compared with 26,723 Swedes from a general population sample	297 participants from the military population reported use of moist snuff (783 nonusers), while 2,886 from the general population reported use (23,837 nonusers)  # of exposed cases was not provided	Not stated	Other	Snoring	alcohol intoxication , use of cannabis, conduct problems, parental characteristics, school adjustment, perceived social acceptance, sport and leisure-time activities Military assignment , age, sex, BMI, asthma history, smoking history, educational level, physical exercise	Daily moist snuff use	No current use of moist snuff	OR (95% CI)	1.28	1.15	1.41		Yes	EU FP6 project GAZLEN, the Centre for Allergy Research at Karolinska Institutet, the Swedish Heart Lung Foundation, the Swedish Heart and Lung Association, and the Swedish Asthma and Allergy Association	Veterans were combined with control group in these analyses.  "The main finding in the present study was that the Swedish veterans had fewer problems with insomnia and daytime sleepiness than a matched control group from the general Swedish population."  "Smoking and oral tobacco were related to a higher risk of snoring and DIS, which confirms the effects of smoke and nicotine on sleep (20,21)."
	Weak																			
	Weak																			
								Other	Difficulty inducing sleep	Military assignment , age, sex, BMI, asthma history, smoking history, educational level, physical exercise	Daily moist snuff use	No current use of moist snuff	OR (95% CI)	1.65	1.48	1.83		Yes		"The Swedish veterans were almost three times more likely to use oral tobacco than the reference group."
								Other	Difficulty maintaining sleep	Military assignment , age, sex, BMI, asthma history, smoking history, educational level, physical exercise	Daily moist snuff use	No current use of moist snuff	OR (95% CI)	0.74	0.67	0.82		Yes		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					# of exposed cases was not provided 297 participants from the military population reported use of moist snuff (783 nonusers), while 2,886 from the general population reported use (23,837 nonusers)		Other	Early morning awakenings	Military assignment, age, sex, BMI, asthma history, smoking history, educational level, physical exercise	Daily moist snuff use	No current use of moist snuff	OR (95% CI)	0.81	0.72	0.92		Yes		
	Weak					# of exposed cases was not provided 297 participants from the military population reported use of moist snuff (783 nonusers), while 2,886 from the general population reported use (23,837 nonusers)		Other	Insomnia	Military assignment, age, sex, BMI, asthma history, smoking history, educational level, physical exercise	Daily moist snuff use	No current use of moist snuff	OR (95% CI)	1.02	0.94	1.11		No		
	Weak					# of exposed cases was not provided 297 participants from the military population reported use of moist snuff (783 nonusers), while 2,886 from the general population reported use (23,837 nonusers)		Other	Excessive daytime sleepiness	Military assignment, age, sex, BMI, asthma history, smoking history, educational level, physical exercise	Daily moist snuff use	No current use of moist snuff	OR (95% CI)	1.11	1.02	1.22		Yes		
Rasouli B, Andersson T, Carlsson P-O, Grill V, Groop	Moderate	Possible recall bias; small number of	"Swedish smokeless tobacco (snus)"	Case-control (ESTRI D) and	ESTRID/ANDIS: all people with incident latent autoimmune	# of exposed cases was not provided 200 LADA cases, 724 Type 2 diabetes	2010-2015	Diabetes/MetSy	Type 2 diabetes incidence, verified by	age, BMI, family history of diabetes	Current snus use, never smokers	Never snus use, never smokers	OR (95% CI)	1.17 0.53	0.58 0.20	2.37 1.39		No	Swedish Medical Research Council;	The authors reported a lack of association between snus use and Type 2 diabetes and LADA. Analyses of smokers

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
L, Martinell M, Midthjell K, Storm P, Tuomi T and Carlsson S. 2017. Use of Swedish smokeless tobacco (snus) and the risk of Type 2 diabetes and latent autoimmune diabetes of adulthood (LADA). Diabetic Medicine, 34(4): 514–521.	Moderate	cases among never smokers		cross-sectional (HUNT)	diabetes of adulthood (LADA) recorded into the All New Diabetes in Scania (ANDIS) study since 2010 (Scania is a region in Southern Sweden); a random sample of people with Type 2 diabetes; and diabetes-free controls randomly selected from the Scania population	cases, 699 controls			blood sample		(27 cases/36 controls)  Former snus use, never smokers (11 cases/104 controls)  <5 boxes/week (ever snus users, 22 cases/46 controls)  5+ boxes/week (ever snus users, 16 cases, 26 controls)	Never snus use, never smokers	OR (95% CI)	0.83	0.41	1.71		No	Swedish Research Council for Health, Working Life, and Welfare; AFA Insurance Company; Swedish Diabetes Association; ALF- Swedish Research Council; Research Grant from Swedish Government ; HUNT Research Centre; Nord-Trøndelag County Council; Norwegian Institute of Public Health; GlaxoSmith Kline Norway	only or formerly smoking snus users showed associations with diabetes, but the association was not seen when analyses were restricted to never smokers.  Smoking-adjusted results were not materially different from exclusive snus user results, and were higher powered.
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Type 2 diabetes incidence, verified by blood sample	age, BMI, family history of diabetes	<5 boxes/week (ever snus users, 22 cases/46 controls)	Never snus use, never smokers	OR (95% CI)	1.01	0.42	2.41		No		
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Type 2 diabetes incidence, verified by blood sample	age, BMI, family history of diabetes	<10 box-years (ever snus users, 13 cases/39 controls)	Never snus use, never smokers	OR (95% CI)	0.74	0.31	1.77		No		
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Latent autoimmune diabetes of adulthood (LADA) incidence	age, BMI, family history of diabetes	10+ box-years (ever snus users, 22 cases/32 controls) Current snus use, never smokers (13 cases/41 controls)	Never snus use, never smokers	OR (95% CI)	0.98	0.45	2.11		No		
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Latent autoimmune diabetes of adulthood (LADA) incidence	age, BMI, family history of diabetes	Former snus use, never smokers (4 cases/31 controls) <5 boxes/week (ever snus users, 10 cases/46 controls)	Never snus use, never smokers	OR (95% CI)	0.75	0.34	1.67		No		
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Latent autoimmune diabetes of adulthood (LADA) incidence	age, BMI, family history of diabetes	5+ boxes/week (ever snus users, 6 cases, 26 controls) <10 box-years (ever snus users, 5 cases/39 controls)	Never snus use, never smokers	OR (95% CI)	0.46	0.16	1.31		No		
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Latent autoimmune diabetes of adulthood (LADA) incidence	age, BMI, family history of diabetes	10+ box-years (ever snus users, 5 cases/39 controls)	Never snus use, never smokers	OR (95% CI)	1.01	0.45	2.29		No		
	Moderate					200 LADA cases, 724 Type 2 diabetes cases, 699 controls			Latent autoimmune diabetes of adulthood (LADA) incidence	age, BMI, family history of diabetes	10+ box-years (ever snus users, 5 cases/39 controls)	Never snus use, never smokers	OR (95% CI)	1.01	0.45	2.29		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak	Cross-sectional measurements of exposure and outcome; recall bias more likely among prevalent cases				200 LADA cases, 724 Type 2 diabetes cases, 699 controls		Diabetes/MetSy	Type 2 diabetes (cross-sectional measurement)	age, BMI, family history of diabetes	users, 11 cases/32 controls) Ever snus users among never-smokers (27 cases)	Never snus use, never smokers	OR (95% CI)	1.12	0.72	1.72		No		
	Weak							Diabetes/MetSy	Type 2 diabetes (cross-sectional measurement)	age, BMI, family history of diabetes	Ever snus users among never-smokers, <3 boxes/week (23 cases)	Never snus use, never smokers	OR (95% CI)	1.15	0.72	1.82		No		
											ever snus users among never-smokers, 3+ boxes/week (2 cases)			0.89	0.21	3.78				
Rygh E, Gallefoss F and Reiso H. 2016. Use of snus and smoking tobacco among pregnant women in the Agder counties. Tidsskrift for den Norske Lægeforening , 136(16): 1351-1355.	Weak	Non-English translation. Unclear if snuff group included occasional and/or daily users. No adjustment for potential confounders such as SES, and no quantitative details of results.	Swedish "Snus"	Cohort	10,583 births, with data obtained from electronic food records at Sorlandet Hospital, Norway.	351 daily snuff users before pregnancy, 141 during 1st trimester, and 90 during 3rd trimester	2012-2014	Reproductive	Birthweight and Apgar score (health summary of newborn)	NA	Snuff use	Non-users of snuff						No	The first author has received a scholarship from the Medical Association's general medical research committee	Translation: "The average birth weight for children of mothers who had smoked daily or occasionally in the last trimester was 3 331 g, against 3 533 non-smokers. The average reduction in birth weight of 202 g was statistically significant (p <0.001).  No significant difference in birth weight was found between children of mothers who had used snuff and the children of those who had not used snuff. There was also no difference in Apgar score where mothers had used snuff or smoking tobacco in the last trimester, compared with non-users."  "In our study snuff-users had a clear tendency towards lower endothelial function compared to non-users, and were no better than in smokers, despite younger age and a more favourable cardiovascular risk profile. Inactive snuff-using men had lower endothelial function than their physically active counterparts, indicating that physical activity and cardiorespiratory fitness modified the effect of snuff on endothelial function."
Skaug E-AE, A, Nes B, Aspenes ST and Ellingsen O. 2016. Non-Smoking tobacco affects endothelial function in healthy men in one of the largest health studies ever performed; the nord-trøndelag health study in Norway; HUNT3. PLoS ONE, 11(8): e0160205.	Weak	Cross-sectional design, potential selection bias (self-selection of participants from the healthiest part of the population + exclusion of participants with established CVD)	Swedish "Snuff"	Cross-sectional	5,633 men and women from the HUNT Fitness study, a subset of participants from the third wave of the Nord-Trøndelag Health Study (HUNT3)	238 exclusive snuff users, 21 dual users, 447 exclusive smokers, 886 non-users of tobacco	2006-2008	CV Effects	Endothelial Function: Flow mediated dilation (FMD) (percent difference in vessel diameter)	age, education, income, and physical activity index	Exclusive snuff	Non-user of tobacco	Difference (b)	-0.53	-1.09	0.02		No	HUNT Research Centre (Faculty of Medicine, Norwegian University of Science and Technology NTNU), Nord-Trøndelag County Council and The Norwegian Institute of Public Health	
	Weak							CV Effects	Endothelial Function: Flow mediated dilation (FMD) (percent difference in vessel diameter)	age, education, income, and physical activity index	Dual users	Non-user of tobacco	Difference (b)	-0.93	-2.6	0.73		No		
	Weak							CV Effects	Endothelial Function: Flow mediated dilation (FMD) (percent difference in vessel diameter)	age, education, income	Exclusive snuff, recommended physical activity level	Non-user of tobacco	Difference (b)	-0.29	-1.25	0.68		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Weak					tobacco 238 exclusive snuff users, 21 dual users, 447 exclusive smokers, 886 non-users of tobacco		CV Effects	Endothelial Function: Flow mediated dilation (FMD) (percent difference in vessel diameter)	age, education, income	Exclusive snuff, not recommended physical activity level	Non-user of tobacco	Difference (b)	-0.83	1.59	-0.06		Yes		
	Weak					tobacco 238 exclusive snuff users, 21 dual users, 447 exclusive smokers, 886 non-users of tobacco		CV Effects	Endothelial Function: Flow mediated dilation (FMD) (percent difference in vessel diameter)	age, education, income	Exclusive snuff, high aerobic capacity	Non-user of tobacco	Difference (b)	-0.19	0.96	0.57		No		
	Weak					tobacco 238 exclusive snuff users, 21 dual users, 447 exclusive smokers, 886 non-users of tobacco		CV Effects	Endothelial Function: Flow mediated dilation (FMD) (percent difference in vessel diameter)	age, education, income	Exclusive snuff, low aerobic capacity	Non-user of tobacco	Difference (b)	-0.74	1.55	0.07		No		
Varga T V, Hallmans G, Hu FB, Renström F and Franks PW. 2013. Smoking status, snus use, and variation at the CHRNA5-CHRNA3-CHRNA4 locus in relation to obesity: The GLACIER study. American Journal of Epidemiology, 178(1): 31–37.	Weak	Cross-sectional design (exposure and outcome assessed at baseline), lack of adjustment for potential confounders (alcohol consumption was positively associated, and diet was negatively associated with snus use - as was BMI)	Swedish "Snus (Oral moist tobacco)"	Cross-sectional	16,426 participants from the Gene-Lifestyle Interactions and Complex Traits Involved in Elevated Disease Risk (GLACIER) study, a population-based cohort nested within the Vasterbotten Health Survey in Northern Sweden	2,680 ever and 1,582 current snus users / 12,479 never users	1985–2004	Body Weight	BMI	None	Current snus users	Never snus users	b	0.35	0.12	0.58	0.003	Yes	Novo Nordisk, the Swedish Heart-Lung Foundation, the Swedish Diabetes Association, Pihlssons Foundation, the Swedish Research Council, Umeå Medical Research Foundation, and The Heart Foundation of Northern Sweden.	"In the present study, we identified an inverse association between smoking and BMI and a positive association between snus use and BMI. These findings are compatible with those reported elsewhere."  "As shown in Table 3, the correlation coefficients differ in magnitude and sometimes direction between smoking status or snus use and the putative confounders, which supports our hypothesis that although cigarettes and snus share the factor that is believed to be causally related with obesity (i.e., nicotine), they do not share the same confounding factors in this population. Although it is possible that cigarettes contain active substances absent from snus that drive the interactions described above, it seems more plausible that it is the obesogenic correlates of snus (i.e., confounders) that underlie the association of snus with obesity, rather than a direct causal effect of snus."
Wilson KM, Markt SC, Fang F, Nordenvall C, Rider JR, Ye W, Adami HO, Stattin P, Nyren O and Mucci LA. 2016. Snus use, smoking and survival among prostate	Moderate	Tobacco use after diagnosis was not assessed, only on average 20 years prior to diagnosis (potential misclassification), lack of covariate data with	"Snus (Scandinavian smokeless tobacco)"	Cohort	Swedish construction workers admitted to cohort between 1971 and 1992. Total cohort included 336, 831 construction workers. Nested study included 9,582 prostate cancer cases.	460 exclusive snus users / 2,762 never-users.	1971–2007	Other	Overall mortality	Age group at diagnosis, time period of diagnosis, BMI, time between examination and diagnosis.	Exclusive snus users (full cohort; includes all 9,582 men diagnosed with prostate cancer during follow-up)	Never tobacco users  n=1,207 never tobacco user deaths	HR (95% CI)	1.19	1.04	1.37		Yes	Prostate Cancer Foundation Young Investigator Awards, National Cancer Institute	"We found that a history of both smoking and snus use was associated with increased risk of prostate cancer-specific mortality and total mortality among men with prostate cancer in a large cohort in Sweden. Our results suggest that nicotine or other carcinogens in smokeless tobacco products may promote cancer progression independent of the combustion products of

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
cancer patients. International journal of cancer, 139(12): 2753–2759.	Moderate	BMI assessed only at study entry			Mean age of nested exclusive snus user cases: 71.3 years. Mean age of never tobacco user cases: 70.4 years.	460 exclusive snus users / 2,762 never-users.		Other	Overall mortality	Age group at diagnosis, time period of diagnosis, BMI, time between examination and diagnosis, clinical risk category	n=261 exclusive snus user deaths Exclusive snus users (in subcohort with "clinical data," which includes 5,346 men diagnosed after 1995 with available tumor characteristics from the National Prostate Cancer Register)	Never tobacco users	HR (95% CI)	1.15	0.88	1.51		No		tobacco smoke <sup>a</sup>
	Moderate					460 exclusive snus users / 2,762 never-users.		Other	Prostate cancer mortality	Age group at diagnosis, time period of diagnosis, BMI, time between examination and diagnosis.	n=261 exclusive snus user deaths Exclusive snus users (full cohort; includes all 9,582 men diagnosed with prostate cancer during follow-up)	Never tobacco users	HR (95% CI)	1.24	1.03	1.49		Yes		
	Moderate					460 exclusive snus users / 2,762 never-users.		Other	Prostate cancer mortality	Age group at diagnosis, time period of diagnosis, BMI, time between examination and diagnosis, clinical risk category	n=141 exclusive snus user deaths Exclusive snus users (in subcohort with "clinical data," which includes 5,346 men diagnosed after 1995 with available tumor characteristics from the National Prostate Cancer Register)	Never tobacco users	HR (95% CI)	1.28	0.88	1.88		No		
	Moderate					460		Other	Overall	Age group	Exclusive	Never	HR (95%	1.36	0.88	2.11		No		

Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
						exclusive snus users / 2,762 never-users.			mortality among nonmetastatic risk groups (includes men in "low"/"intermediate"/"high" categories, excludes "regionally metastatic" and "distant metastases" classification)	at diagnosis, time period of diagnosis, BMI, time between examination and diagnosis, clinical risk category	snus users (in subcohort with "clinical data," which includes 5,346 men diagnosed after 1995 with available tumor characteristics from the National Prostate Cancer Register)	tobacco users  n=107 never tobacco user deaths	CI)							
	Moderate					460 exclusive snus users / 2,762 never-users.		Other	Prostate cancer mortality among nonmetastatic risk groups (includes men in "low"/"intermediate"/"high" categories, excludes "regionally metastatic" and "distant metastases" classification)	Age group at diagnosis, time period of diagnosis, BMI, time between examination and diagnosis, clinical risk category	Exclusive snus users (in subcohort with "clinical data," which includes 5,346 men diagnosed after 1995 with available tumor characteristics from the National Prostate Cancer Register)	Never tobacco users  n=28 never tobacco user deaths	HR (95% CI)	3.17	1.66	6.06		Yes		
Wrangsjö K, Alderling M, Lindahl G, Meding B, Wrangsjö K, Alderling M, Lindahl G and Meding B. 2015. Hand eczema and use of snus (Moist snuff) – A population-based study. Acta Dermato-Venereologica, 95(3): 298–302.	Moderate	Cross-sectional measurements of exposure and outcome; not possible to estimate causality	"snus (Swedish Moist Snuff)"	Cross-sectional	47,931 people aged 18-64 years randomly chosen from the Stockholm, Sweden population register. 27,466 respondents included in study.	2,925 daily exclusive snus users 431 daily dual users (snus/smoking) # exposed cases reported as percentage: 7.5% of exclusive snus users were cases 2,925 daily exclusive snus users 431 daily dual users (snus/smoking) # exposed cases	2006	Other	Hand eczema (prevalence in past year)	Unclear; likely stress, obesity, and physical exercise	Daily exclusive snus use, total  Daily exclusive snus use, men  Daily exclusive snus use, women	No tobacco use	Prevalence proportion ratio (PPR), 95% CI	0.813 0.820 1.081	0.686 0.692 0.855	0.964 0.971 1.366	0.017 0.022 0.515	Yes Yes No	FORTE; The Swedish Research Council for Health, Working Life, and Welfare	The authors found no positive association between snus use and hand eczema.
	Moderate							Other	Hand eczema (prevalence in past year)	Unclear; likely stress, obesity, and physical exercise	Daily dual use (snus+smoking), total  Daily dual use (snus+)	No tobacco use	Prevalence proportion ratio (PPR), 95% CI	1.187 1.235 0.883	0.851 0.886 0.474	1.655 1.722 1.647	0.313 0.214 0.697	No No No		The authors found no positive association between snus use and hand eczema or psoriasis.

Reference	Evidence Quality	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
	Moderate					reported as percentage: 7.5% of exclusive snus users were cases					smoking), men									
						2,925 daily exclusive snus users		Other	Psoriasis (prevalence in past year)	Unclear; likely stress, obesity, and physical exercise	Daily dual use (snus+ smoking), women	No tobacco use	Prevalence proportion ratio (PPR), 95% CI	1.064	0.861	1.316	0.566	No		
Yang F, Pedersen NL, Ye W, Liu Z, Norberg M, Forsgren L, Trolle Lagerros Y, Bellocco R, Alfreðsson L, Knutsson A, Jansson J-H, Wennberg P, Galanti MR, Lager ACJ, Araghi M, Lundberg M, Magnusson C and Wirdefeldt K. 2016. Moist smokeless tobacco (Snus) use and risk of Parkinson's disease. International journal of epidemiology.	Strong	Possible misclassification of exposure, as snus exposure was measured at baseline and may have changed over time. Different adjustments in different subcohorts. Relatively small number of exposed cases.	Swedish "Moist smokeless tobacco (Snus)"	Cohort	351,640 participants in the Swedish Collaboration on Health Effects of Snus Use (7 pooled cohort studies)	Among never smokers, fully adjusted model: 531 unexposed cases, 27 cases among ever snus users, 10 cases among former snus users, 17 cases among current snus users	Recruitment into 7 cohorts from 1978-2013	Other	Parkinson's disease incidence ICD-7: 350 ICD-8: 342 ICD-9: 332.0 ICD-10: G20	adjusted differently in different subcohorts; covariates include age, education, alcohol, physical activity, coffee intake	Ever snus users	Never tobacco users	HR (95% CI)	0.41	0.28	0.61	Not reported (p for heterogeneity among cohort s was reported; see Table 2)	Yes for ever and current; No for former	Swedish Research Council; regional agreement on medical training and clinical research between Stockholm County and Karolinska Institutet	"In conclusion, data from this large pooling project showed that non-smoking men who used snus had a substantially reduced risk of Parkinson's disease. Results also indicated an inverse dose-response relationship between use of snus and subsequent risk of Parkinson's disease. Our findings hence suggest that nicotine or other components of tobacco leaves may influence the development of Parkinson's disease and explain the inverse association between cigarette smoking and Parkinson's disease risk."
	Strong					Among never smokers, fully adjusted model: 531 unexposed cases, 27 cases among ever snus users, 10 cases among former snus users, 17 cases among current snus users		Other	Parkinson's disease incidence ICD-7: 350 ICD-8: 342 ICD-9: 332.0 ICD-10: G20	adjusted differently in different subcohorts; covariates include age, education, alcohol, physical activity, coffee intake	Light snus use (<2 cans/week; 7 cases)	Never tobacco users	HR (95% CI)	0.71	0.35	1.43	Not reported (p for heterogeneity among cohort s was reported; see Table 2)	No for light, Yes for moderate-heavy		
	Strong					Among never smokers, fully adjusted model: 531 unexposed cases, 27 cases among ever snus users, 10 cases among former snus users, 17 cases among current snus users		Other	Parkinson's disease incidence ICD-7: 350 ICD-8: 342 ICD-9: 332.0 ICD-10: G20	adjusted differently in different subcohorts; covariates include age, education, alcohol, physical activity, coffee intake	1-20 years of snus use (6 cases)	Never tobacco users	HR (95% CI)	0.56	0.19	1.68	Not reported (p for heterogeneity among cohort s was reported; see Table 2)	No for 1-20 years, Yes for 20+ years and per year		
						Among never smokers, fully adjusted model: 531 unexposed cases, 27 cases among ever snus users, 10 cases among former snus users, 17 cases among current snus users					Moderate-heavy snus use (2+ cans/week, 9 cases)			0.41	0.19	0.90				
						Among never smokers, fully adjusted model: 531 unexposed cases, 27 cases among ever snus users, 10 cases among former snus users, 17 cases among current snus users					21+ years of snus use (10 cases)			0.96	0.94	0.98				
						Per year of using snus (16 cases)														



Reference	Evidence Quality  Strong, Moderate, Weak, Excluded, Commentary	Limitations + Potential Biases, or reason for exclusion	Product Description (Brand and type of snus, as applicable, author description)	Study design	Population (description, and total number before exclusions)	Number of cases/controls or exposed / unexposed  # exposed cases	Study period	Endpoint Category (Non-cancer Oral, Dental, Cancer, CVD, Heart/IHD, Stroke, CV Effects, Diabetes/MetSy, Body Weight, GI Effects, Reproductive, Other)	Endpoint Analyzed	Covariates	Exposed Group	Referent Group	Risk Estimate Description	Risk Estimate	LCL	UCL	p Value (if available)	Statistically Significant? (Yes/No)	Funding Source	Author Conclusion + Comments
Zandonai T, Tam E, Bruseghini P, Pizzolato F, Franceschi L, Baraldo M, Capelli C, Cesari P and Chiamulera C. 2016. The effects of oral smokeless tobacco administration on endurance performance. Journal of Sport and Health Science. Neuropsychopharmacology Laboratory, Department of Diagnostic and Public Health, University of Verona, Verona 37134, Italy: Elsevier B.V.	Moderate	small sample size	"Swedish snus, Catch White Eucalyptus 8 mg nicotine"	Clinical trial (double-blind, randomized crossover)	14 healthy male (18-45 years old) non-smokers and non-snus users that used snus or a snus placebo during exercise	snus users 12 participants (received either Swedish snus or Snus placebo, crossover)	Not stated	CV Effects	Heart rate (HR)	None	Swedish snus (SS)	Snus Placebo (SP)						No	University of Verona: Neurosciences, Biomedicine and Movement Sciences, and Diagnostic and Public Health	"Q and HR in SS and SP conditions were not significantly different during the time trial."
	Moderate					12 participants (received either Swedish snus or Snus placebo, crossover)		CV Effects	Cardiac output (Q)	None	Swedish snus (SS)	Snus Placebo (SP)						No		
	Moderate					12 participants (received either Swedish snus or Snus placebo, crossover)		CV Effects	Systolic blood pressure (SBP)	None	Swedish snus (SS)	Snus Placebo (SP)						No		Not addressed by authors
	Moderate					12 participants (received either Swedish snus or Snus placebo, crossover)		CV Effects	Diastolic blood pressure (DBP)	None	Swedish snus (SS)	Snus Placebo (SP)					0.0068	Yes		"DBP at TTE [time to exhaustion] was significantly smaller in SS ( $73.10 \pm 8.53$ mmHg) than in SP ( $80.70 \pm 8.56$ mmHg) ( $p = 0.0068$ )."
	Moderate					12 participants (received either Swedish snus or Snus placebo, crossover)		Other	Respiratory responses ( $\dot{V}_E$ , $\dot{V}O_2$ , $\dot{V}CO_2$ )	None	Swedish snus (SS)	Snus Placebo (SP)						No		"In our non-smokers and non-snus users, nicotine induced diastolic hypotension at exhaustion." "No significant differences between SP and SS were observed throughout the trials as for $\dot{V}_E$ , $\dot{V}O_2$ , and $\dot{V}CO_2$ . The average RER during exercise was the same ( $1.03 \pm 0.04$ ) in both SS and SP."

## **Appendix G: Literature Abstraction Tables per Endpoint for Risk Comparison (Section 3)**

## Oral-Pharyngeal Cancer

Summary of Findings Table: Oral and Pharyngeal Cancer (ICD7: 140-148, ICD8, 9: 140-149, and ICD10: C00-C014)													
Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Ahlbom 1937								Only provides prevalence data without any effect measures					
Axell et al. 1978								No English-language equivalent existed that could be reviewed.					
Boffetta et al. 2005	Cohort	Systematic sample of 1960 Census and relatives of US migrants	1966-2001	ICD7: 141-148	Incidence	Multivariate adjustment	Men only. Age	Reference: Never or occasional use Ever Current Former	1.1 (0.5-2.41) 1.04 (0.31-3.5) 1.13 (0.45-2.83)	9 3 6			
Hirsch et al. 2012	Case series							As this was a case series, it was not considered any further					
Lewin et al. 1998	Case-control	Stockholm county or Southern healthcare region of Sweden	1988-1990	Nominal: "Oral Cavity Cancer"  "Pharynx cancer"	Incidence	Multivariate adjustment to control for smoking in snus users.  No described control of snus use for smoker effect measures.	Age, region, and alcohol intake	Reference: Never used  Ever used Current users Ex-users	<u>Oral cavity</u>  1.4 (0.8-2.4) 1.0 (0.5-2.2) 1.8 (0.9-3.7)	25 10 15	Reference: Never smoked Current ≥45 years	<u>Oral cavity</u>  4.9 (2.6-9.2) 6.3 (3.2-12.4)	NG NG
								Reference: Never used  Ever used Current users Ex-users	<u>Pharynx</u>  0.7 (0.4-1.3) 0.7 (0.3-1.5) 0.8 (0.3-1.9)	15 8 7	Reference: Never smoked Current ≥45 years  Ex-smokers, >5 years (n=189)	<u>Pharynx</u>  8.5 (4.0-18.2) 10.1 (4.6-22.1)  1.0 (0.9-1.2)	NG NG NG
Luo et al. 2007	Cohort	Swedish Construction Worker cohort	1978-1992, 2004	ICD7: 140, 141, 143, 144	Incidence	Multivariate adjustment or stratification	Age and BMI	Reference: Never-users of any tobacco Ever-users of snus	<u>Among all cohort members</u>  0.7 (0.5-0.9)	NG	Reference: Never-users of any tobacco Ever-smokers Ex-smokers Current smokers	<u>Among all cohort members</u>  2.0 (1.4-2.7) 1.1 (0.8-1.7) 2.5 (1.7-3.5)	198 48 150
								Reference: Never-users of any tobacco Ever-users of snus Ex-users Current users	<u>Among never-smokers</u>  0.8 (0.4-1.7) 0.7 (0.1-5.0) 0.9 (0.4-1.8)	10 1 9	Note: Estimates for smokers includes snus users who have smoked.		
								<u>Dose-Response in Current Users:</u> 1-9 g/day ≥10 g/day	0.7 (0.2-2.8) 0.9 (0.4-2.0)	2 8			

								trend p-value=0.80			
Roosaar et al. 2008	Cohort	Uppsala County, central Sweden	1973-1974, 2002	ICD7: 140-148	Incidence	Multivariate adjustment or stratification	Men only. Age, area of residence, and alcohol consumption.	Reference: ≥45 years Ex-smokers, >5 years	1.0 (0.9-1.2)	189	
								Reference: Never daily use			Reference: Never daily smoking
								Ever daily use	3.1 (1.5-6.6)	11	Ever daily smoking
									<u>Restricted to never smokers</u>		Age <70 years 0.5 (0.1-1.4) 5
Rosenquist et al. 2005	Case-control	Southern Healthcare Region of Sweden	2000-2004	ICD7: 141, 143, 144, 145	Incidence	Multivariate adjustment (However, unclear if smoking estimates were adjusted for snus use)	age, sex, alcohol use, HPV (data not shown), and county	Reference: Never daily use	2.3 (0.7-8.3)	5	
								Ever daily use	<u>Oral Snuff Use</u>		<u>Cigarette consumption (cigarettes/day)</u>
								Reference: Never used			
								Had used	0.7 (0.3-1.3)	20	1-10 1.1 (0.6-2.1) 21
								Current user	1.1 (0.5-2.5)	13	11-20 2.4 (1.3-4.1) 49
								Ex-user	0.3 (0.1-0.9)	7	>20 2.8 (1.3-6.1) 20
									<u>Type of Snuff</u>		<u>Total tobacco consumption (kg)</u>
								Reference: Never Used			
								Fermented	0.7 (0.3-1.4)	16	Reference: Never smoked <125 1.1 (0.6-2.0) 23
								Non-fermented	0.6 (0.2-1.9)	4	125-250 1.8 (1.0-3.5) 24
									<u>Duration</u>		>250 4.7 (2.4-9.1) 47
								Reference: Never used			
								<30 years	0.6 (0.3-1.3)	16	
								≥30 years	0.8 (0.2-2.8)	4	
									<u>Exposure Time</u>		
								Reference: Never used			
								<10 hr/day	0.7 (0.3-1.5)	15	
								>10 hr/day	0.5 (0.2-1.6)	5	
									<u>Consumption</u>		
								Reference: Never used			
								1-14 g/day	0.9 (0.3-2.5)	8	
								>14 g/day	1.7 (0.5-5.7)	5	
Schildt et al. 1998a	Matched Case-control	Four Northernmost counties of Sweden	1980-1989	ICD7: 140, 141, 143, 144, 145	Incidence	Multivariate adjustment	Age, sex, and county, oral infections, and liquor consumption.	Reference: Never snus			Reference: Never smoker
								<u>Univariate</u>			
								Current	0.6 (0.3-1.1)	NG	Current 1.7 (0.8-3.5) NG
								Former	1.4 (0.7-2.8)	NG	Former 1 (0.6-1.5) NG
Schildt et al. 1998b	Matched Case-control	Four Northernmost counties of	1980-1989	ICD7: 140, 141, 143, 144, 145	Incidence	Multivariate adjustment or	Matched for gender, age and county	<u>Multivariate</u>			
								Current	0.6 (0.3-1.1)	NG	Multivariate Current 1.5 (0.9-2.5) NG
								Former	1.7 (0.8-3.5)	NG	Former 0.8 (0.5-1.4) NG
									<u>Univariate analysis</u>		<u>Univariate analysis</u>
Schildt et al. 1998b	Matched Case-control	Four Northernmost counties of	1980-1989	ICD7: 140, 141, 143, 144, 145	Incidence	Multivariate adjustment or	Matched for gender, age and county	Reference: Never snuff user			Reference: Never smoker

Sweden	stratification	and multivariate estimates adjusted for alcohol	Active	0.7 (0.4-1.1)	39	Active	1.8 (1.1-2.7)	122
			Ex-user	1.5 (0.8-2.9)	28	Ex-smoker	1.0 (0.6-1.6)	80
			Ever user	0.9 (0.6-1.4)	67	Ever smoker	1.3 (0.9-1.9)	202
				<u>Among never smokers</u>			<u>Among never snuff user</u>	
			Reference: Never snuff user			Reference: Never smoker		
			Ex-user of snuff	1.8 (0.9-3.5)	9	Ex-smoker	0.9 (0.6-1.4)	54
			Active snuff user	0.7 (0.4-1.2)	19	Active smoker	1.7 (1.1-2.6)	109
				<u>Among ex-smokers</u>			<u>Among ex-user of snuff</u>	
			Reference: Never snuff user			Reference: Never smoker		
			Ex-user of snuff	1.6 (0.8-3.4)	16	Ex-smoker	1.6 (0.8-3.4)	16
			Active snuff user	0.6 (0.3-1.3)	15	Active smoker	3.1 (1.4-6.8)	3
				<u>Among active smokers</u>			<u>Among active snuff users</u>	
			Reference: Never snuff user			Never smoker	0.7 (0.4-1.2)	
			Ex-user of snuff	3.1 (1.4-6.8)	3	Ex-smoker	0.6 (0.3-1.3)	15
			Active snuff user	1.2 (0.6-2.4)	10	Active smoker	1.2 (0.6-2.4)	10
				<u>Multivariate analysis</u>			<u>Multivariate analysis</u>	
			Snuff (ever)	0.8 (0.5-1.3)	NG	Smoking (ever)	1.1 (0.7-1.6)	NG
				<u>Among never smokers</u>			<u>Among never snuff</u>	
			Reference: Never snuff		NG	Never smokers	1.0 (reference)	NG
			Low consumption (≤ 156 kg consumed over lifetime)	0.8 (0.4-1.6)	NG	Low consumption (≤ 124.8 kg consumed over lifetime)	1.2 (0.7-1.9)	NG
			High consumption (>156 kg consumed over lifetime)	1.3 (0.6-2.6)	NG	High consumption (> 124.8 kg consumed over lifetime)	1.8 (1.1-2.9)	NG
				<u>Among low smoking consumption</u>			<u>Among low snuff consumption</u>	
			Reference: Never snuff			Reference: Never smokers		
			Low consumption (≤ 156 kg consumed over lifetime)	1.0 (0.4-2.1)	6	Low consumption (≤ 124.8 kg consumed over lifetime)	1.0 (0.4-2.1)	6
			High consumption (>156 kg consumed over lifetime)	1.5 (0.6-3.5)	7	High consumption (> 124.8 kg consumed over lifetime)	1.5 (0.6-3.3)	10
				<u>Among high smoking consumption</u>			<u>Among high snuff consumption</u>	

						Reference: Never snuff			Reference: Never smokers		
						Low consumption (≤ 156 kg consumed over lifetime)	1.5 (0.6-3.3)	10	Low consumption (≤ 124.8 kg consumed over lifetime)	1.5 (0.6-3.5)	7
						High consumption (>156 kg consumed over lifetime)	2.3 (0.9-5.6)	3	High consumption (> 124.8 kg consumed over lifetime)	2.3 (0.9-5.6)	3
							<u>Among all</u>				
						Reference: Never snuff/Never smoker					
						Active snuff/Active smoker ( <b>Dual User</b> )	1.2 (0.6-2.4)	26			
						Active snuff/Ex-smoker ( <b>Switcher</b> )	0.6 (0.3-1.3)	25			
<b>U.S Cohorts with Cigarette or Smoker Relative Risks</b>											
McLaughlin et al. 1995	Large U.S. Cohort	US veterans who held government life insurance policies active at the end of 1953	1953-1980	-	Mortality				Reference: NG		
									Ever smoker	2.6 (1.8-3.9)	NG
									Current smoker	3.4 (2.3-5.0)	NG
									Former smoker	1.5 (0.9-2.4)	NG
									Smoking Dose (cigarettes/day)		
									1-9	0.6 (0.2-2.1)	NG
									10-20	2.5 (1.6-4.0)	NG
									31-39	5.4 (3.5-8.4)	NG
									40+	8.6 (4.7-15.7)	NG
									<b>p &lt; 0.01</b>		
SAMMEC	Large U.S. Cohort	CPS II Population 1982 – 1988	1982-1988	-	Mortality	35 years and older			<u>Males</u>		
									Reference: Not given		
									Current smoker	10.89	NG
									Former smoker	3.4	NG
									<u>Females</u>		
									Reference: Not given		
									Current smoker	5.08	NG
									Former smoker	2.29	NG
USDHHS 1989	Large U.S. Cohort	CPS II Population 1982 – 1986		-	Mortality	35 years and older			<u>Males</u>		
									Reference: Never smoker		
									Current smoker	27.48 (9.96-75.83)	NG
									Former smoker	8.80 (3.15-24.59)	NG
									<u>Females</u>		
									Reference: Never smoker		
									Current smoker	5.59 (3.15-9.91)	NG
									Former smoker	2.88 (1.57-5.26)	NG
<b>Prior Meta-Analyses of Swedish Snus</b>											
Lee and Hamling 2009b; Lee 2011	Meta-analysis	-	-	Nominal: Oropharynx	Incidence		Overall data	0.97 (0.68-1.37)			
							Smoking-adjusted	0.97 (0.68-1.37)			
							Smoking and alcohol adjusted	1.10 (0.64-1.90)			
							Never smokers	1.01 (0.71-1.45)			
							Never smokers – alcohol adjusted	2.30 (0.67-7.92)			
Boffetta et	Meta-				Incidence		Ever use	1.0 (0.7-1.3)			

al. 2008	analysis								
Lee	Meta-	Oral cancer	Incidence	Unadjusted	Current dual user			Interaction terms for	
2013;2014	analysis				compared to current			current dual users	
					exclusive smoker				
					Schildt et al. (1998b)	0.40 (0.17-0.93)		Schildt et al. (1998b)	0.47 (0.17-1.26)
					Ever dual user			Interaction term for	
					compared to ever-			ever dual user	
					exclusive smoker				
					Schildt et al. (1998b)	0.73 (0.45-1.19)		Schildt et al. (1998b)	0.61 (0.29-1.30)
					Switchers compared			Switchers compared	
					to never tobacco			to smokers in Schildt	
								et al. (1998b)	
					Schildt et al. (1998b)	0.77 (0.34-1.79)		Current smokers	0.43 (0.18-1.02)
								Former smokers	0.83 (0.34-1.99)
Lee 2014	Meta-	Oropharyngeal	Incidence	Unadjusted	Dual users compared			Interaction term for	
	analysis	and oral cancer			to exclusive smokers:			ever dual users	
					Roosaar et al. (2008)	3.66 (1.45-9.24)		Roosaar et al. (2008)	1.59 (1.45-9.24)

## Esophageal Cancer

**Summary of Findings Table: Esophageal Cancer (ICD8,9: 150, ICD10: C15)**

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Boffetta et al. 2005	Cohort	Systematic sample of 1960 Census and relatives of US migrants	1966-2001	ICD7-150	Incidence	Multivariate adjustment	Age and amount of smoking	Reference: Never or Occasional user of snus Ever Current Former	1.4 (0.61-3.24) 1.06 (0.35-3.23) 1.9 (0.69-5.27)				
Lagergren et al. 2000	Case-control	Swedish population	1995-1997	Nominal: "Cancer of the oesophagus"	Incidence	Multivariate adjustment	Age, gender, alcohol use, educational level, BMI, reflux symptoms, intake of fruit and vegetables, energy intake and physical activity	Reference: Never user of snuff Ever  <u>Duration of use (years)</u>  Reference: Never user of snuff 1-10 11-25 >25  <u>Intensity of use (quids/week)</u> Reference: Never user of snuff 1-14 15-35 >35  <u>Squamous cell carcinoma</u>  Reference: Never user of snuff Ever	<u>Adenocarcinoma</u>  1.2 (0.7-2.0)   1.0 (0.5-2.1) 1.0 (0.5-2.0) 1.7 (0.9-3.3) <b>trend p-value = 0.31</b>   1.0 (0.5-2.1) 2.2 (1.2-4.1) 0.7 (0.3-1.6) <b>trend p-value = 0.53</b>   1.4 (0.9-2.3)	35   10 10 15   11 17 7   33	Reference: Never-smoker Previous Current   Duration of smoking (years) Reference: Never-smoker 1-20 21-35 >35   Smoking dose (cigs/day) Reference: Never-smoker 1-9 10-19 >19   Years since cessation Reference: Never-smoker 0-2 3-10 11-25 >25  <u>Squamous cell carcinoma</u>  Reference: Never-smoker Previous Current	1.9 (1.2-2.9) 1.6 (0.9-2.7)   1.8 (1.1-3.1) 1.5 (0.9-2.6) 2.0 (1.2-3.3)   1.2 (0.7-2.2) 1.7 (1.0-2.9) 1.1 (0.6-2.0)   1.7 (1.0-3.0) 2.4 (1.2-4.8) 1.6 (0.9-2.5) 1.6 (0.9-2.8) <b>trend p-value &lt; 0.0001</b> <u>Squamous cell carcinoma</u>  2.5 (1.4-4.7) 9.3 (5.1-17)	89 43   42 37 53   32 46 41   40 20 29 30  44 101



								<u>Duration of use (years)</u> Reference: Never user of snuff			<u>Duration of smoking (years)</u> Reference: Never-smoker		
								1-10	1.2 (0.5-2.5)	11			
								11-25	0.9 (0.4-2.1)	8	1-20	2.3 (1.1-4.6)	21
								>25	2.0 (0.9-4.1)	14	21-35	2.9 (1.5-5.8)	27
								<b>trend p-value = 0.18</b>			>35	8.8 (4.9-16.1)	97
								<u>Intensity of use (quids/week)</u> Reference: Never user of snuff			<u>Smoking dose (cigs/day)</u> Reference: Never-smoker		
								1-14	1.2 (0.5-2.5)	10			
								15-35	2.1 (1.0-4.4)	15	1-9	2.8 (1.5-5.2)	28
								>35	1.0 (0.4-2.4)	7	10-19	3.9 (2.2-6.9)	54
								<b>trend p-value = 0.27</b>			>19	4.9 (2.7-9.0)	7
											<u>Years since cessation</u> Reference: Never-smoker		
											0-2	10.3 (5.6-19.1)	93
											3-10	5.2 (2.4-11.3)	18
											11-25	2.1 (1.0-4.7)	15
											>25	1.9 (0.8-4.0)	13
											<b>trend p-value &lt; 0.0001</b>		
Lewin et al. 1998	Case-control	Stockholm county or Southern healthcare region of Sweden	1988 – 1990	Nominal: "Squamous cell carcinoma of the ... esophagus"	Incidence	Multivariate adjustment to control for smoking in snus users.	Men only. Age, region, and alcohol intake	Reference: Never used snus			Reference: Never smoked		
								Ever used	1.2 (0.7-2.2)	19	Current	5.2 (2.6-10.3)	NG
								Current users	1.1 (0.5-2.4)	10	≥45 years	5.4 (2.7-11.0)	NG
								Ex-users	1.3 (0.6-3.1)	9			
						No described control of snus use for smoker effect measures.							
Zendehdel et al. 2008	Cohort	Swedish Construction Worker cohort	1971 – 1993, 2004	ICD-150	Incidence	Multivariate adjustment or stratification	Men Only. Age and BMI	Reference: Non-users of snus	<u>Adenocarcinoma</u>			<u>Adenocarcinoma</u>	
								Snus user (full cohort)	1.0 (0.6-1.5)	27	Reference: Never-users of any tobacco		NG
											Ever smoker only	2.3 (1.4–3.7)	NG
											Current smoker only	2.9 (1.8–4.8)	NG
								<i>Among never-smokers</i>			<10 g/day	1.8 (0.9–3.2)	NG
								Reference: Never-users of any tobacco		NG	10-19 g/day	3.8 (2.1–6.7)	NG
								Snus user only	0.2 (0.0-1.9)	1	≥20 g/day	4.7 (2.5–9.0)	NG
											<b>trend p-value =</b>		

					Among ever-smokers		Previous exclusive smoker	0.001 1.2 (0.6-2.4)	NG
					Reference: Non-users of snus		Smoke free < 5 yr	2.1 (0.9-4.9)	NG
					User of snus (Dual User among ever-smokers)	1.3 (0.8-2.0) 26	Smoke free ≥ 5 yr	0.8 (0.3-1.8)	NG
								trend p-value=0.1	
						- Squamous cell carcinoma		Squamous cell carcinoma	
					Reference: Non-users of snus	NG	Reference: Never-users of any tobacco		NG
					Snus user (full cohort)	1.0 (0.8-1.4) 50	Ever smoker only	5.2 (3.1-8.6)	NG
					Among never-smokers		Current smoker only <10 g/day	7.6 (4.5-12.7)	NG
					Reference: Never-users of any tobacco	NG		6.9 (4.0-11.8)	NG
					Snus user only	3.5 (1.6-7.6) 10	10-19 g/day ≥20 g/day	6.3 (3.5-11.1) 11.2 (6.2-20.2)	NG
								trend p-value = 0.02	
					Among ever-smokers		Previous exclusive smoker	0.9 (0.4-2.0)	
					Reference: Non-users of snus	NG	Smoke free < 5 yr	1.0 (0.3-3.5)	NG
					User of snus (Dual User among ever-smokers)	1.2 (0.8-1.7) 40	Smoke free ≥ 5 yr	0.8 (0.3-2.1)	NG
								trend p-value=0.1	
U.S Cohorts with Cigarette or Smoker Relative Risks									
Friedman et al. 1997	Large U.S. Cohort	Kaiser Population	1979-1986, 1987	-	Mortality	Age-adjusted	Reference: Never-smokers		
							Current male smokers	8.1 (4.4-15.0)	4
							Current female smokers	15.1 (7.7-29.7)	1
McLaughlin et al. 1995	Large U.S. Cohort	US veterans who held government life insurance policies active at the end of 1953	1953-1980	-	Mortality		Reference: NG		
							Ever smoker	3.0 (2.3-4.1)	NG
							Current smoker	4.1 (3.0-5.6)	NG
							Former smoker	1.5 (1.0-2.2)	NG
							Smoking Dose (cigarettes/day)		
							1-9	1.4 (0.7-2.7)	NG
							10-20	3.3 (2.4-4.7)	NG
							31-39	6.7 (4.7-9.4)	NG
							40+	6.1 (3.5-10.7)	NG
								p < 0.01	
SAMMEC	Large U.S. Cohort	CPS II Population 1982 – 1988	1982-1988	-	Mortality	35 years and older	Reference: Not given		
							Current smoker	6.76	NG
							Former smoker	4.46	NG
								Females	

							Reference: Not given		
							Current smoker	7.75	NG
							Former smoker	2.79	NG
USDHHS 1989	Large U.S. Cohort	CPS II Population 1982 – 1986	-	Mortality	35 years and older			<u>Males</u>	
							Reference: Never smoker		
							Current smoker	7.60 (3.81-15.17)	NG
							Former smoker	5.83 (3.02-11.25)	NG
								<u>Females</u>	
							Reference: Never smoker		
							Current smoker	10.25 (4.94-21.27)	NG
							Former smoker	3.16 (1.45-6.85)	NG
Prior Meta-Analyses of Swedish Snus									
Lee and Hamling 200b; Lee 2011	Meta-analyses	-	-	Nominal: Oesophageal	Incidence	Adenocarcinoma and squamous cell carcinoma risk estimates combined for Lagergren et al. 2000 and Zendehdel et al. 2008.	Overall data Smoking-adjusted Never smokers	1.10 (0.92-1.33) 1.10 (0.92-1.33) 1.92 (1.00-3.68)	
Boffetta et al. 2008	Meta-analyses				Incidence		Ever use	1.6 (1.1-2.2)	
Lee (2014)	Meta-analyses				Age-standardized estimates from Zendehdel et al. (2008)		Adenocarcinoma Reference: Ever-exclusive smoker Ever dual user: 1.00 (0.60-1.50)  Squamous cell carcinoma Reference: Ever-exclusive smoker Ever dual user: 0.80 (0.60-1.20)	Adenocarcinoma Reference: Never users of any tobacco Ever snus users: 0.20 (0.02-1.90)  Squamous cell carcinoma Reference: Never users of any tobacco Ever snus users: 3.50 (1.60-7.60)	Adenocarcinoma Interaction term for ever dual users 5.00 (0.50-49.74)  Squamous cell carcinoma Interaction term for ever dual users: 0.23 (0.10-0.54)

## Pancreatic Cancer

Summary of Findings Table: Pancreatic Cancer (ICD7,8,9: 157; ICD10: C25)

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Boffetta et al. 2005	Cohort	Systematic sample of 1960 Census and relatives of US migrants	1966-2001	ICD7-157	Incidence	Multivariate adjustment or stratification	Age and amount of smoking	Reference: Never or occasional user of snus Ever regular user of snus Former user Current regular user of snus  Reference: Never or occasional user of snus Ever regular snus/never smoker Ever regular snus/former smoker Ever regular snus/current smoker (Ever dual users)	<u>Among all cohort members</u>  1.67 (1.12-2.50) 1.80 (1.04-3.09) 1.60 (1.00-2.55)  0.85 (0.24-3.07) 1.37 (0.59-3.17) 1.86 (1.13-3.05)	45 18 27  3 14 28			
Luo et al. 2007	Cohort	Swedish Construction Worker Cohort	1978-1992, December 2004	ICD7-157	Incidence	Multivariate adjustment or stratification	Age and BMI	Reference: Never-users of any tobacco Ever-users of snus   Reference: Never-users of any tobacco Ever-users of snus Ex-users Current users 1-9 g/day ≥10 g/day trend p-value	<u>Among all cohort members</u>  0.9 (0.7-1.2)   <u>Among never-smokers</u>  2.0 (1.2-3.3) 1.4 (0.4-5.9) 2.1 (1.2-3.6) 1.9 (0.8-4.3) 2.1 (1.1-3.8) 0.01	NG   20 2 18 6 13	Reference: Never-users of any tobacco Ever-smokers Ex-smokers Current smokers  <b>Note:</b> "Combined use of snus and smoking tobacco was allowed in these analyses...", but these effect measures exclude exclusive snus users	<u>Among all cohort members</u>  2.8 (2.1-3.7) 1.8 (1.3-2.4) 3.5 (2.6-4.6)	385 105 280
Heuch et al. 1983	Case-control	1960 Norwegian population, Brothers of US migrants, and a Gastrointestinal Paired Case-Control	1964, 1967 – 1968	Nominal	Incidence	Multivariate adjustment	Region, urban/rural place of residence, age and sex.  Tobacco type unclear and population followed up by	Among all individuals with chewing data	<u>All cases of pancreatic cancer (regular use vs. never used)</u> 1.34 (p=0.21)  <u>Histologically-verified cases only (regular use vs. never used)</u>	12	Among men with cigarette data	<u>All cases of pancreatic cancer (≥10 cigs/day vs. never smoked)</u> 1.13 (p=0.35)  <u>Histologically-verified cases only (≥10 cigs/day vs. never smoked)</u>	6

Boffetta et al. 2005.	Among all individuals with chewing data	2.20 (p=0.045)	9	Among men with cigarette data	2.04 (p=0.087)	5
	Among men with alcohol, cigarette and chewing data	2.31 (p=0.067)	6	Among men with alcohol, cigarette and chewing data	1.88 (p=0.13)	4
	Among men with alcohol, cigarette and chewing data, with adjustment for alcohol use and cigarette smoking	2.85 (p=0.060)	6	Among men with alcohol, cigarette and chewing data, with adjustment for alcohol use and tobacco chewing	2.13 (p=0.12)	4

Araghi et al. 2017	Pooled cohort	ICD7-157 and ICD10-C25	Incidence	Multivariate adjustment	Reference: never users of snus	-
					<u>Pooled Cohort</u>	
					Ever	0.93 (0.82, 1.06)
					Former users	0.88 (0.71-1.10)
					Current users	0.96 (0.83-1.11)
					< 4 cans/week	0.87 (0.70-1.08)
					4-6 cans/week	1.16 (0.93-1.46)
					≥ 7 cans/week	0.87 (0.65-1.17)
					<b>no p for trend</b>	
					< 5 years	0.82 (0.56-1.21)
					5-9 years	1.00 (0.72-1.39)
					10-14 years	0.99 (0.72-1.36)
					15-19	0.98 (0.67-1.44)
					≥ 20 years	0.95 (0.75-1.19)
					<b>no p for trend</b>	
					<u>Pooled Cohort excluding Swedish Construction Worker cohort</u>	
					Ever	1.13 (0.87, 1.45)
					Current users	1.30 (0.97-1.73)
					Former users	0.90 (0.61-1.31)
					<u>Pooled Cohort restriction to never smokers</u>	
					Ever	1.04 (0.77-1.42)
					Current	1.07 (0.77-1.50)
					Former	0.92 (0.47-1.80)
					<u>CWC estimate</u>	
					Current	0.86 (0.72-1.02)

#### U.S Cohorts with Cigarette or Smoker Relative Risks

Friedman et al. 1997	Large U.S. Cohort	Kaiser Population	1979-1986, 1987	-	Mortality	Age-adjusted	Reference: Never-smokers		
								Current male smokers	2.1 (0.8-5.6) 8
								Current female smokers	3.9 (1.7-9.3) 12

Iodice et al. 2008	Meta-analysis	82 study meta-analyses	??	??			Reference: Not given		
							Current smoker	1.74 (1.61-1.87)	NG
							Former smoker	1.2 (1.11-1.29)	NG
McLaughlin et al. 1995	Large U.S. Cohort	US veterans who held government life insurance policies active at the end of 1953	1953-1980	-	Mortality		Reference: NG		
							Ever smoker	1.4 (1.3-1.6)	NG
							Current smoker	1.7 (1.5-1.9)	NG
							Former smoker	1.1 (0.9-1.3)	NG
							Smoking Dose (cigarettes/day)		
							1-9	1.4 (1.1-1.8)	NG
							10-20	1.7 (1.4-1.9)	NG
							31-39	1.8 (1.5-2.2)	NG
							40+	1.6 (1.1-2.3)	NG
							<b>p &lt; 0.01</b>		
SAMMEC	Large U.S. Cohort	CPS II Population 1982 – 1988	1982-1988	-	Mortality	35 years and older	Reference: Not given		
							Current smoker	2.31	NG
							Former smoker	1.15	NG
							<u>Females</u>		
							Reference: Not given		
							Current smoker	2.25	NG
							Former smoker	1.55	NG
							<u>Males</u>		
USDHHS 1989	Large U.S. Cohort	CPS II Population 1982 – 1986		-	Mortality	35 years and older	Reference: Never smoker		
							Current smoker	2.14 (1.62-2.85)	NG
							Former smoker	1.12 (0.86-1.45)	NG
							<u>Females</u>		
							Reference: Never smoker		
							Current smoker	2.33 (1.77-3.08)	NG
							Former smoker	1.78 (1.37-2.30)	NG
<b>Prior Meta-Analyses of Swedish Snus</b>									
Bertuccio et al. 2011	Pooled-analysis	11 international case-control studies			Incidence	Center, race, sex, age, education, history of diabetes, body mass index and total alcohol consumption.	Reference: Never tobacco user		Reference: Never tobacco user
							Ever smokeless tobacco	0.98 (0.75-1.27)	Cigarette-only smokers
							Smokeless tobacco-only	0.62 (0.37-1.04)	Cigar-only smokers
							Smokeless tobacco users and cigarette (dual users)	1.36 (0.94-1.96)	Cigarette and cigar and pipe
							Smokeless tobacco users and cigar and pipe	1.44 (0.65-3.21)	Cigarette and cigar and pipe
							Smokeless tobacco users and cigarette and cigar or pipe	0.77 (0.49-1.21)	Cigarette and pipe
									Cigar and pipe
									1.13 (0.76-1.69)
Boffetta et al. 2008	Meta-analysis				Incidence		Ever use	1.8 (1.32-2.5)	
Lee and Hamling 2009b; Lee	Meta-analysis	-	-		Incidence	Combined and presented estimates for	Overall data	1.2 (0.66-2.20)	
							Smoking-adjusted	1.2 (0.66-2.20)	
							Never smokers	1.61 (0.77-3.34)	

2011		smoking-adjusted and never-smokers separately from Boffetta et al. 2005 and Luo et al. 2007.	
Sponsiello-Wang et al. 2008	Meta-analysis		Sweden or Norway <u>Overall (never-smokers used if overall estimate not available)</u> 1.09 (0.87-1.36) 1.20 (0.66-2.20) <u>Never-smokers (overall used if never-smokers estimate not available)</u> 1.78 (1.11-2.85) 1.61 (0.77-3.34)
		Fixed-effect Random-effects	
		Fixed-effect Random-effects	

## Stomach Cancer

Summary of Findings Table: Stomach Cancer (ICD7,8,9: 151 ICD10: C16)

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Hansson et al. 1994	Case-control	5 counties in central and northern Sweden: Uppsala, Västmanland, Södermanland, Västerbotten, and Norrbotten Counties	1989-1992	Nominal: "Gastric Cancer"	Incidence	Multivariate Adjustment	Age, gender, SES, and vegetable intake	Reference: Unspecified Snuff dipping	0.70 (0.47-1.06)	NR	Reference: Non-users of tobacco Current cigarette smokers Ex-cigarette smokers Duration of cigarette smoking (years) 1-10 11-20 21-30 31-40 ≥41  Amount smoked (cig/day while being smoker) 1-5 6-10 11-15 ≥16  trend p-value= 0.01	1.72 (1.16-2.54) 1.09 (0.75-1.59) 1.13(0.60-2.11) 1.07(0.58-1.97) 0.83(0.49-1.40) 1.84(1.15-2.95) 1.62(1.05-2.49)  1.08(0.68-1.73) 1.38 (0.89-2.12) 2.08 (1.22-3.52) 1.17(0.75-1.84)  trend p-value= 0.10	85 78 18 20 25 42 57  34 51 34 44
Lagergren et al. 2000	Case-control	Swedish population	1995-1997	Nominal: "Gastric cardia adenocarcinoma"	Incidence	Multivariate Adjustment	Age, gender, alcohol use, educational level, BMI, reflux symptoms, intake of fruit and vegetables, energy intake and physical activity	Reference: Never user of snuff Ever  Duration of use (years)  Reference: Never user of snuff 1-10 11-25 >25  Intensity of use (quids per week) Reference: Never user of snuff 1-14	1.2 (0.8-1.8)    1.0 (0.5-1.8) 1.1 (0.6-2.0) 1.1 (0.6-2.2)  1.2 (0.6-2.1)	53   18 19 15  19	Reference: Never-smoker Previous smoker Current smoker  Duration of smoking of cigarettes, cigars, or pipes (years) Reference: Never-smoker 1-20 21-35 >35  Intensity of cigarette use per day Reference: Never-smoker 1-9	3.4 (2.2-5.2) 4.5 (2.9-7.1)   2.1 (1.2-3.4) 3.9 (2.4-6.2) 5.7 (3.6-9.1)  2.3 (1.4-3.7)	124 95   38 77 104  46



								15-35	1.3 (0.7-2.5)	15	10-19	3.1 (2.0-4.9)	73
								>35	1.3 (0.7-2.4)	18	>19	3.6 (2.3-5.7)	86
									trend p-value = 0.53			trend p-value stated as significant, but not given	
Ye et al. 1999	Case-control	5 counties in central and northern Sweden: Uppsala, Västmanland, Södermanland, Västerbotten, and Norrbotten Counties	1989-1995	Nominal: "Total gastric cancer, Cardia cancer, intestinal-type gastric cancer, and diffuse-type gastric cancer"	Incidence	Multivariate Adjusted for stomach cancer subtypes. Stratification for overall stomach cancer.	Risk estimates for snuff use were adjusted for age, residence area, BMI, socio-economic status, and smoking. Odds ratios among smokers and exclusive tobacco groups were adjusted for age, gender, residence area, BMI, SES, use of smokeless tobacco, and use of beer, wine and liquor.	Reference: Never-users	<u>Cardia cancer</u>		Reference: Never-smokers	<u>Cardia cancer</u>	
								Ex-users	0.8 (0.3-1.9)	6	Ex-smokers	0.9 (0.5-1.6)	25
								Current users	0.5 (0.2-1.1)	9	Current smokers	1.7 (1.0-3.1)	31
								Ever-users	0.6 (0.3-1.2)	15			
								<u>Intensity of use (times/day)</u>			<u>Intensity of use (cigarettes/day)</u>		
								≤5	0.5 (0.2-1.2)	7	1-10	1.7 (0.7-3.8)	9
								>5	0.8 (0.3-1.8)	8	11-15	1.2 (0.4-3.8)	4
									trend p-value = 0.30		≥16	2.2 (1.0-4.8)	13
								<u>Duration (years)</u>			<u>Duration of cigarette use (years)</u>		
								1-10	0.9 (0.3-2.2)	6	1-30	1.3 (0.5-3.6)	8
								11-30	0.7 (0.2-1.7)	6	≥31	2.2 (1.1-4.3)	18
								≥31	0.3 (0.0-1.1)	3		trend p-value = 0.03	
								<u>Age at start (years)</u>					
								≥21	0.4 (0.1-1.0)	6			
								16-20	1.0 (0.4-2.0)	9			
									trend p-value = 0.45				
									<u>Distal gastric cancer-intestinal</u>			<u>Distal gastric cancer-intestinal</u>	
								Reference: Never-users			Reference: Never-smokers		
								Ex-users	0.9 (0.5-1.6)	18	Ex-smokers	1.4 (1.0-2.0)	101
								Current users	0.8 (0.5-1.3)	26	Current smokers	1.8 (1.2-2.7)	67
								Ever-users	0.8 (0.5-1.2)	44			
									<u>Distal gastric cancer-diffuse</u>			<u>Distal gastric cancer-diffuse</u>	
								Reference: Never-users			Reference: Never-smokers		
								Ex-users	0.7 (0.3-1.6)	8	Ex-smokers	1.3 (0.8-2.0)	46
								Current users	0.6 (0.3-1.2)	11	Current smokers	2.2 (1.4-3.5)	57
								Ever-users	0.7 (0.4-1.2)	19			
									<u>Total gastric and cardia cancer among all</u>			<u>Total gastric and cardia cancer among all</u>	
								Reference: Never smoker/Never snuff use			Reference: Never smoker/Never snuff		

Ever snuff user/Never Smoker	0.5 (0.2-1.2)	11	use Current smoker/Never snuff	2.0 (1.3-2.9)	101
Ever snuff user/Ex-smoker	1.2 (0.8-1.9)	56	Ex-smoker/Never snuff	1.2 (0.8-1.9)	111
Ever snuff user/Current smoker ( <b>Dual User</b> )	1.0 (0.5-1.8)	16			

Zendehdel et al. 2008	Cohort	Swedish Construction Worker Cohort	1971-1993, 2004	ICD7-151 with analysis of only Cardia (151.1) and Non-cardia (all other 151) cancer	Incidence	Multivariate Adjustment or Stratification	Men only. Attained age, BMI and smoking (among ever smokers or entire cohort).	<u>Cardia</u>			<u>Cardia</u>		
								Reference: Non-users of snus			Reference: Never-users of any tobacco		
								Snus user (full cohort)	1.0 (0.8-1.4)	58	Ever smoker only	2.1 (1.5-3.0)	NG
								<i>Among never-smokers</i>			Current smoker only	2.3 (1.6-3.3)	NG
								Reference: Never-users of any tobacco			<u>Dose-response:</u>		
								User of snus only	0.9 (0.4-2.0)	8	<10 g/day	2.1 (1.4-3.1)	NG
								<i>Among ever-smokers</i>			10-19 g/day	2.4 (1.6-3.7)	NG
								Reference: Non-users of snus			≥20 g/day	3.0 (1.8-5.0)	NG
								User of snus ( <b>Dual User</b> as among ever-smokers)	1.1 (0.8-1.6)	50	Previous exclusive smoker	<b>trend p-value=0.1</b> 1.8 (1.2-2.7)	NG
											Smoke free < 5 yr	1.9 (1.1-3.4)	NG
											Smoke free ≥ 5 yr	1.7 (1.1-2.6)	NG
											<b>trend p-value = 0.7</b>		
								<u>Noncardia</u>					
								Reference: Non-users of snus			<u>Noncardia</u>		
								Snus user (full cohort)	1.1 (1.0-1.3)	253	Reference: Never-users of any tobacco		
								<i>Among never-smokers</i>			Ever smoker only	1.3 (1.2-1.6)	NG
								Reference: Never-users of any tobacco			Current smoker only	1.4 (1.2-1.6)	NG
								User of snus only	1.4 (1.1-1.9)	68	<u>Dose-response:</u>		
								<i>Among ever-smokers</i>			<10 g/day	1.3 (1.1-1.6)	NG
								Reference: Non-users of snus			10-19 g/day	1.4 (1.2-1.8)	NG
								User of snus ( <b>Dual User</b> as among ever-smokers)	1.0 (0.9-1.2)	185	≥20 g/day	1.4 (1.1-1.9)	NG
											<b>trend p-value=0.3</b>		
											Previous exclusive smoker	1.3 (1.1-1.5)	Ng
											Smoke free < 5 yr	1.2 (0.9-1.6)	Ng
											Smoke free ≥ 5 yr	1.3 (1.1-1.6)	Ng
											<b>trend p-value = 0.6</b>		
Boffetta et al. 2005	Cohort	Systematic sample of 1960 Census and relatives of US migrants	1964-1967, 2001	ICD7: 151	Incidence	Multivariate Adjustment	Men only Age	<u>Among all cohort members</u>					
								Reference: Never or occasional use of snus					
								Ever regular use	1.11 (0.83-1.48)				
								Current regular use	1.29 (0.87-1.91)				
								Former regular use	1 (0.71-1.42)				

U.S Cohorts with Cigarette or Smoker Relative Risks											
Friedman et al. 1997	Large U.S. Cohort	Kaiser Population	1979-1986, 1987	-	Mortality	Age-adjusted			Reference: Never Smokers Current smokers Current smokers	Males: 2.4 (1.0-5.5) Females: 0.8 (0.2-2.8)	12 3
McLaughlin et al. 1995	Large U.S. Cohort	US veterans who held government life insurance policies active at the end of 1953	1953-1980	-	Mortality				Reference: NG Ever smoker Current smoker Former smoker Smoking dose (Cigarettes/day) 1-9: 10-20: 31-39: 40+	1.3 (1.1-1.4) 1.4 (1.2-1.6) 1.0 (0.9-1.2)  1.3 (1.0-1.7) 1.4 (1.2-1.6) 1.4 (1.2-1.8) 1.9 (1.3-2.7) <b>p &lt; 0.01</b>	NG NG NG NG NG NG NG NG
SAMMEC	Large U.S. Cohort	CPS II Population 1982 – 1988	1982-1988	-	Mortality	35 years and older			Current smoker vs. Never smoker  Former smoker vs. Never smoker	Males: 1.96 Females: 1.36  Males: 1.47 Females: 1.32	
Prior Meta-Analyses of Swedish Snus											
Lee and Hamling 2009b; Lee 2011	Meta-Analyses	-	-	-	Incidence	Multivariate Adjustment or Stratification	Overall data  0.98 (0.82-1.17) <u>Smoking-adjusted</u> 0.98 (0.82-1.17) <u>Among never-smokers</u> 0.90 (0.35-2.30)				
Lee (2014)						Age-standardized estimates from Zendejdel et al. (1998)	Cardia stomach cancer Reference: Ever-exclusive smoker Ever dual user: 0.90 (0.70-1.30)  Non-cardia stomach cancer Reference: Ever-exclusive smoker Ever dual user: 1.00 (0.90-1.20)	Cardia stomach cancer Reference: Never users of any tobacco Ever exclusive snus: 0.9 (0.4-2.0)  Non-cardia stomach cancer Reference: Never users of any tobacco Ever exclusive snus: 1.4 (1.1-1.9)	Adenocarcinoma Interaction term for ever dual users 1.00 (0.42-1.37)  Squamous cell carcinoma Interaction term for ever dual users: 0.71 (0.52-0.97)		
						Unadjusted estimates from Ye et al. (1999)	Stomach cancer among full cohort: Reference: Ever-exclusive smoker Ever snuff user/Ever smoker: 0.80 (0.57-1.13)	Stomach cancer among full cohort: Reference: Never snuff/smoker  Ever exclusive snus: 0.50 (0.20-1.22)	Stomach cancer Interaction term for ever dual users:  1.60 (0.61-4.18)		



## Lung Cancer

Summary of Findings Table: Lung Cancer (ICD7,8,9: 162; ICD10: C33-C34)

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Bolinder et al. 1994	Cohort	Swedish Construction Worker Cohort	1971-1974, 1985	ICD8: 162	Mortality	Stratification	Men only Age and Region of Origin	Current smokeless tobacco users vs Never Tobacco	<u>Among all cohort members</u> 0.9 (0.2-3.0)	3			
								Current smokeless tobacco vs Never Tobacco	<u>Among those aged 35-54:</u> 1.2 (0.2-9.1)	1	Current cigarette vs. Never Tobacco	<u>Among those aged 35-54:</u> <15 cig/day: 8.1 (3.2-20.4) >15 cig/day: 21.4 (8.5-54.1)	16 43
								Current smokeless tobacco vs Never Tobacco	<u>Among those aged 55-65:</u> 0.8 (0.1-3.9)	2	Current cigarette vs. Never Tobacco	<u>Among those aged 55-65:</u> <15 cig/day: 11.9 (5.5-25.6) >15 cig/day: 30.6 (14.6-64.1)	36 57
											Former cigarette vs. Never Tobacco	<u>Among those aged 35-54:</u> 1-5 years: 6.7 (2.3-19.7) >5 years: 1.2 (0.3-4.5)	7 3
											Former cigarette vs. Never Tobacco	<u>Among those aged 55-65:</u> 1-5 years: 9.4 (3.9-22.3) >5 years: 2.3 (1.0-5.7)	14 12
Luo et al. 2007	Cohort	Swedish Construction Worker Cohort	1978-1992, 2003	ICD7: 162	Incidence	Multivariate Adjustment or Stratification	Men only Age and BMI	Reference: Never-users of any tobacco	<u>Among all cohort members</u>		Reference: Never-users of any tobacco	<u>Among all cohort members</u>	
								Ever-users of snus	0.7 (0.6-0.7)	18	Ever-smokers Ex-smokers Current smokers	7.2 (6.0-8.5) 2.6 (2.2-3.2) 10.2 (8.6-12.2)	2062 329 1733
								Reference: Never-users of any tobacco	<u>Among never-smokers</u>		<b>Note:</b> "Combined use of snus and smoking tobacco was allowed in these analyses...", but these effect measures exclude exclusive snus users		
								Ever-users of snus	0.8 (0.5-1.3)	18			
								Ex-users	0.9 (0.3-3.0)	3			
								Current users	0.8 (0.4-1.3)	15			
								1-9 g/day	1.0 (0.5-2.1)	7			
								≥10 g/day	0.7 (0.4-1.3)	10			
								<b>trend p-value</b>	<b>0.2</b>				
Boffetta et al. 2005	Cohort	Systematic sample of 1960 Census	1964-1967, 2001	ICD7: 162, with additional subanalyses of	Incidence	Multivariate Adjustment	Men only Age	Reference: Never or occasional user of snus Ever regular user of snus	<u>Among all cohort members</u> 0.8 (0.61-1.05)	72			

and  
relative  
s of US  
migrant  
s

Lung  
Adenocar  
cinoma

Current regular user of snus	0.8 (0.54-1.19)	44
Former regular user of snus	0.8 (0.58-1.11)	28
Reference: Never or occasional user of snus		
Ever regular snus/never smoker	0.96 (0.26-3.56)	3
Ever regular snus/former smoker	0.64 (0.24-1.68)	7
Ever regular snus/current smoker (Ever dual users)	0.68 (0.51-0.9)	62
<u>Lung Adenocarcinoma among all cohort members</u>		
Reference: Never or occasional user of snus		11
Ever regular user of snus	0.83 (0.42-1.65)	
Current regular user of snus	0.86 (0.3-2.43)	7
Former regular user of snus	0.81 (0.36-1.85)	4

#### U.S Cohorts with Cigarette or Smoker Relative Risks

Friedman et al. 1997	Large U.S. Cohort	Kaiser Population	1979-1986, 1987	-	Mortality	Age-adjusted	Current Smokers vs Never Smokers	Males: 8.1 (4.4-15.0) Females: 15.1 (7.7-29.7)	53 54
McLaughlin et al. 1995	Large U.S. Cohort	US veterans who held government life insurance policies active at the end of 1953	1953-1980	-	Mortality		Ever smoker vs. Never smoker	8.4 (7.5-9.4)	
							Current smoker vs. Never smoker	11.6 (10.4-13.0)	
							Former smoker vs. Never smoker	3.6 (3.1-4.1)	
							Does-response for Current Smokers (cigs/day) vs. Never smoker	1-9: 3.7 (3.1-4.5) 10-20: 9.9 (8.8-11.2) 31-39: 16.9 (15.0-19.0) 40+: 22.9 (19.8-26.6) p < 0.01	
Rostrom 2012	Large U.S. Cohort	National Health Interview Survey (NHIS) – Linked Mortality Files	1997 – 2004, followed through 2006	-	Mortality		Current smoker vs. Never smoker	Males: 11.71 (8.30-16.53) Females: 14.30 (10.67-19.15)	
							Former smoker vs. Never smoker	Males: 3.85 (2.80-5.31) Females: 6.01 (4.53-7.97)	
SAMM	Large	CPS II		-	Mortality	35 years and	Current smoker	Males: 23.26	

EC	U.S. Cohort	Population 1982 – 1988			older			vs. Never smoker	Females: 12.69
USDHHS 1989	Large U.S. Cohort	CPS II Population 1982 – 1986	-		Mortality	35 years and older		Former smoker vs. Never smoker	Males: 8.70 Females: 4.53
								Current smoker vs. Never smoker	Males: 22.36 (17.77-28.13) Females: 11.94 (9.99-14.26)
								Former smoker vs. Never smoker	Males: 9.36 (7.43-11.77) Females: 4.69 (3.86-5.70)
<b>Prior Meta-Analyses of Swedish Snus</b>									
Lee and Hamling 2009b; Lee 2011	Meta-Analysis	-	-	-	Incidence	Multivariate Adjustment or Stratification		<u>Overall data</u> 0.71 (0.66-0.76) <u>Smoking-adjusted</u> 0.71 (0.66-0.76) <u>Among never-smokers</u> 0.82 (0.52-1.28)	
Boffetta et al. 2008	Meta-Analysis	-	-	-	Incidence			Ever use: 0.8 (0.6-1.0)	

## Cardiovascular Disease

Summary of Findings Table: CVD (ICD8, 9: 390-458, ICD10: I00-I99) and MI, IHD (ICD8,9: 410-414, ICD10:I20-I25)

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Arefalk et al. 2011	Cohort	Uppsala Longitudinal Study of Adult Men (ULSAM)	1991-2002	Nominal: First hospitalization for heart failure and first hospitalization for non-ischemic heart failure	Incidence	Multivariate Adjustment	Men only Main: Age, current smoking dose, pack- years of smoking, diabetes, BMI, occupational classification, alcohol use, and myocardial infarction before baseline  Mechanistic: Age, office systolic blood pressure, antihypertensive medication use, electrocardiogram-left ventricular hypertrophy and replacing MI before baseline with MI during follow up (as a time-dependent covariate).	Reference: No current snus Current snus Age-adjusted only Main model Mechanistic model  <i>Non-ischemic heart failure</i> Main model  Relative Excess Risk due to Interaction (RERI) RERI between snus use (vs. non-use) and current smoking (vs. not)  Bootstrapped comparison of hazard ratios between snus use (vs. non-use) and smoking (vs. non-smoking)	  2.42 (1.37-4.27) 2.08 (1.03-4.22) 2.09 (1-4.39)  2.55 (1.12-5.82)  1.14 (-2.40-4.69)  0.76 (-1.45-3.51)	14 14 14			
Arefalk et al. 2011	Cohort	Swedish Construction Workers cohort	1978-1993	ICD-7: 434.1, 434.2, 440.99, 441.99; ICD-8: 427.00, 427.10, 428.99; ICD-9: 428; ICD-10: I50, I11.0  First hospitalization for heart failure based on ICD code above and first hospitalization for non-ischemic heart failure as a nominal definition.	Incidence	Stratification	Men only Main: Age, BMI, region of residence and myocardial infarction before baseline  Mechanistic: Age, BMI, region of residence, further adjusted for systolic and diastolic blood pressures and replacing MI before baseline with MI during follow up (as a time-dependent	Reference: Never tobacco <u>Current snus</u> Age-adjusted only Main model Mechanistic model <u>Current snus dose (main model)</u> < 12.5 g/day 12.5-24.9 g/day 25-49.9 g/day ≥ 50 g /day <i>p for trend = 0.9</i> <u>Former snus</u> Age-adjusted only Main model Mechanistic model <i>Non-ischemic heart failure</i> Main model	  1.35 (1.05-1.72) 1.28 (1-1.64) 1.24 (0.97-1.59)  1.18 (0.80-1.73) 1.46 (1.03-2.06) 1.03 (0.51-2.08) 1.25 (0.47-3.84)  1.02 (0.46-2.29) 1 (0.45-2.23) 0.99 (0.44-2.22)  1.28 (0.97-1.68)	75 75 75  28 35 8 4  6 6 6			



covariate).												
Arefalk et al. 2014	Cohort	Swedeheart	2005-2009	Nominal: Post-MI Mortality	Mortality	Stratification	Age, sex, past smoking, present sun exposure, occupation status, and participation in cardiac rehabilitation program.	Reference: Post-MI Snus users	69	Reference: Post-MI smokers	149	
								Post-MI Snus quitter	0.57 (0.32-1.02)	14	Post-MI smoke quitter	0.54 (0.42-0.69) 120
Bolinder et al. 1992	Cross-sectional	Swedish Construction Workers cohort	1971 – 1974	Nominal: Cardiovascular disease	Prevalence	Stratification	Men only. Age		<u>Cardiovascular diagnosis Ages 46-55</u>		<u>Cardiovascular diagnosis Ages 46-55</u>	
								Reference: Never-users of tobacco Snuff users	1.6 (0.7-3.5)	8	Reference: Never-users of tobacco >15 cig/day	2.2 (1.3-3.9) 22
									<u>Cardiovascular diagnosis Ages 56-65</u>		<u>Cardiovascular diagnosis Ages 56-65</u>	
								Reference: Never-users of tobacco Snuff users	1.5 (1.1-1.9)	69	Reference: Never-users of tobacco >15 cig/day	1.3 (0.9-1.9) 33
Bolinder et al. 1994	Cohort	Swedish Construction Workers cohort	1971 – 1974, 1985	ICD8: 390-458 (All CVD), 410-414 (IHD)	Mortality	Stratification	Men only. Age and region of origin, however, high blood pressure, diabetes, BMI, region, blood pressure meds, and previous cardiac symptoms were considered and not found to significantly alter RR.		<u>All CVD Mortality</u>		<u>All CVD Mortality</u>	
								Reference: Never-users of tobacco Exclusive current snuff users	1.4 (1.2-1.6)	220	Reference: Never-users of tobacco <15 cig/day exclusively >15 cig/day exclusively	1.8 (1.6-2.0) 450
											1.9 (1.7-2.2) 381	
											Exclusive ex-smokers, 1-5 years	1.4 (1.1-1.6) 169
											Exclusive ex-smokers, >5 years	1.1 (0.9-1.2) 402
									<u>All CVD Mortality Ages 35-54</u>		<u>All CVD Mortality Ages 35-54</u>	
								Reference: Never-users of tobacco Exclusive current snuff users	2.1 (1.5-2.9)	44	Reference: Never-users of tobacco <15 cig/day exclusively >15 cig/day exclusively	2.7 (2.2-3.4) 164
											Exclusive ex-smokers, 1-5 years	3.2 (2.6-3.9) 199
											Exclusive ex-smokers, >5 years	1.4 (1.0-2.0) 46
									<u>All CVD Mortality Ages 55-65</u>		<u>All CVD Mortality Ages 55-65</u>	
								Reference: Never-users of tobacco			Reference: Never-users of tobacco	1.1 (0.9-1.5) 83

									Exclusive current snuff users	1.1 (1.0-1.4)	174	<15 cig/day exclusively	1.5 (1.3-1.7)	272
												>15 cig/day exclusively	1.5 (1.3-1.7)	167
												Exclusive ex-smokers, 1-5 years	1.3 (1.1-1.6)	120
												Exclusive ex-smokers, >5 years	1.0 (0.9-1.2)	317
										<u>IHD Mortality Ages 35-54</u>			<u>IHD Mortality Ages 35-54</u>	
									Reference: Never-users of tobacco			Reference: Never-users of tobacco		
									Exclusive current snuff users	2.0 (1.4-2.9)	35	<15 cig/day exclusively	2.6 (2.1-3.4)	128
												>15 cig/day exclusively	3.3 (2.6-4.2)	162
												Exclusive ex-smokers, 1-5 years	1.4 (1.0-2.1)	37
												Exclusive ex-smokers, >5 years	1.2 (0.9-1.6)	67
										<u>IHD Mortality Ages 55-65</u>			<u>IHD Mortality Ages 55-65</u>	
									Reference: Never-users of tobacco			Reference: Never-users of tobacco		
									Snuff users	1.2 (1.0-1.5)	137	<15 cig/day exclusively	1.7 (1.4-1.9)	225
												>15 cig/day exclusively	1.4 (1.2-1.8)	122
												Exclusive ex-smokers, 1-5 years	1.3 (1.1-1.6)	89
												Exclusive ex-smokers, >5 years	1.1 (0.9-1.2)	248
Haglund et al. 2007	Cohort	Swedish Survey of Living Conditions	1989-1989, 2003	Nominal: "Ischemic heart disease" ICD9: 410-414; ICD10: I20-I25 (IHD)	Incidence and Mortality	Stratification	Men only. Age, socioeconomic status, residential area, self-reported health, number of longstanding illnesses, and physical activity.	Reference: No tobacco	<u>IHD Incidence</u>			Reference: No tobacco	<u>IHD Incidence</u>	
						Tobacco use categories were exclusive (but may include former smokers/snuff users).		Daily Exclusive Snuff	0.77 (0.51-1.15)	28	Daily Exclusive Smoke	1.74 (1.41-2.14)	153	
								Daily Exclusive Smoke & Snuff (Dual User)	1.64 (0.96-2.79)	15				
									<u>IHD Mortality</u>			<u>IHD Mortality</u>		
								Reference: No tobacco			Reference: No tobacco			
								Daily Exclusive Snuff	1.15 (0.54-2.41)	8	Daily Exclusive Smoke	1.98 (1.35-2.91)	52	
								Daily Exclusive Smoke & Snuff (Dual User)	1.69 (0.52-5.46)	3				
Hansson et al. 2009	Cohort	Swedish Twin Registry	Born 1928 – 1958 & followed through 2003 for	All CVD nominally and Ischemic Heart Disease: ICD10: I20-I21, I24-I25	Incidence	Stratification	Age, sex, diabetes, high blood pressure, and high cholesterol.	Reference: Never snus and never smoking	<u>All CVD</u>			Reference: Never snus and never smoking	<u>All CVD</u>	
								Exclusive former	1.21 (0.75-1.97)	19	Exclusive former	1.17 (1.00-1.38)	318	

mortality  
and 2005  
for  
hospitaliza  
tion.

[excluding I25.2]

snuff users  
Exclusive current  
snuff users 1.00 (0.69-1.46) 32  
Current snus/Former  
Smoker (**Switchers**) 1.04 (0.78-1.39) 58  
Current (**Dual Users**) 1.51 (0.86-2.65) 14  
IHD  
Reference: Never  
snus and never  
smoking  
Exclusive former  
snuff users 1.07 (0.56-2.03) 11  
Exclusive current  
snuff users 0.85 (0.51-1.41) 18  
Current snus/Former  
Smoker (**Switchers**) 1.22 (0.82-1.74) 43  
Current (**Dual Users**) 1.50 (0.73-3.08) 9

smokers  
Exclusive current  
smokers 1.86 (1.56-2.22) 230  
  
IHD  
Reference: Never  
snus and never  
smoking  
Exclusive former  
smokers 1.34 (1.10-1.64) 229  
Exclusive current  
smokers 1.99 (1.59-2.50) 155

Hergens et al. 2005	Case-control	Residents of Stockholm county	1992-1994	Nominal: MI	Incidence and Mortality	Stratification	Age, sex, hospital catchment area, diabetes, hyperlipidemia, hypertension, overweight, physical inactivity, and job strain						
								Reference: Never-snus and never smokers				Reference: Never smoker and never snus	
								Former exclusive snus	1.2 (0.46-3.1)			Former exclusive smokers	1.3 (1.1-1.6)
								Current exclusive snus	0.73 (0.35-1.5)			Current exclusive smokers	2.8 (2.3-3.4)
								Current snus/Former smoker ( <b>Switchers</b> )	1.60 (1.10-2.20)				
								Current snus/smoker ( <b>Dual Users</b> )	2.30 (1.6-3.4)				
									<u>Nonfatal cases</u>				<u>Nonfatal cases</u>
								Reference: Never-snus and never smokers				Reference: Never smoker and never snus	
								Former exclusive snus	1.2 (0.43-3.2)			Former exclusive smokers	1.2 (0.98-1.5)
								Current exclusive snus	0.59 (0.25-1.4)			Current exclusive smokers	2.7 (2.2-3.3)
								Current snus/Former smoker ( <b>Switchers</b> )	1.60 (1.10-2.20)				
								Current snus/smoker ( <b>Dual Users</b> )	2.10 (1.4-3.1)				
									<u>Fatal cases</u>				<u>Fatal cases</u>
								Reference: Never-snus and never smokers				Reference: Never smoker and never snus	
								Former exclusive snus	1.7 (0.21-13.6)			Former exclusive smokers	1.7 (1.6-2.6)
								Current exclusive snus	1.7 (0.48-5.5)			Current exclusive smokers	3.6 (2.4-5.2)
								Current snus/Former smoker ( <b>Switchers</b> )	1.50 (0.69-3.20)				
								Current snus/smoker ( <b>Dual Users</b> )	3.80 (1.9-7.5)				

Hergens et al. 2007	Cohort	Swedish Construction Workers cohort	1978-2004	Acute MI: ICD7: 420.10-420.17, ICD8: 410, ICD9: 410, or ICD10: I21-I22	Incidence and Mortality	Stratification	Adjusted for age (age at follow-up was used as time scale), body mass index [weight(kg)/height(m)2, categorized into <20, 20–24.9, 25–29.9 and ≥30] and region of residence (northern, middle and southern Sweden).	Reference: Never-smus Ever Regular Former Regular Current Regular < 12.5 g/day 12.5-24.9 g/day 25-49.9 g/day ≥ 50 g/day  Reference: Never-smus Ever Regular Former Regular Current Regular < 12.5 g/day 12.5-24.9 g/day 25-49.9 g/day ≥ 50 g/day  <u>Incident non-fatal MI</u>  Reference: Never-smus Ever Regular Former Regular Current Regular	<i>Among never-smokers</i> <u>Incident MI</u>  <
---------------------	--------	-------------------------------------	-----------	--	-------------------------	----------------	---	--	---

et al. 1992	control study	Sweden MONICA project:	1991		on	Age		Reference: No tobacco Regular Snuff dipping	<u>years</u> 0.96 (0.56-1.67)  <u>Among ages 55-64 years</u>  Reference: No tobacco Regular Snuff dipping  1.24 (0.67-2.30)  <u>All subjects</u>  Reference: No tobacco Regular Snuff dipping <2 cans weekly >2 cans weekly	Reference: No tobacco Regular Smoking  Reference: No tobacco Regular Smoking  Reference: No tobacco Regular Smoking <10 daily >10 daily  Reference: Snuff use Regular Smoking  Reference: Snuff use Regular Smoking  <b>Reference: Snuff use Regular Smoking</b>	<u>54 years</u> 3.11 (2.09-4.63)  <u>Among ages 55-64 years</u> 1.35 (0.87-2.10)  <u>All subjects</u> 1.87 (1.40-2.48) 0.98 (0.68-1.42) 1.77 (1.31-2.39) <u>Among ages 35-54 years</u> 3.22 (1.82-5.70) <u>Among ages 55-64 years</u> 1.09 (0.55-2.16) <u>All subjects</u> <b>2.09 (1.39-3.15)</b>
Huhtasaari et al. 1999	Case-control study	MONICA project	1991-1993	ICD:410-414 (MI)	Incidence and Mortality	Stratification	Men only. Matched on age Adjusted for hypertension, diabetes, high cholesterol, family history of early cardiac death, low education level, and marital status	Reference: Never used tobacco Current snuff user, no current smoking* Former snuff user , never smoked Current snuff user and smoker ( <b>Dual Users</b> ) Former snuff user and former smoker ( <b>Former Dual Users</b> )	<u>Univariate:</u> 0.96 (0.65-1.41) 1.23 (0.54-2.82) 2.66 (1.24-5.71) 0.99 (0.62-1.59)  <u>Multivariate: Fatal and nonfatal acute MI</u>  Reference: Never used tobacco Regular use of snuff	Reference: Never used tobacco Current smoker, no current snuff use* Former smoker, never used snuff      Reference: Never used tobacco Regular smoking	<u>Univariate</u> 3.65 (2.67-4.99) 1.05 (0.77-1.43)      <u>Multivariate: Fatal and nonfatal acute MI</u> 3.53 (2.48-5.03)

									<u>Fatal acute MI only</u>				<u>Fatal acute MI only</u>		
									Regular use of snuff	1.50 (0.45-5.03)	Regular smoking		8.57 (2.48-30.3)		
Janzon and Hedblad 2009	Cohort	Malmo Diet and Cancer Study	1991-2004	ICD9: 410-414 (MI)	Incidence	Multivariate Adjustment and Stratification  Only snus users controlled for smoking by stratification  Independent Smoking estimates were not available	Men Only. Age, BMI, smoking habits, diabetes mellitus, hypertension, physical activity, marital status and occupation	Reference: Nontobacco users Current Snuff user, never-smoker Regular Smoker, current snuff user <b>(Dual user)</b>	<u>MI</u>  0.75 (0.3-1.8)  1.31 (0.8-2.0)						
Johansson et al. 2005	Cohort	SALLS Survey	1988-1989, 2000	ICD9: 410-414; ICD10: I20-I25 (CHD event)	Incidence	Stratification  Tobacco use categories were exclusive (but smoking category may include former snuff users).	Men only. Age, BMI, physical activity, diabetes, and hypertension. Risk estimates did not change much when socioeconomic status was considered.	Reference: Never-smoker  Daily snuffer  Daily snuffer/Former smoker <b>(Switchers)</b> Daily snuffer and Smoker <b>(Dual Users)</b>	  1.41 (0.61-3.28)  1.18 (0.67-2.06)  2.73 (1.35-5.53)	NG  NG	Reference: Never-smoker Daily smoker	May include former snuff users  2.30 (1.66-3.19)	NG  NG		
Roosaar et al. 2008	Cohort	Uppsala County, central Sweden	1973-1974, 2002	ICD8,9: 390-458; ICD10: I00-I99 (CVD death)	Mortality	Multivariate adjustment and Stratification	Men only. Age, calendar period (attained), area of residence, and alcohol consumption	Reference: Never snus user Ever daily snus   Reference: Never snus user Ever daily snus	<u>Smoking adjusted</u>  1.11 (0.98-1.25)   <u>Among never-smokers</u>  1.15 (0.97-1.37)	NG   NG	Reference: Never-smoker Ever daily smoking age <75 Ever daily smoking age 75+	<u>Snus adjusted</u>  1.63 (1.37-1.93)  1.23 (1.09-1.38)	NG  NG		
Wennberg	Nested	MONICA	1985-	ICD9: 410-414,	Incidence	Multivariate	Men only.		MI			MI			



	Former snuff user/Former Smoker <b>(Former Dual Users)</b>	0.50 (0.12–2.03)	3			
		<u>SCD with survival</u> <u>&lt;1 h</u>			<u>SCD with survival</u> <u>&lt;1 h</u>	
	Reference: Never used tobacco			Reference: Never used tobacco		
	Former snuff user/Never smoker	0.35 (0.03-4.56)	1	Former smoker/never used snuff	0.35 (0.07-1.78)	4
	Current snuff user/Never smoker	0.38 (0.08-1.89)	4	Current smoker/No current snuff use	4.54 (1.55-13.25)	21
	Current snuff user/Former smoker <b>(Switchers)</b>	2.67 (0.52–13.80)	5			
	Current snuff user/Current Smoker <b>(Dual Users)</b>	0.13 (0.01–2.10)	1			
	Former snuff user/Former Smoker <b>(Former Dual Users)</b>	-	0			



	U.S. Cohort	Population 1982 – 1988	1988		older		given		
								<u>Males 35-64</u>	
							Current smoker	2.80	NG
							Former smoker	1.64	NG
								<u>Males 65+</u>	
							Current smoker	1.51	NG
							Former smoker	1.21	NG
								<u>Females 35-64</u>	
							Current smoker	3.08	NG
							Former smoker	1.32	NG
								<u>Females 65+</u>	
							Current smoker	1.60	NG
							Former smoker	1.20	NG
Teo et al. 2006	Case- control	52 countries		Nominal: non-fatal acute MI	Incidence			<u>Current Smokers</u>	
							Overall	2.95 (2.77-3.14)	NG
							1-9 cigs/day	1.63 (1.45-1.82)	NG
							<u>10-19 cigs/day</u>	2.59 (2.35-2.85)	NG
							>20 cigs/day	4.59 (4.21-5.00)	NG
USDHHS 1989	Large U.S. Cohort	CPS II Population 1982 – 1986		CHD death (ICD-9 410-414)	Mortality	35 years and older	Reference: Not given		
								<u>Males &gt; 35</u>	
							Current smoker	1.94 (1.80-2.08)	NG
							Former smoker	1.41 (1.33-1.50)	NG
								<u>Males 35-64</u>	
							Current smoker	2.81 (2.49-3.18)	NG
							Former smoker	1.75 (1.55-1.99)	NG
								<u>Males 65+</u>	
							Current smoker	1.62 (1.48-1.77)	NG
							Former smoker	1.29 (1.20-1.38)	NG
								<u>Females &gt; 35</u>	
							Current smoker	1.78 (1.62-1.97)	NG
							Former smoker	1.31 (1.19-1.44)	NG
								<u>Females 35-64</u>	
							Current smoker	3.00 (2.50-3.59)	NG
							Former smoker	1.43 (1.15-1.77)	NG
								<u>Females 65+</u>	
							Current smoker	1.60 (1.42-1.80)	NG
							Former smoker	1.29 (1.16-1.43)	NG
<b>Prior Meta-Analyses of Swedish Snus</b>									
Boffetta and Straif 2009	Meta- analysi s		MI: Any and fatal MI	Incidence and Mortality	-	-	Reference: Not given		
							Sweden	<u>Any MI</u> 0.87 (0.75-1.02)	
							Sweden	<u>Fatal MI</u> 1.27 (1.07-1.52)	
Lee 2011	Meta- analysi s		IHD/MI	Incidence	-	-	Reference: Not given		
							Whole population	1.01 (0.91-1.12)	
							Never-smokers	0.99 (0.85-1.14)	
Lee 2007	Meta- analysi		IHD/AMI	Incidence			Reference: Not given		
							Fixed effect for	1.17 (1.01-1.35)	

s					current use (never-smokers) Random effect for current use (never-smokers)	1.06 (0.83-1.37)	
					Dual user compared to smoker never snus user with studies from US and Sweden	1.01 (0.87-1.18)	
Hansson et al. 2012	Pooled analyses	Acute myocardial infarction	Incidence and Mortality		Reference: Not given Any MI Fatal MI (28 days)	1.04 (0.93-1.17) 1.28 (0.99-1.68)	
Vidyasagar et al. 2016	Meta-analyses	IHD	Incidence and Mortality		Incidence in ever smokeless tobacco Incidence in ever smokeless tobacco	0.91 (0.83, 1.01) 1.38 (1.13, 1.67)	
Lee 2013; 2014	Meta-analyses	CVD, IHD/MI	Incident cardiovascular disease	Lee (2014) estimates from Hansson et al. (2009) for overall cardiovascular disease	Reference: Exclusive current smokers	Reference: Neither current snus or current smoker Exclusive current snus: 0.93 (0.74-1.17)	Interaction term for current dual users: 0.87 (0.47-1.60)
					Reference: Exclusive ever smokers	Reference: Neither ever snus or ever smoker Exclusive ever snus: 1.07 (0.79-1.45)	Interaction term for ever dual users: 0.85 (0.59-1.22)
					Ever dual users: 0.91 (0.75-1.11)		
			Incident IHD/MI	Lee (2014) estimates from Haglund et al. (2007)	Reference: Exclusive current smokers	Reference: Neither current snus or current smoker Exclusive current snus: 0.77 (0.51-1.15)	Interaction term for current dual users: 1.22 (0.63-2.37)
					Current dual users 0.94 (0.56-1.59)		
					Reference: Exclusive current smokers	Reference: Neither current snus or current smoker Exclusive current snus: 0.90 (0.67-1.21)	Interaction term for current dual users: 0.83 (0.38-1.82)
					Current dual users 0.75 (0.36-1.55)		
				Lee (2014) estimates from Hansson et al. (2009)	Reference: Exclusive ever smokers	Reference: Neither ever snus or ever smoker Exclusive ever snus: 0.92 (0.61-1.39)	Interaction term for ever dual users: 1.03 (0.64-1.67)
					Ever dual users: 0.95 (0.74-1.22)		
				Lee (2013; 2014) estimates from	Reference: Exclusive current smokers	Reference: Neither current snus or	Interaction term for current dual users:

Hergens et al. (2005)	Current dual users 0.80 (0.55-1.16)	current smoker Exclusive current snus: 1.21 (0.89- 1.63)	0.66 (0.41-1.07)
	Reference: Exclusive ever smokers	Reference: Neither ever snus or ever smoker	Interaction term for ever dual users: 1.14 (0.62-2.13)
	Ever dual users: 0.99 (0.80-1.22)	Exclusive ever snus: 0.87 (0.48- 1.55)	
Lee (2014) estimates from Huhtasaari et al. (1992)	Reference: Never snus and never smoker Switcher: 1.60 (1.10- 2.20)	Reference: Never snus and never smoker Exclusive current smokers: 2.8 (2.3- 3.4)	Switchers vs continuers: 0.57 (0.40-0.81)
	Reference: Exclusive current smokers	Reference: Neither current snus or current smoker	Interaction term for current dual users:
	Current dual users 0.68 (0.40-1.17)	Exclusive current snus: 0.79 (0.54- 1.13)	0.87 (0.45-1.67)
Lee (2014) estimates from Huhtasaari et al. (1999)	Reference: Exclusive current smokers	Reference: Neither current snus or current smoker	Interaction term for current dual users:
	Current dual users 0.73 (0.34-1.57)	Exclusive current snus: 0.96 (0.65- 1.41)	0.76 (0.32-1.80)
	Reference: Exclusive current smokers	Reference: Neither current snus or current smoker	Interaction term for current dual users:
Lee (2013; 2014) estimates from Johansson et al. (2005)	Current dual users 1.19 (0.60-2.37)	Exclusive current snus: 0.99 (0.63- 1.56)	1.20 (0.52-2.73)
	Reference: Never snus and never smoker Switcher: 1.18 (0.67- 2.06)	Reference: Never snus and never smoker Exclusive current smokers: 2.3 (1.66- 3.19)	Switchers vs continuers: 0.51 (0.30-0.88)
	Reference: Exclusive current smokers	Reference: Neither current snus or current smoker	Interaction term for current dual users:
Lee (2013; 2014) estimates from Wennberg et al. (2007)	Current dual users 0.82 (0.48-1.40)	Exclusive current snus: 1.00 (0.71- 1.43)	0.82 (0.43-1.55)

		Reference: Never snus and never smoker Switcher: 1.25 (0.80- 1.96)	Reference: Never snus and never smoker Exclusive current smokers: 2.60 (1.91-3.54)	Switchers vs continuers: 0.48 (0.30-0.76)
Fatal IHD/MI	Lee (2014) estimates from Haglund et al. (2007)			Interaction term for current dual users: 0.74 (0.19-2.97)
	Lee (2013; 2014) estimates from Hergens et al. (2005)	Reference: Never snus and never smoker Switcher: 1.50 (0.69- 3.20)	Reference: Never snus and never smoker Exclusive current smokers: 3.60 (2.40-5.20)	Interaction term for current dual users:  0.89 (0.36-2.18)
				Interaction term for ever dual users: 0.50 (0.16-1.58) Switchers vs continuers: 0.57 (0.40-0.81)
	Lee (2013; 2014) estimates from Wennberg et al. (2007)	Reference: Never snus and never smoker Switcher: 1.24 (0.44- 3.53)	Reference: Never snus and never smoker Exclusive current smokers: 3.53 (1.83-6.84)	Interaction term for current dual users:  0.25 (0.06-1.03)  Switchers vs continuers: 0.35 (0.12-1.02)

## Stroke

Summary of Findings Table: Stroke (ICD8, 9: 430-438; ICD10: I60-I69)

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Asplund et al. 2003	Nested case-control	Vasterbotten Intervention Project and MONICA	1985-2000	Nominal	Incidence	Stratification*  *Exclusive and adjusted snuff exam, and user/smoker groups may have included former users.	Matching on age, sex, geographic area, year of baseline exam, and cohort. Risk estimates from conditional logistic regression adjusted for elevated blood pressure, low level of education, not married or cohabitant, diabetes, and serum cholesterol.	Reference: Never users of tobacco All snuff users  Exclusive snuff users  Exclusive regular snuff users	<u>Univariate Analysis</u>  1.16 (0.60-2.22) 1.05 (0.37-2.94) <u>Conditional Logistic Regression</u> 0.87 (0.41-1.83)	30  NG  NG	Reference: Never users of tobacco All smokers  Regular cigarette smokers  Regular cigarette smokers	<u>Univariate Analysis</u>  1.86 (1.13-3.05) 2.21 (1.29-3.79) <u>Conditional Logistic Regression</u> 1.74 (0.85-3.54)	67  NG  NG
Bolinder et al. 1994	Cohort	Swedish Construction Workers cohort	1971 – 1974, 1985	ICD8: 430-438	Mortality	Stratification	Men only. Age, however, high blood pressure, diabetes, BMI, region, blood pressure meds, and previous cardiac symptoms were considered and not found to	Reference: Never-users of tobacco Exclusive current snuff users  -  Reference: Never-users of tobacco Exclusive current snuff users	<u>Stroke Mortality Ages 35-54</u>  1.9 (0.6-5.7)  <u>Stroke Mortality Ages 55-65</u>  1.2 (0.7-1.8)	4    26	Reference: Never-users of tobacco <15 cig/day exclusively >15 cig/day exclusively Exclusive ex-smokers, 1-5 years  Exclusive ex-smokers, >5 years  Reference: Never-users of tobacco <15 cig/day exclusively >15 cig/day exclusively	<u>Stroke Mortality Ages 35-54</u>  2.7 (1.4-5.4) 3.0 (1.5-5.7) 1.2 (0.4-3.7)  0.7 (0.2-1.9)  <u>Stroke Mortality Ages 55-65</u>  0.7 (0.4-1.2) 1.6 (1.0-2.5)	17 19 4  5  19 25

significantly alter RR.													
Haglund et al. 2007	Cohort	Swedish Survey of Living Conditions	1988 – 1989, 2003	ICD9: 430-438; ICD10: I60-I69	Incidence and Mortality	Stratification  Tobacco use categories were exclusive (but may include former smokers/snuff users).	Age, socioeconomic status, residential area, self-reported health, number of longstanding illnesses, and physical activity	Reference: No tobacco Daily Exclusive Snuff	1.07 (0.65-1.77)	19	Reference: No tobacco Daily Exclusive Smoke	1.40 (1.03-1.91)	66
							Daily Exclusive Smoke & Snuff (Dual User)	1.98 (1.00-3.95)	9				
							Stroke Incidence						
							Stroke Mortality						
							Reference: No tobacco Daily Exclusive Snuff	1.01 (0.35-2.92)	4	Reference: No tobacco Daily Exclusive Smoke	1.02 (0.50-2.05)	12	
							Daily Exclusive Smoke & Snuff (Dual User)	4.30 (1.22-15.1)	3				
Janzon and Hedblad 2009	Cohort	Malmo Diet and Cancer	1991 – 1996, 2004	ICD9: 430, 431, 434, 436	Incidence	Multivariate Adjustment and Stratification  Only snus users controlled for smoking by stratification  Independent Smoking estimates were not available	Adjusted for age, BMI, diabetes, hypertension, physical activity, marital status, and occupation.	Reference: Nontobacco users Current Snuff user, never-smoker Regular Smoker, current snuff user (Dual user)	0.59 (0.2-1.5)	4		-	
								1.13 (0.6-2.0)	13				
Koskinen and Blomstedt 2006	Case-control	Umea University Hospital	1997-1998	Nominal: Cardiovascular - subarachnoid hemorrhage	Incidence	Unclear, appears to be no control for tobacco use	Direct age standardization	Reference: Non-consumers Current Snuff use	0.48 (0.17-1.30)	NG	Reference: Non-consumers Current smoker	2.63 (1.20-5.72)	NG
								Reference: Non-consumers Current Snuff use	1.30 (0.33-5.18)	NG	Reference: Non-consumers Current smoker	2.26 (1.69-3.01)	NG
Hansson et al. 2009	Cohort	Swedish Twin Registry	1928 – 1958 & followed through 2003 for mortality and 2005	ICD10: I60-I61, I63-I64, G45; ICD9: 430-431, 433-436	Incidence	Stratification	Age, sex, diabetes, high blood pressure, and high cholesterol.	Reference: Never smoking and never snus Exclusive Former Snus	1.35 (0.65-2.82)	8	Reference: Never smoking and never snus Exclusive Former Smoker	1.01 (0.78-1.30)	115
							Exclusive Current Snus	1.18 (0.67-2.08)	14	Exclusive Current Smoker	1.61 (1.22-2.13)	81	

394

					Ever Regular	1.27 (0.92-1.76)		
					Former Regular	0.3 (0.04-2.11)		
					Current Regular	1.38 (0.99-1.91)		
					< 12.5 g/day	1.42 (0.86-2.32)	17	
					12.5-24.9 g/day	1.57 (0.99-2.49)	20	
					25-49.9 g/day	1.24 (0.51-3.03)	5	
					≥ 50 g/day	1.16 (0.29-4.69)	2	

U.S Cohorts with Cigarette or Smoker Relative Risks								
Friedman et al. 1997	Large U.S. Cohort	Kaiser Population	1979-1986, 1987	-	Mortality	Age-adjusted	Reference: Never-smokers	
							Current male smokers	0.8 (0.4-1.7)
							Current female smokers	1.3 (0.8-2.2)
							Reference: Not given	
								<u>Males 35-64</u>
							Current smoker	1.59 (0.81-3.11)
							Former smoker	1.07 (0.50-2.26)
								<u>Males 65+</u>
							Current smoker	1.08 (0.71-1.64)
							Former smoker	1.00 (0.75-1.33)
								<u>Females 35-64</u>
							Current smoker	3.39 (1.81-6.33)
							Former smoker	2.07 (0.85-5.07)
								<u>Females 65+</u>
							Current smoker	2.11 (1.59-2.81)
							Former smoker	1.09 (0.85-1.41)
							Reference: Not given	
								<u>Males 35-64</u>
							Current smoker	3.27
							Former smoker	1.04
								<u>Males 65+</u>
							Current smoker	1.63
							Former smoker	1.04
								<u>Females 35-64</u>
							Current smoker	4
							Former smoker	1.3
								<u>Females 65+</u>
							Current smoker	1.49
							Former smoker	1.03
								NG





						Sweden	1.02 (0.93-1.13)	
							<u>Fatal stroke</u>	
						Sweden	1.25 (0.91-1.70)	
Lee 2011	Meta-analysis	Stroke	Incidence	-	-	Reference: Not given		
						Whole population	1.05 (0.95-1.15)	
						Never-smokers	1.06 (0.96-1.17)	
Lee 2007	Meta-analysis					Reference: Not given		
						Current use (never-smokers)	1.17 (0.80-1.70)	
Vidyasagaran et al. 2016	Meta-analysis	Stroke	Incidence and Mortality			Incidence ever ST	1.01 (0.90-1.13)	
						Mortality in ever ST	1.28 (0.98, 1.68)	
Lee (2013;2014)	Meta-analysis		Incident stroke and mortality		Lee (2013) reported risk estimates from Hansson et al. (2009)	Reference: Never snus and never smoker	Reference: Never snus and never smoker	Switchers vs continuers:
					Lee (2014) reported risk estimates from Hansson et al. (2009)	Switcher: 0.77 (0.46-1.29)	Current exclusive smoker: 1.61 (1.22-2.13)	0.48 (0.28-0.82)
						Reference: Exclusive smokers	Reference: Never snus and never smoker	Interaction term for current dual users:
						Current dual users: 0.90 (0.36-2.27)	Current exclusive snus user: 0.89 (0.61-1.31)	1.01 (0.37-2.73)
						Ever dual users: 0.83 (0.59-1.16)	Ever exclusive snus user: 1.24 (0.78-1.97)	Interaction term for ever dual users:
					Lee (2014) reported risk estimates from Haglund et al. (2007)	<i>Incidence</i> Reference: Exclusive smokers	<i>Incidence</i> Reference: No tobacco	0.67 (0.38-1.19)
						Current dual users: 1.41 (0.71-2.83)	Current snus user: 1.07 (0.65-1.77)	<i>Incidence</i> interaction term for current dual users: 1.32 (0.56-3.11)

*Mortality*  
Interaction term for current dual  
users  
4.17 (0.78-22.36)

## Diabetes

Summary of Findings Table: Diabetes (ICD9: 250, ICD10: E11, E14)

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Eliasson et al. 2004	Cross-sectional and follow-up study	Northern Sweden MONICA participants	Study entry in 1986, 1990, 1994, and 1999 with follow-up of 5 to 13 years	Nominal: known type 2 diabetes using "Self report with Oral Glucose Tolerance test in a subset"	Prevalence and Incidence	Stratification	Men only. Prevalence adjusted for age and waist circumference. Incidence adjusted for age, follow-up and annual % weight gain between baseline and follow-up. Adjusted for physical activity, however no change in direction or significance of results.	Reference: Never user of tobacco Ever exclusive snus use  Current exclusive snus user Ex-snus user  Reference: Consistent no tobacco Consistent exclusive snus Ex-snus users	<u>Prevalence</u>  1.21 (0.59-2.49)  1.06 (0.43-2.64)  1.45 (0.54-3.87) <u>Incidence</u>  0 cases 1.72 (0.20-14.8)	NG NG NG NG  0 NG	Reference: Never user of tobacco Ever exclusive smoking Current exclusive smoker Ex-smoker  Reference: Consistent no tobacco Consistent exclus. smoker Ex-smoker Smokers switched to snus ( <b>Switchers</b> )	<u>Prevalence</u>   1.77 (1.10-2.87) 1.62 (0.86-3.05) 1.87 (1.10-3.20) <u>Incidence</u>  4.61 (1.37-15.5) 3.13 (1.13-8.67) 3.25 (0.78-13.6)	NG NG NG NG  NG NG NG
Ostenon et al. 2012	Cohort, but reports OR	Stockholm Diabetes Prevention Programme in four municipalities within Stockholm County	1992-1994 with 10 year follow-up	Nominal: Type 2 diabetes (oral glucose tolerance test)	Incidence	Multivariate adjustment or stratification	Men Only. Only 35-56 years old Tobacco use, age, BMI, glucose tolerance at baseline, physical activity, alcohol consumption, socioeconomic position, and family history of diabetes.	Reference: Never-snus user Former snus use Consistent snus use  1-5 boxes/week >5 boxes/week  Consistent current snus	<u>Overall</u>  0.5 (0.2-1.2) 1.1 (0.6-2.0)  <u>Dose</u> 0.6 (0.2-1.4) 3.3 (1.4-8.1)  <u>Never smokers</u> 2.3 (0.5-9.8)	6 16  7 9  3	Reference: Never-smoker Former smoking Consistent smoking  1-15 cigarettes/day >15 cigarettes/day  Consistent smoking	<u>Overall</u>  0.9 (0.5-1.7) 1.5 (0.8-3.0)  <u>Dose</u> 0.8 (0.3-2.1) 2.4 (1.0-5.8)  <u>Never-snus</u>  Not given	30 17  7 10
Persson et al. 2000	Cross-sectional study	Stockholm Diabetes Prevention Programme	1992 – 1994	Nominal: Type 2 diabetes (oral glucose tolerance test)	Prevalence	Multivariate adjustment or stratification	Men only. Only 35-56 years old Age, BMI,	Reference: Never-snus user	<u>Overall</u>		Reference: Never-cigarette user	<u>Overall</u>	

in four municipalities within Stockholm County	n	family history of diabetes, physical activity, and alcohol consumption. Exclusive categories may include former smokers/snus users. Overall and dose estimates are unadjusted for tobacco use.	Former	0.8 (0.3-2.0)	5	Former	1.3 (0.7-2.7)	21
			Current	1.5 (0.8-3.0)	13	Current	1.3 (0.6-2.7)	17
			<u>Dose</u>			<u>Dose</u>		
			≤2 boxes/week	0.2 (0.0-2.0)	1	1-24 cigs/day	1.1 (0.5-2.1)	25
			3+ boxes/week	2.7 (1.3-5.5)	12	25+ cigs/day	2.6 (1.1-5.8)	13
			<u>Never cigarettes</u>			<u>Never snuff</u>		
			Current Moist snuff only	3.9 (1.1-14.3)	4	Current Cigarettes only	1.8 (0.7-4.5)	15

Wandell et al. 2008	Cross-sectional study	Men living in Stockholm county, Sweden 1997-1999	1997-1999	Nominal: Type 2 diabetes. fasting morning serum (fs) glucose levels ≥7.0 mmol/l in subjects with no known diagnosis of diabetes	Prevalence	Multivariate adjustment with interaction terms	Men Only. Only 60 years old. BMI, waist circumference, employment, educational level, living in an apartment, physical activity, alcohol intake	Reference: Never smoke or snuff			Reference: Never smoke or snuff			
								Ex-snuffers	3.10 (0.36-26.84)	NG	Ex-smokers	1.41 (0.76-2.60)	NG	
								Current snuffers	2.12 (0.25-17.71)	NG	Current smokers	1.40 (0.68-2.89)	NG	
								Current snuff/ex-smoker ( <b>Switcher</b> )	1.71 (0.67-4.35)					
								Current snuffer and smoker ( <b>Dual Users</b> )	2.48 (0.52-11.82)		-			
								<u>Consumption</u>			<u>Duration</u>			
								<3 cans/week	1.30 (0.49-3.40)	NG	< 20 years	1.30 (0.64-2.66)	NG	
								≥3 cans/w	1.80 (0.67-4.85)	NG	≥ 20 years	1.46 (0.79-2.68)	NG	
Hilding et al. 2005 (abstract)	Cohort, but reports OR	Stockholm Diabetes Prevention Programme in four municipalities within Stockholm County	1992-1994, follow for 10 years	Nominal: Type 2 Diabetes	Incidence	Unclear if controlled for tobacco use	Men Only. 35-56 years old only. Age, BMI, physical activity, and family history of diabetes	Reference: Never-snus user	<u>Overall</u>	1.0 (reference)	NG	Reference: Never-cigarette user	<u>Overall</u>	NG
								Current	1.2 (0.7-2.1)	NG	Current	2.0 (1.1-4.0)	NG	
								≥ 4 boxes/week	<u>Dose</u>	1.7 (0.8-3.4)	NG	> 10 cigarettes/day	<u>Dose</u>	NG
								≥ 5 boxes/week	2.3 (1.1-4.9)	NG		2.4 (1.1-5.0)		
								≥ 6 boxes/week	3.6 (1.6-8.1)	NG				
Janzon and Hedblad 2009	Cohort	Malmo Diet and Cancer Study	1991-1996	Nominal: Diabetes Mellitus	Prevalence	-	-	Relative risk of diabetes not determined in study, although there was no statistically significant difference in prevalence between snus users compared to snus non-users among each men and women						
Rasouli et al. 2017	Matched Case-control	ESTRID	2010-2015	Nominal: Type 2 Diabetes	Incidence	Multivariate adjustment or stratification	Men Only. Age, smoking, BMI, and FHD matched for participation date and residence.		<u>Overall</u>					
								Reference: Never Snus		515				
								Former	0.63 (0.41-0.95)	80				
								Current	0.96 (0.67-1.37)	129				
								Boxes per week (ever snus users)						
								Reference: Never Snus		515				
								Light snus users (< 5)	0.78 (0.56-1.09)	143				
								Heavy snus users (≥ 5)	0.95 (0.57-1.58)	62				
	Box-years in ever snus users													

Rasouli et al. 2017	Cross-sectional	HUNT	1984-2008	Nominal: Type 2 Diabetes with diagnosis at ≥ 35 years and were GAD antibody negative (< 0.08 antibody index; n = 829).	Prevalence	Multivariate adjustment or stratification	Men Only. Age, smoking, BMI, and FHD	Reference: Never Snus	390	
								< 10	0.74 (0.52-1.06)	92
								≥ 10	1.05 (0.67-1.63)	68
								<u>Never Smokers</u>		
								Reference: Never Snus	205	
								Former	0.53 (0.20-1.39)	11
								Current	1.17 (0.58-2.37)	27
								Boxes per week (ever snus users)		
								Reference: Never Snus	205	
								Light snus users (< 5)	0.83 (0.41-1.71)	22
								Heavy snus users (≥ 5)	1.01 (0.42-2.41)	16
								Box-years in ever snus users		
								Reference: Never Snus	205	
								< 10	0.74 (0.31-1.77)	13
								≥ 10	1.00 (0.47-2.11)	22
								<u>Ever Smokers</u>		
								Reference: Never Snus	310	
								Former	0.63 (0.39-1.37)	58
								Current ( <b>Dual Users</b> )	0.91 (0.39-1.01)	92
								Boxes per week (ever snus users)		
								Reference: Never Snus	310	
								Light snus users (< 5)	0.78 (0.53-1.14)	121
								Heavy snus users (≥ 5)	0.92 (0.49-1.72)	46
								Box-years in ever snus users		
								Reference: Never Snus	310	
								< 10	0.77 (0.52-1.15)	105
								≥ 10	1.00 (0.57-1.74)	60
								<u>Overall</u>		
								Reference: Never Snus	672	
								Ever snus use	0.91 (0.75-1.10)	157
Boxes per week (ever snus users)										
Reference: Never Snus	669									
Light snus users (< 3)	0.88 (0.72-1.08)	130								
Heavy snus users (≥ 3)	0.92 (0.46-1.83)	438								
<u>Never Smokers</u>										
Reference: Never Snus	184									
Ever snus use	1.12 (0.72-1.72)	27								
Boxes per week (ever snus users)										
Reference: Never Snus	181									
Light snus users (< 3)	1.15 (0.72-1.82)	23								
Heavy snus users (≥ 3)	0.89 (0.21-3.78)	2								
<u>Ever Smokers</u>										
Reference: Never Snus	488									
Ever snus use ( <b>Dual</b> )	0.86 (0.70-1.07)	130								

								Users)		
								Boxes per week (ever snus users)		
								Reference: Never Snus		488
								Light snus users (< 3)		107
								Heavy snus users (≥ 3)		7
Byhamre et al. 2017	Cohort	Northern Swedish Cohort: Lulea Municipality, Sweden	1981-2008	Nominal: Type 2 Diabetes and Type 1 Diabetes by Self-report	Incidence	Stratification	Sex, cumulative smoking, BMI at 16 years, socioeconomic status at 16 years, family history of diabetes mellitus, alcohol consumption at 43 years and physical activity level at 43 years.	Reference: Never-User of Tobacco		
								Current Exclusive Snus Use		
								At age 16	1.08 (0.59-1.97)	81
								At age 21	1.28 (0.63-2.62)	53
								At age 30	1.01 (0.48-2.11)	57
At age 43	0.38 (0.12-1.16)	37								
Carlsson et al. 2017	Pooled cohort	Five Cohorts: Vasterbotten Intervention Programme (VIP), the Stockholm Public Health Cohort, the Malmo Diet and Cancer Study; the National March Cohort; and the Screening Across the Lifespan Twin study (SALT)	1991-2013	ICD10: E11, E14	Incidence	Stratification	Men Only. Age, calendar year, body mass index, physical activity, education and alcohol consumption.	<u>Never smokers</u>		
								Reference: Never snus		-
								Current	1.15 (1-1.32)	
								Former	0.86 (0.71-1.05)	
								<u>Intensity of Use</u>		
								1-2 Boxes/week	1.14 (0.86-1.5)	
								3-4 Boxes/week	1.03 (0.82-1.29)	
								5-6 Boxes/week	1.42 (1.07-1.87)	
								>=7 Boxes/week	1.68 (1.17-2.41)	
								1-4 Boxes/week	1.08 (0.9-1.29)	
								>=4 Boxes/week	1.43 (1.15-1.79)	
								<u>Duration of Use</u>		
								< 30 years	1.34 (1.03-1.73)	
>= 30 years	1.17 (0.98-1.39)									
U.S Cohorts with Cigarette or Smoker Relative Risks										
Friedman et al. 1997	Large U.S. Cohort	Kaiser Population	1979-1986, 1987	-	Mortality	Age-adjusted		Reference: Never Smokers		
								Current smokers	Males: 0.3 (0.0-2.7)	1
								Current smokers	Females: 0.7 (0.2-2.6)	3
Willi et al. 2007	Large U.S. Cohort	Smoking Meta-Analyses					Overall (active smokers)		1.44 (1.31-1.58)	
			Former smokers		1.23 (1.14-1.33)					
			Heavy smokers (≥20 cigs/day)		1.61 (1.43-1.80)					

				Light smokers (<20 cigs/day)	1.29 (1.13-1.48)
Prior Meta-Analyses of Swedish Snus					
Lee (2014)	Meta-analysis		Wikstrom et al (2010c)	Reference: Current Smoker Current Dual user: 0.88 (0.42-0.84)	Reference: No tobacco Current Snuff: 0.93 (0.76-1.14)
				Interaction term for ever dual users: 0.95 (0.44-2.04)	



## Metabolic Syndrome

Summary of Findings Table: Metabolic Syndrome

Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases
Wandell et al. 2008	Cross-sectional study	Men living in Stockholm county, Sweden 1997-1999	1997-1999	Nominal: Defined by the criteria from the National Cholesterol Education Program Adult Treatment Panel III (ATP III), revised in 2005, from the European Group for the Study of Insulin Resistance (EGIR), and from the International Diabetes Federation (IDF).	Prevalence	Multivariate adjustment with interaction terms	Men Only. Only 60 years old. BMI, waist circumference, employment, educational level, living in an apartment, physical activity, alcohol intake	Reference: Never smoke or snuff			Reference: Never smoke or snuff		
								<u>Ex-snuffers</u>			<u>Ex-smokers</u>		
								ATP III	0.69 (0.14-3.28)	2	ATP III	1.49 (1.15-1.92)	233
								EGIR	0.97 (0.20-4.67)	2	EGIR	1.55 (1.17-2.06)	183
								IDF	0.48 (0.10-2.26)	2	IDF	1.44 (1.14-1.83)	295
								<u>Current snuffers</u>			<u>Current smokers</u>		
								ATP III	1.55 (0.52-4.62)	5	ATP III	1.18 (0.86-1.62)	108
								EGIR	0.71 (0.16-3.24)	2	EGIR	0.95 (0.66-1.37)	72
								IDF	1.81 (0.65-5.02)	7	IDF	1.00 (0.74-1.35)	124
								<u>Ex-smokers, current snuffers (Switchers)</u>					
								ATP III	1.14 (0.71-1.82)	32			
								EGIR	1.29 (0.78-2.14)	26			
Byhamre et al. 2017	Cohort	Northern Swedish Cohort: Lulea Municipality, Sweden	1981-2008	Nominal: International Diabetes Federation Definition. Assessed in a sensitive period model for ages 16, 21, 30, and 43. As well as assessment in cumulative number of periods of snus use model.	Incidence	Stratification	In sensitive period model: sex, cumulative smoking, BMI at 16 years, socioeconomic status at 16 years, family history of diabetes mellitus, alcohol consumption at 43 years and physical activity level at 43 years.	Reference: Never-User of Tobacco					
								Current Exclusive Snus Use					
								At age 16	0.95 (0.54-1.65)	81			
								At age 21	1.15 (0.6-2.21)	53			
								At age 30	1.01 (0.52-1.99)	57			
								At age 43	1.15 (0.52-2.51)	37			
								<u>Cumulative Snus Use Model</u>					
								Reference: Never-User of Tobacco					
								Periods of Current Exclusive Snus Use					
								1 period	1.08 (0.59-1.96)	122			
								2 periods	1.11 (0.57-2.17)	97			

							In cumulative snus use model: Sex, smoking, BMI at 16, SES at 16, FHD, alcohol at 43, physical activity at 43	3 periods 4 periods	1.01 (0.5-2.06) 0.91 (0.4-2.05)	64 47
Gustafsson et al. 2011	Cohort	Northern Swedish Cohort: Lulea Municipality, Sweden	1981-2008	Nominal: International Diabetes Federation Definition	Incidence	Multivariate adjustment	Sex, SES, BMI, SBP, DBP, daily smoking, daily snuff use, alcohol consumption, and physical inactivity	Reference: No daily snuff use Daily Snuff Use	Women 0.79 (0.33-1.86) Men 0.96 (0.58-1.56)	Reference: No daily smoking Daily Smoking Women 1.44 (0.76-2.76) Men 1.74 (0.94-3.14)
Norberg et al. 2006	Cohort	Vasterbotten Intervention Programme	1990- 1994, 2004	Nominal: International Diabetes Federation Definition, modified as "We did not use the result of 2-h glucose testing in the case definition of MetSy according to IDF as this only added 9 women and 6 men with MetSy at follow- up."	Incidence	None	Age, sex, and family history of CVD and/or diabetes.	Reference: No current snus use <= 4 cans/week > 4 cans/week	1.0 (0.85-1.22) 1.6 (1.26-2.15)	Reference: No current daily smoking Daily smoking Former Smoking 1.0 (0.89-1.16) 1.2 (1.06-1.38)
U.S Cohorts with Cigarette or Smoker Relative Risks										
None										
Prior Meta-Analyses of Swedish Snus										
None										

## All-cause mortality

Summary of Findings Table: All-Cause Mortality (All ICD8, 9, and 10 codes)														
Reference	Study Design	Study Population	Study Period	Outcome Characterization	Measure	Methods for control of tobacco exposure	Control for Confounders	Snus Exposure Characterization	Snus Effect Measure	Number of Snus Exposed Cases	Smoking Exposure Characterization	Smoking Effect Measure	Number of Smoking Exposed Cases	
Bolinder et al. 1994	Cohort	Swedish Construction Workers	1971-1974, 1985	Nominal: "all cause" mortality	Mortality	Stratification	Men only Age and region of origin	Reference: Never-users of tobacco Present snuff users only	1.4 (1.3-1.8)	440	Reference: Never-users of tobacco Current cigarette only smokers			
												<15 cig/day	1.7 (1.6-1.9)	900
												>15 cig/day	2.2 (2.0-2.4)	923
												Ex-cigarette only smoker		
												1-5 years	1.3 (1.2-1.5)	350
												>5 years	1.1 (1.0-1.2)	776
									<u>Ages 35-54</u>		<u>Ages 35-54</u>			
								Reference: Never-users of tobacco Present snuff users only	1.9 (1.6-2.4)	105	Reference: Never-users of tobacco Current cigarette only smokers			
												<15 cig/day	2.0 (1.7-2.3)	317
												>15 cig/day	2.6 (2.3-3.0)	437
												Ex-cigarette only smoker		
												1-5 years	1.3 (1.1-1.6)	114
												>5 years	1.0 (0.9-1.2)	189
									<u>Ages 55-65</u>		<u>Ages 55-65</u>			
								Reference: Never-users of tobacco Present snuff users only	1.2 (1.0-1.3)	301	Reference: Never-users of tobacco Current cigarette only smokers			
												<15 cig/day	1.6 (1.5-1.8)	496
												>15 cig/day	2.0 (1.8-2.2)	377
												Ex-cigarette only smoker		
1-5 years	1.4 (1.2-1.6)	212												
>5 years	1.1 (1.0-1.2)	576												
Roosaar et al. 2008	Cohort	Uppsala County, central Sweden	1973-1974, 2002	ICD: All-cause mortality includes all ICD8, ICD9, and ICD10 codes.	Mortality	Multivariate adjustment and stratification	Men only Age, calendar period (attained), area of residence, alcohol consumption	Reference: Never snus user Ever daily snus	1.10 (1.01-1.21)	641	Reference: Never-smoker Ever daily smoking			
												age <75	1.63 (1.45-1.83)	NG
											age 75+	1.26 (1.15-1.38)	NG	
									<u>Among never-smokers</u>					
								Reference: Never snus user Ever daily snus	1.23 (1.09-1.40)	NG				
											<u>Among never-snus users</u>	Not given		
U.S Cohorts with Cigarette or Smoker Relative Risks														
Friedman	Large	Kaiser	1979-	-	Mortality		Age-adjusted				Reference: Never			

et al. 1997	U.S. Cohort	Population	1986, 1987				Smokers		
							Current male smokers	1.9 (1.7-2.2)	308
							Current female smokers	1.9 (1.7-2.2)	308
McLaughlin et al. 1995	Large U.S. Cohort	US veterans who held government life insurance policies active at the end of 1953	1953-1980	-	Mortality		Reference: NG		
							Current smoker	1.7 (1.67-1.72)	NG
							Former smoker	1.2 (1.18-1.22)	NG
USDHHS1989	Large U.S. Cohort	CPS II Population 1982 – 1986		-	Mortality	35 years and older	Reference: Never smoker		
							Current smoker	2.34 (2.26-2.43)	NG
							Former smoker	1.58 (1.53-1.64)	NG
								<u>Females</u>	
							Reference: Never smoker		
							Current smoker	1.90 (1.82-1.98)	NG
							Former smoker	1.32 (1.27-1.37)	NG
<b>Prior Meta-Analyses of Swedish Snus</b>									
Lee 2011	Meta-analysis	-	-		Mortality		<u>Never smokers</u>		
							1.30 (1.15-1.47)		

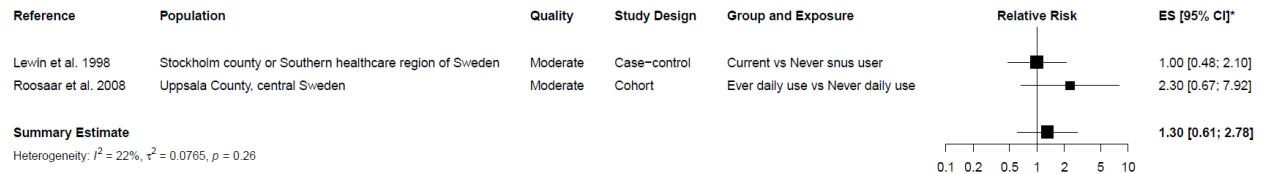
# Appendix H: Sensitivity Analyses

## Head and Neck Cancer

### Oral and Pharyngeal Cancer

*Exclusion of Boffetta et al. 2005 due to its exclusion of ICD7: 140 – Lip Cancer*

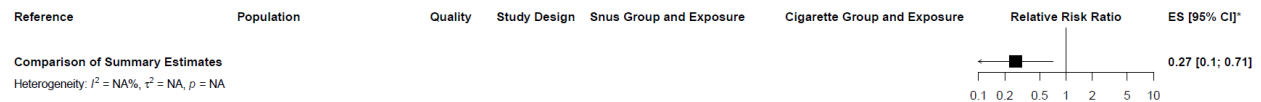
#### Oral-pharyngeal Cancer Incidence in Snus users



#### Oral-pharyngeal Cancer Incidence in Smokers



#### Oral-pharyngeal Cancer Incidence in Snus users compared to Smokers

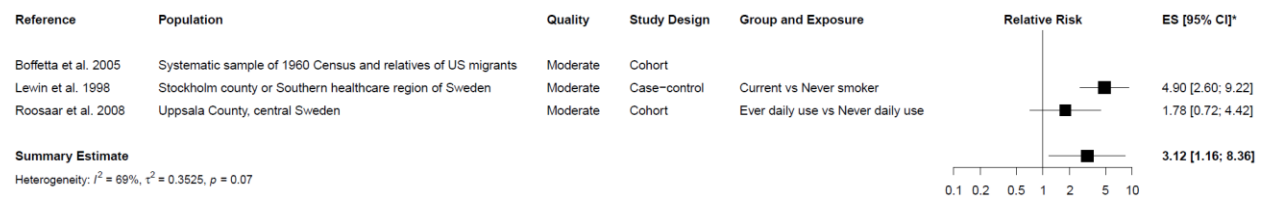


### *Preference for adjusted estimates when available*

#### Oral-pharyngeal Cancer Incidence in Snus users



#### Oral-pharyngeal Cancer Incidence in Smokers



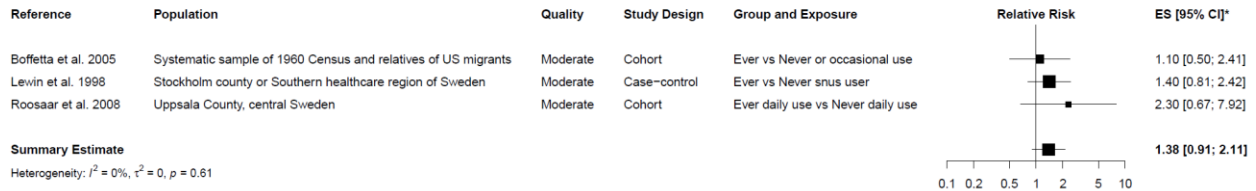
### Oral-pharyngeal Cancer Incidence in Snus users compared to Smokers



### Preference for ever use when available

There is no ever characterization of snus use in Lewin et al. (1998) and consequently no studies with an effect measure.

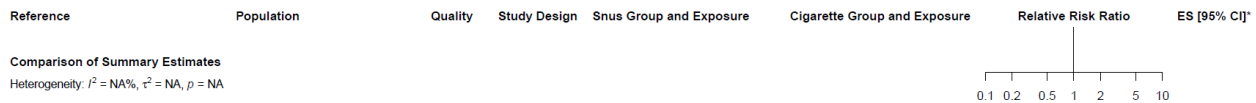
### Oral-pharyngeal Cancer Incidence in Snus users



### Oral-pharyngeal Cancer Incidence in Smokers



### Oral-pharyngeal Cancer Incidence in Snus users compared to Smokers



### Cohort studies only

No smoking exposure effect estimates reported keeping preference for stratified estimates.

### Oral-pharyngeal Cancer Incidence in Snus users



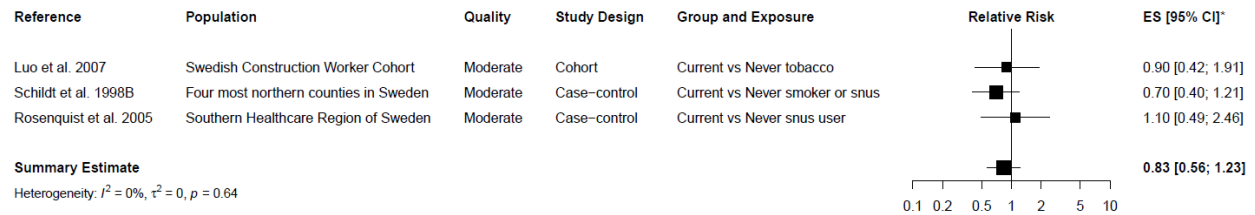
### Fixed effects

Same results as in main analyses

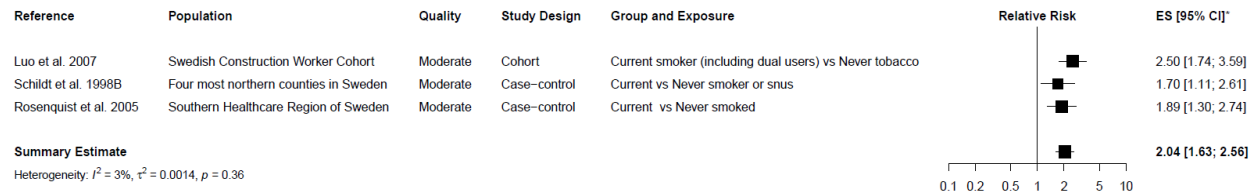
## Oral Cancer

*Exclusion of Lewin et al. (1998), due to outcome definition*

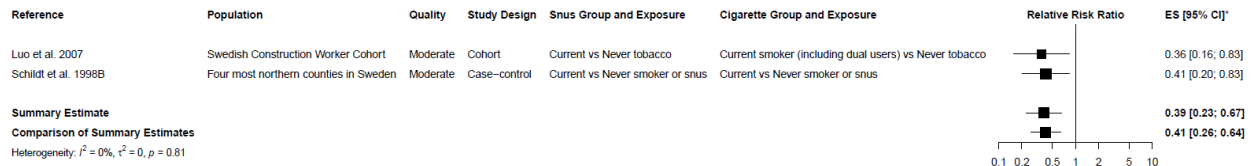
### Oral Cancer Incidence in Snus users



### Oral Cancer Incidence in Smokers

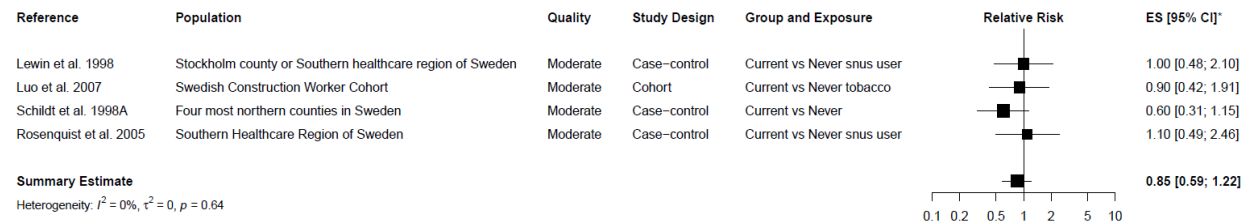


### Oral Cancer Incidence in Snus users compared to Smokers

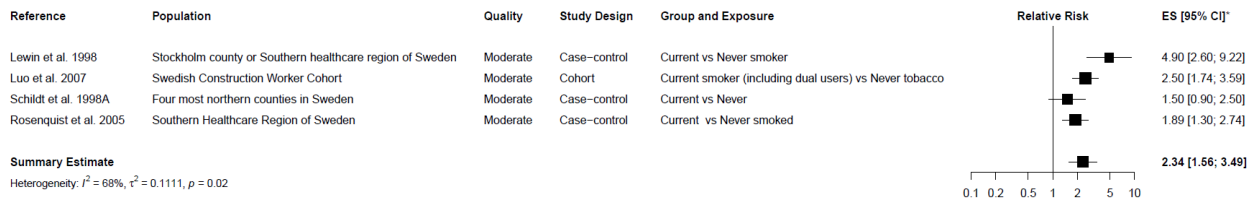


*Change Schildt et al. 1998b with Schildt et al. 1998a*

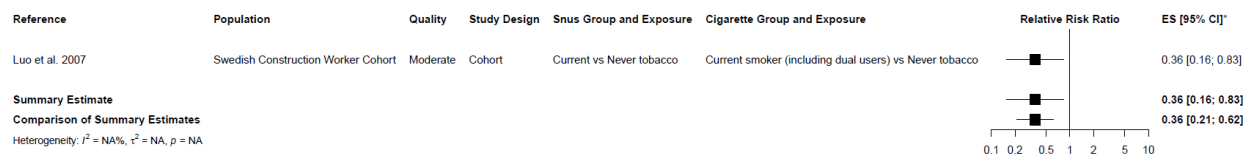
### Oral Cancer Incidence in Snus users



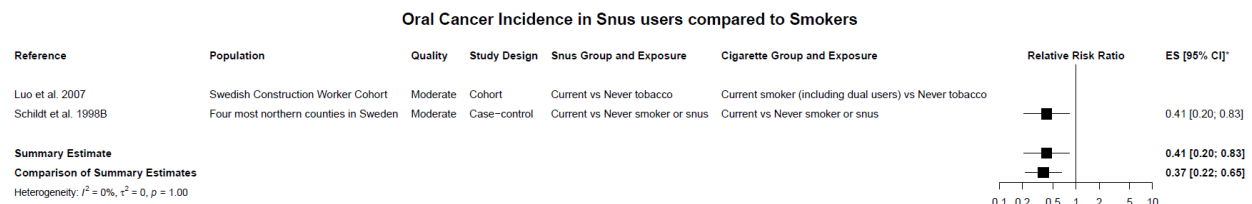
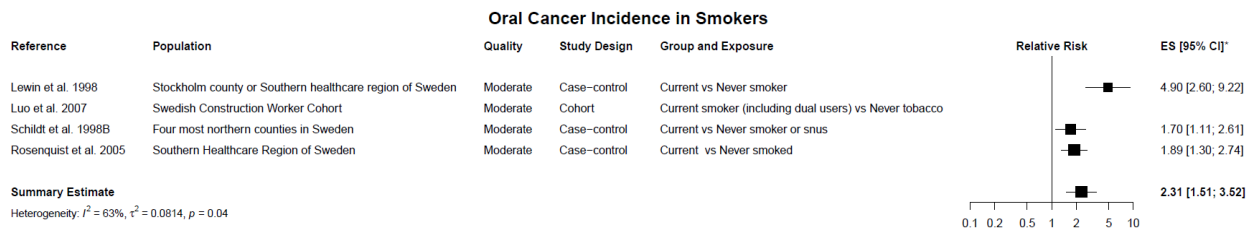
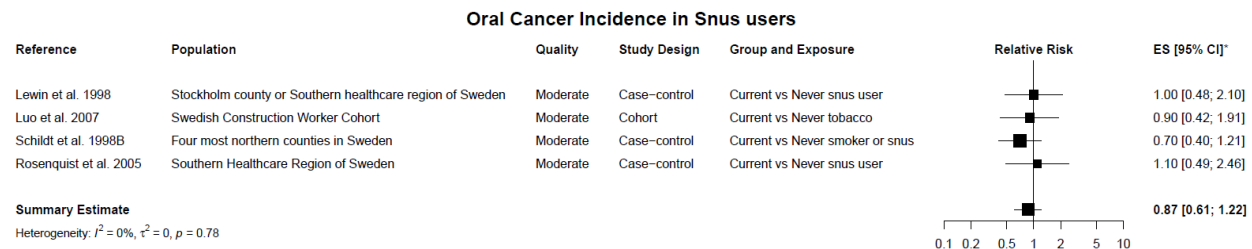
### Oral Cancer Incidence in Smokers



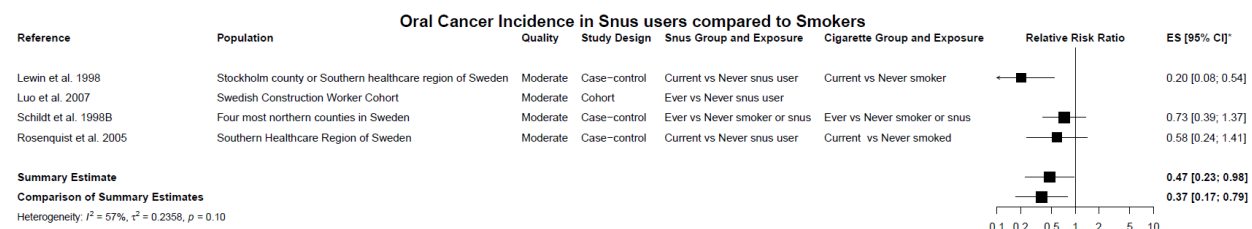
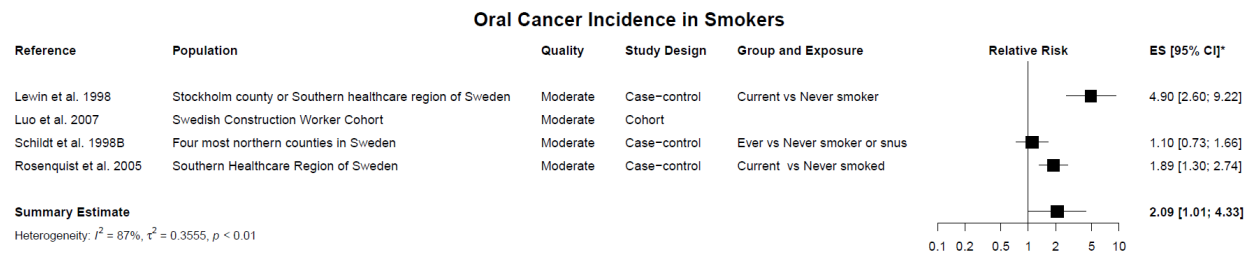
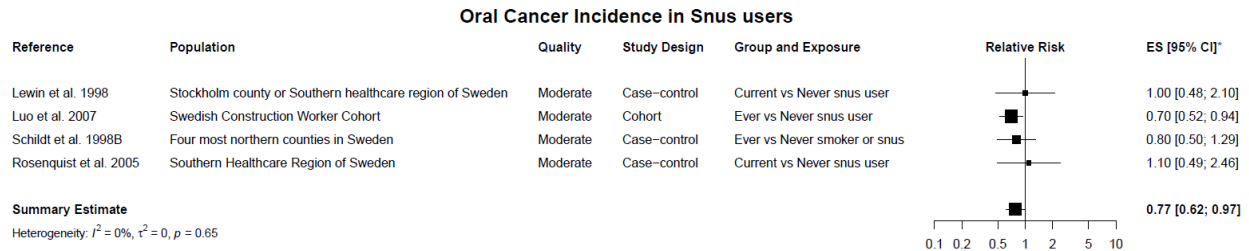
### Oral Cancer Incidence in Snus users compared to Smokers



## Exclusion of smoking and dual user effect estimate from Luo et al. (2007)

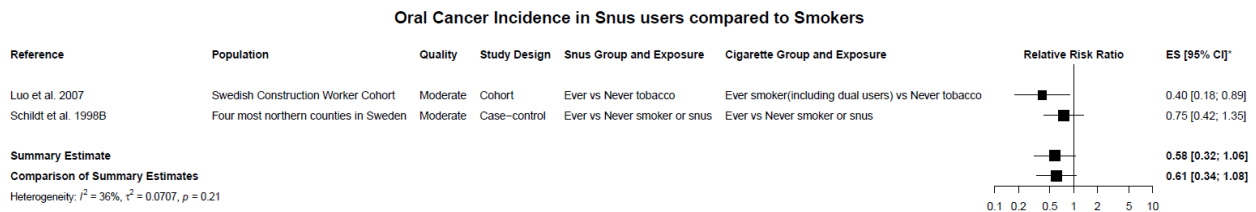
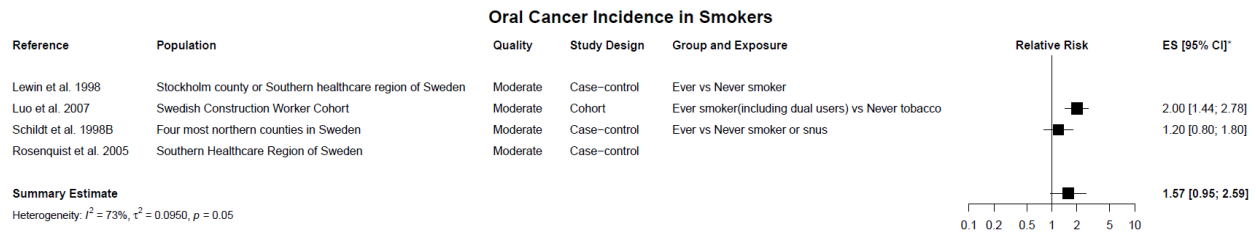
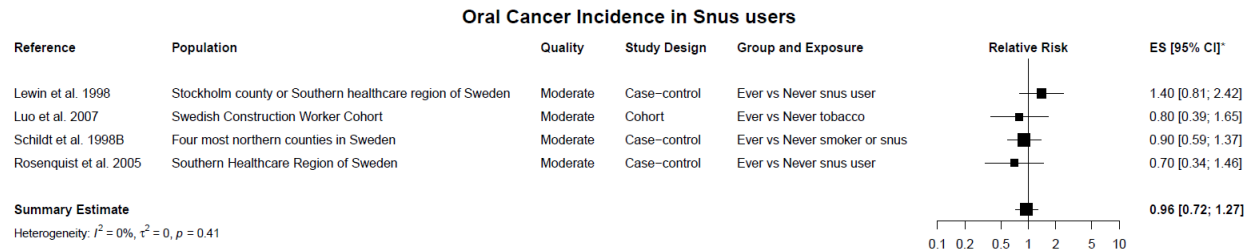


## Preference for adjusted estimates when available



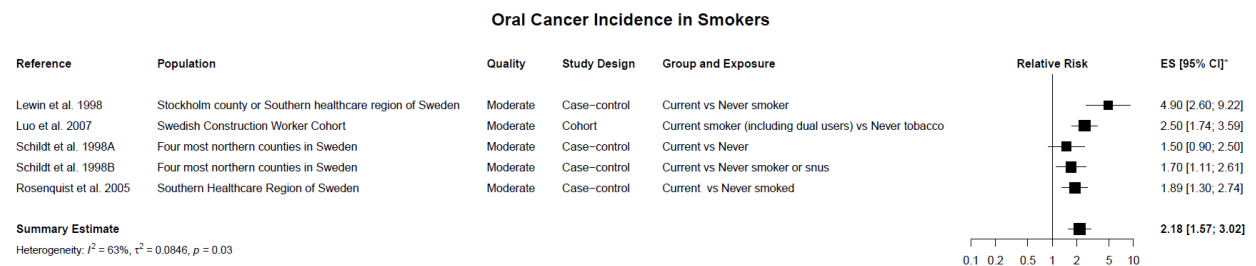
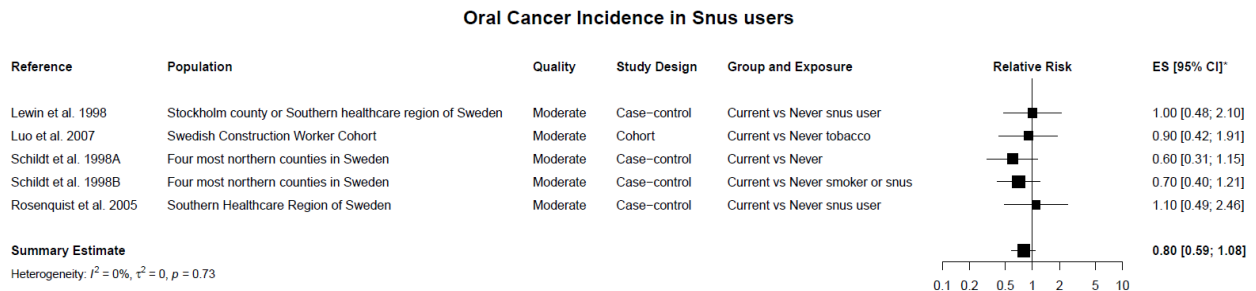


## Preference for ever use when available

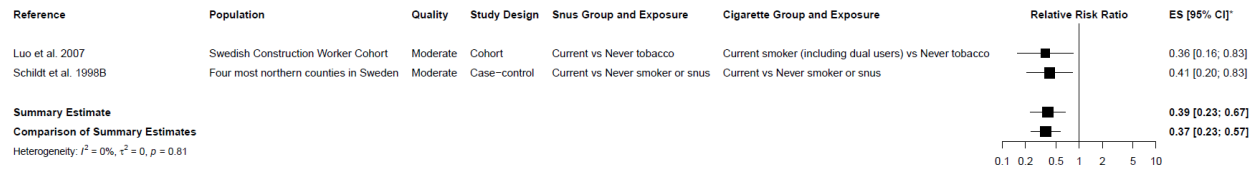


## All "oral cancer" studies

Summary estimates overweight the study population of four most northern counties used in Schildt et al. (1998a) and Schildt et al. (1998b)

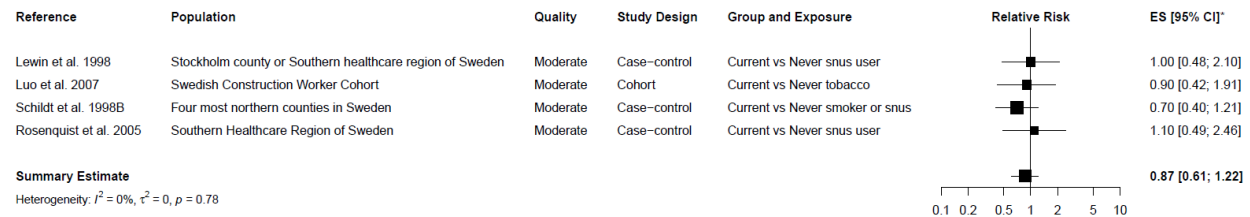


### Oral Cancer Incidence in Snus users compared to Smokers

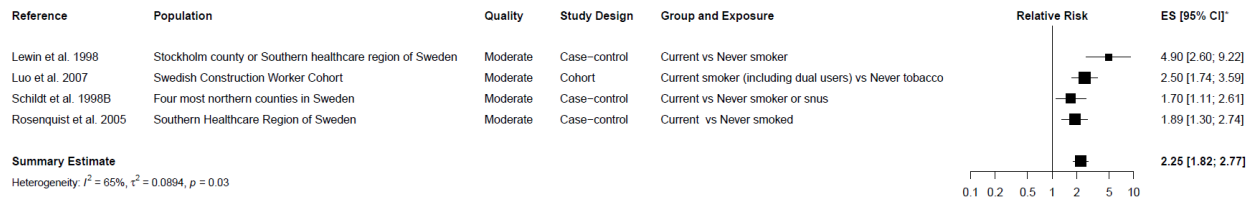


### Fixed-effect meta-analyses

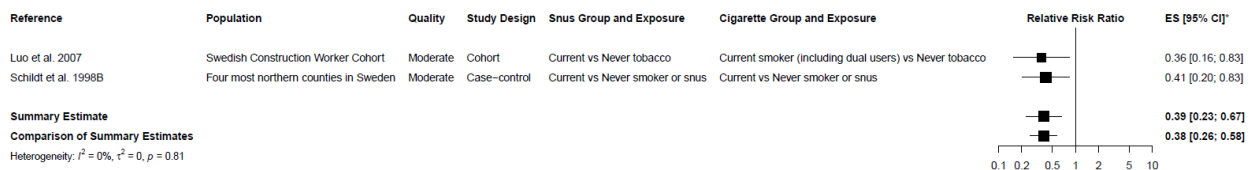
#### Oral Cancer Incidence in Snus users



#### Oral Cancer Incidence in Smokers



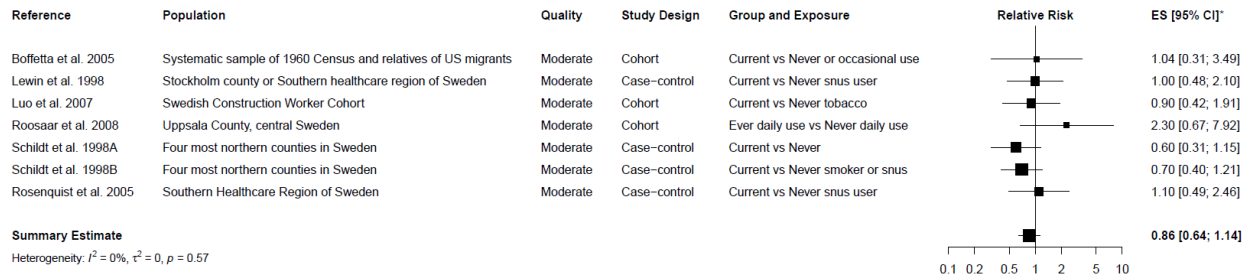
#### Oral Cancer Incidence in Snus users compared to Smokers



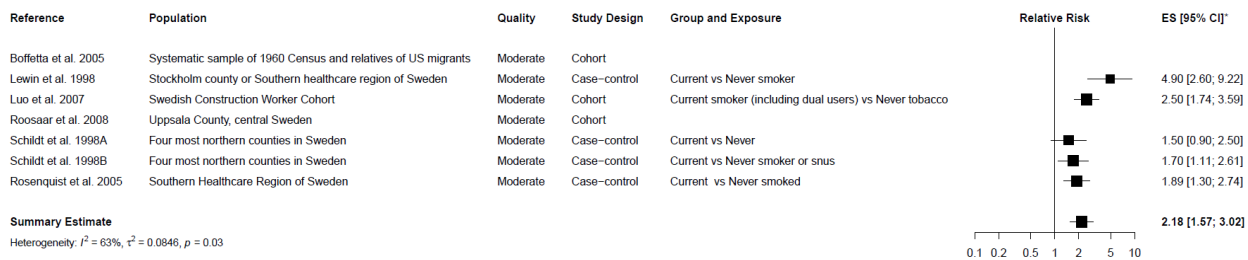
All studies identified in systematic search of Oral and Pharyngeal Cancer

This meta-analysis has been performed by previous meta-analysis of snus but mixes oral cancer specific outcomes with the broader outcomes of “oral and pharyngeal cancer”. These analyses prefer oral-pharyngeal effect measures when available and selects oral cancer estimates otherwise.

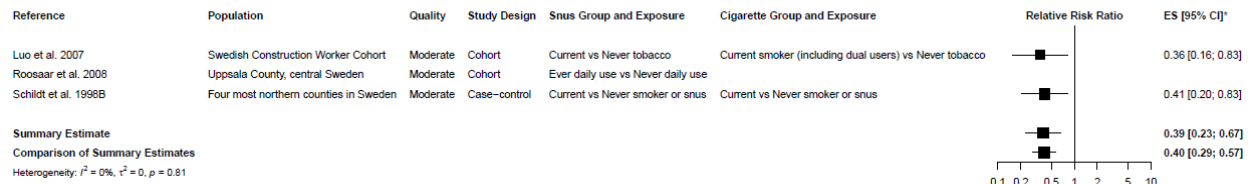
### Oral Cancer Incidence in Snus users



### Oral Cancer Incidence in Smokers



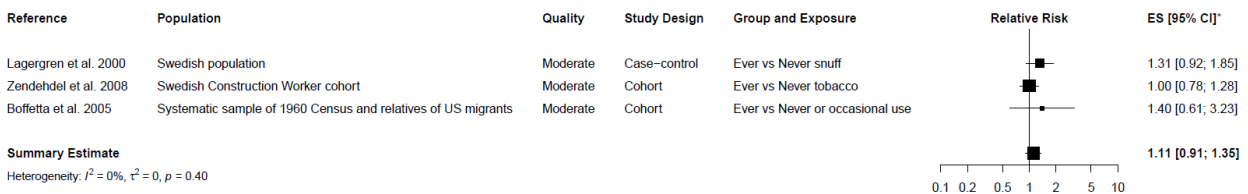
### Oral Cancer Incidence in Snus users compared to Smokers



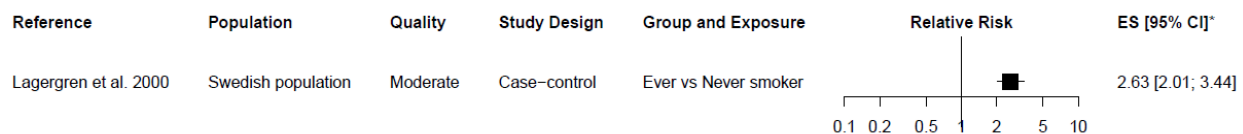
## Esophageal Cancer

### Preference for adjusted estimates when available

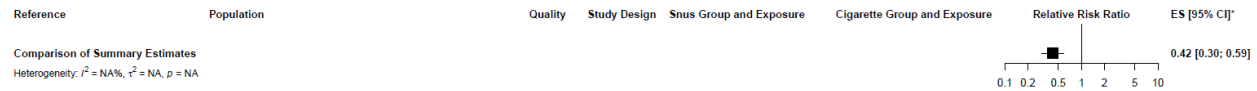
#### Esophageal Cancer Incidence in Snus users



#### Esophageal Cancer Incidence in Smokers



### Esophageal Cancer Incidence in Snus users compared to Smokers



### Exclusion of unclear exposure characterization (Zendehdel et al. 2008)

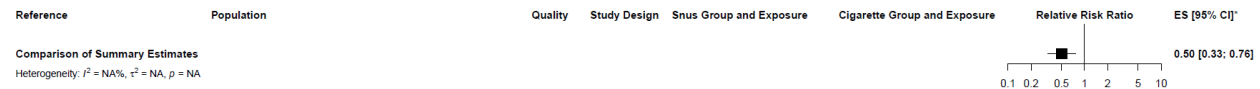
#### Esophageal Cancer Incidence in Snus users



### Esophageal Cancer Incidence in Smokers



### Esophageal Cancer Incidence in Snus users compared to Smokers

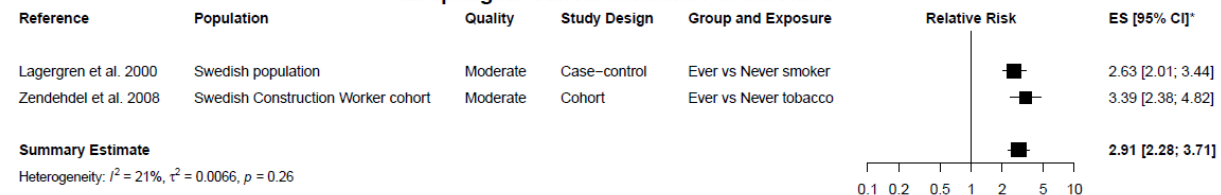


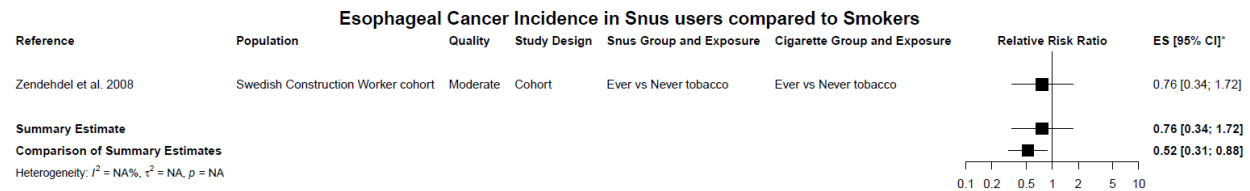
### Preference for current use when available

#### Esophageal Cancer Incidence in Snus users

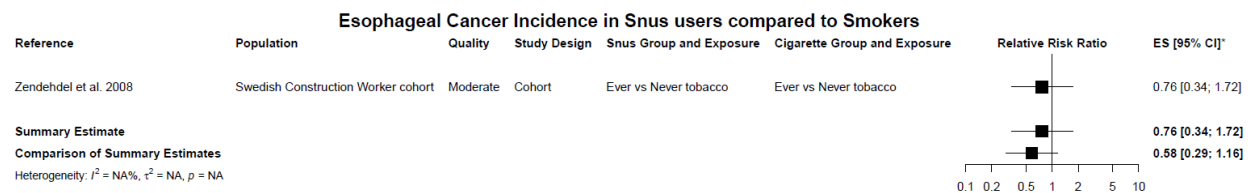
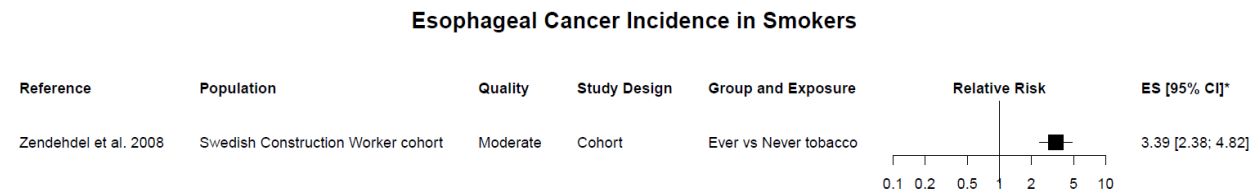
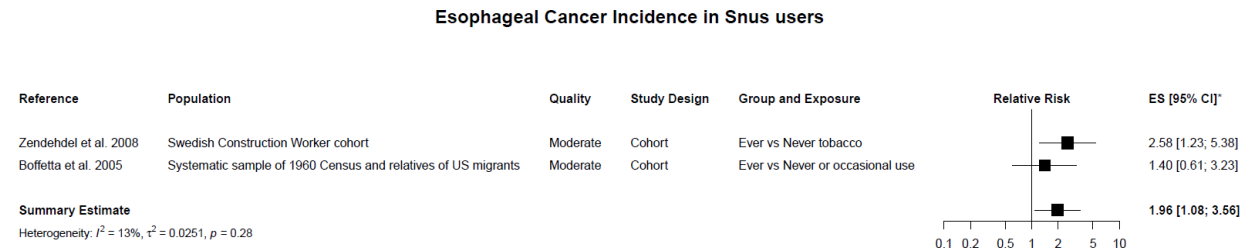


#### Esophageal Cancer Incidence in Smokers

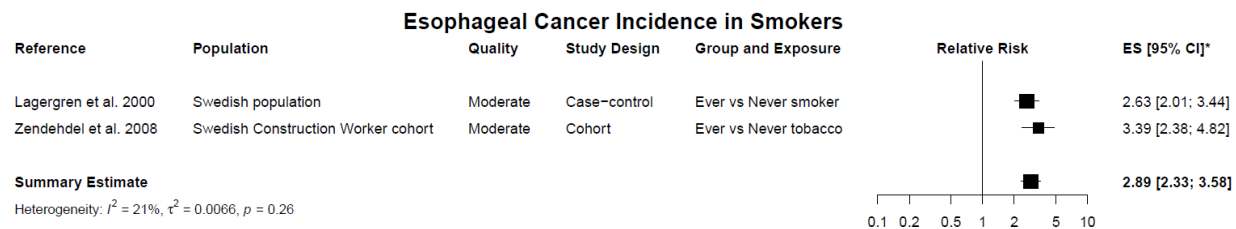
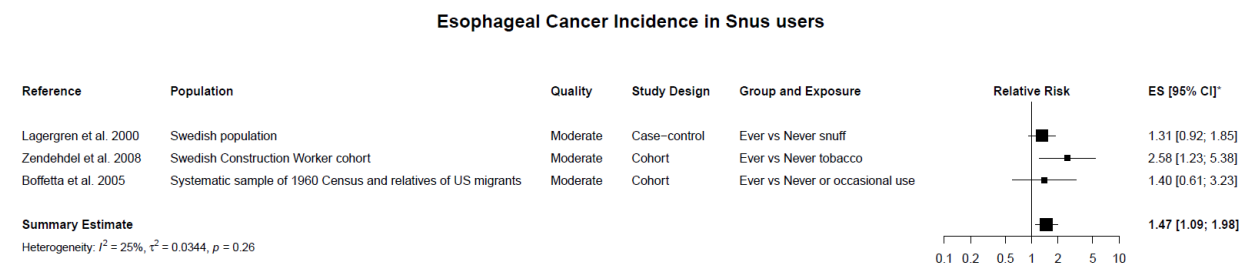


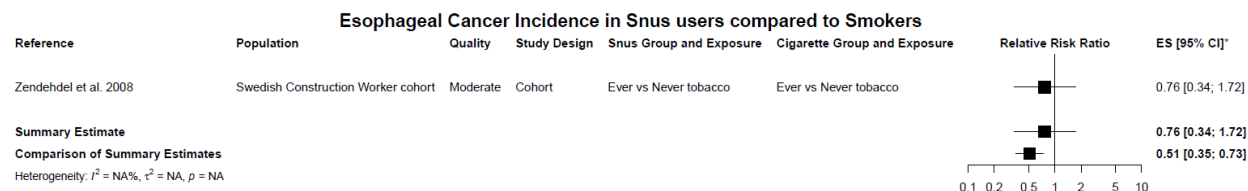


## Cohort studies only



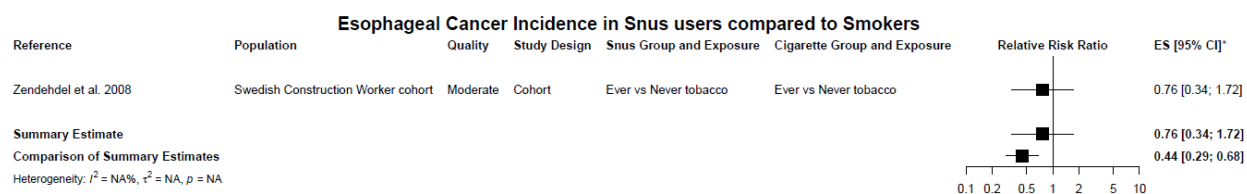
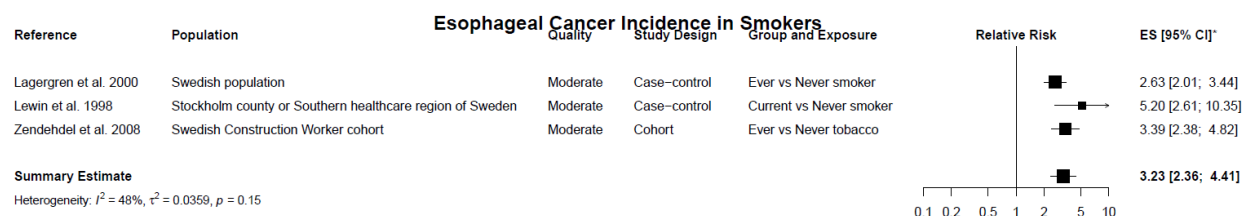
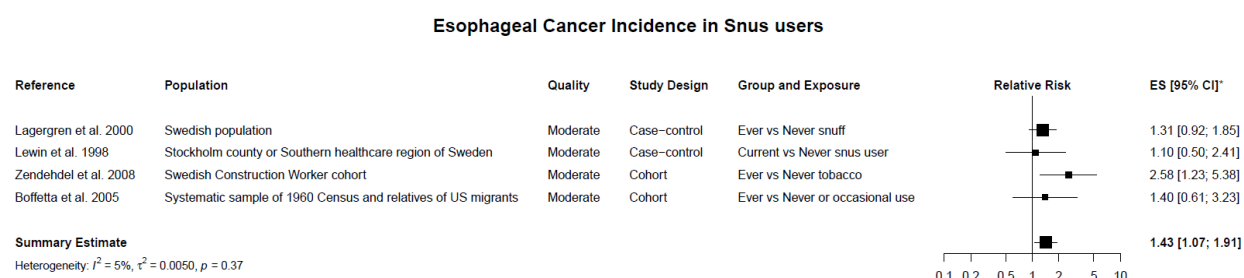
## Fixed-Effects Meta-Analyses





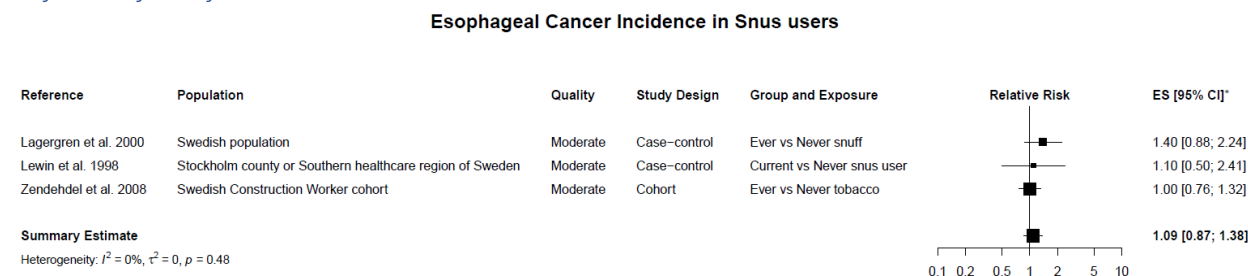
### All studies related to esophageal cancer –

This represents a mixing of squamous cell carcinoma outcome in Lewin et al. (1998) with the broader esophageal cancer outcome. Furthermore, the smoking effect measure in Lewin et al. (1998) is not controlled for smoking.



## Esophageal Squamous Cell Carcinoma

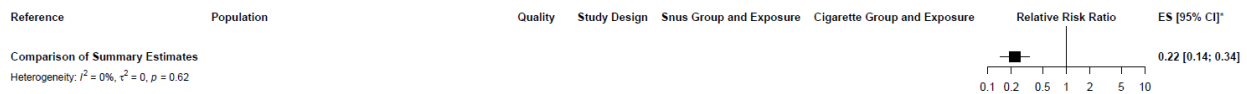
### Preference for adjusted estimates when available



### Esophageal Cancer Incidence in Smokers



### Esophageal Cancer Incidence in Snus users compared to Smokers



### Exclusion of Unclear Snus Exposure

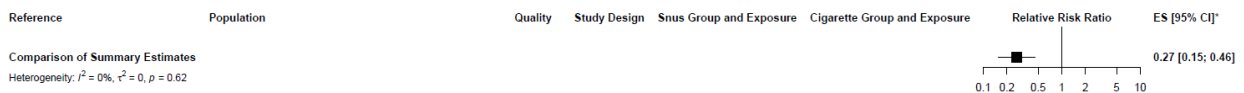
### Esophageal Cancer Incidence in Snus users



### Esophageal Cancer Incidence in Smokers

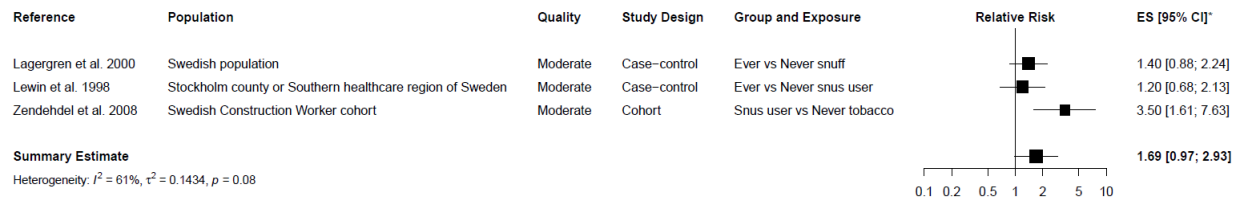


### Esophageal Cancer Incidence in Snus users compared to Smokers

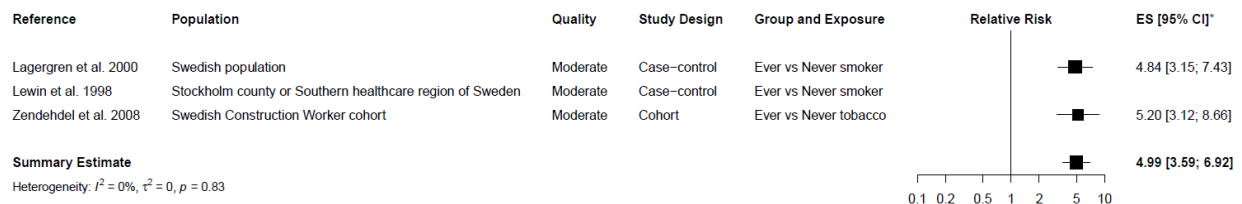


Preference for ever use when available

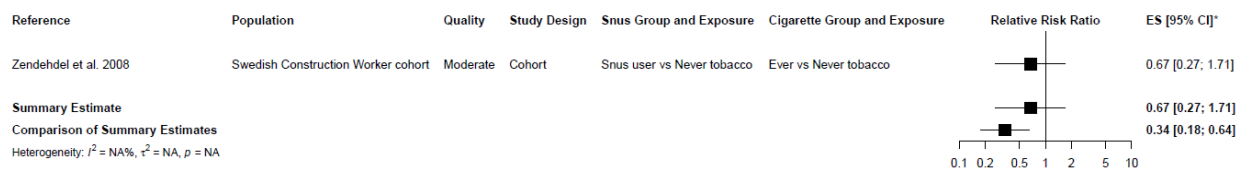
### Esophageal Cancer Incidence in Snus users



### Esophageal Cancer Incidence in Smokers

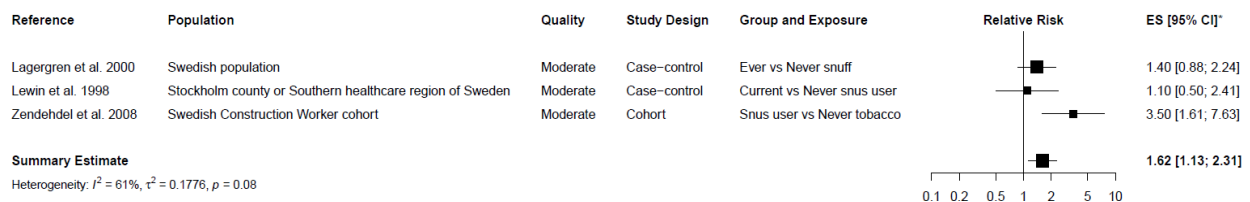


### Esophageal Cancer Incidence in Snus users compared to Smokers

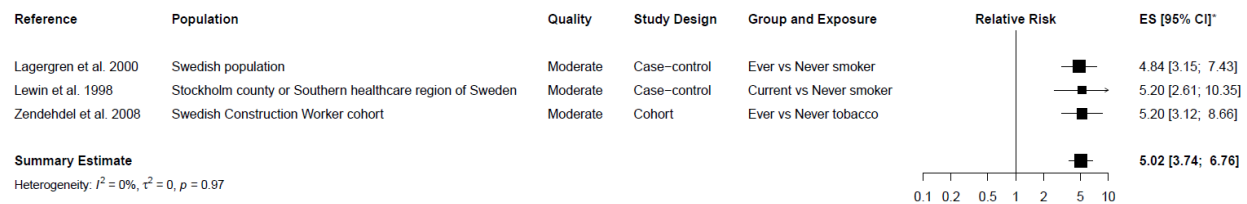


Fixed-effects meta-analysis

### Esophageal Cancer Incidence in Snus users

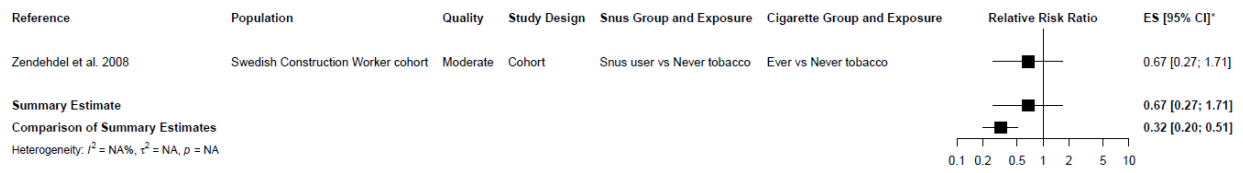


### Esophageal Cancer Incidence in Smokers





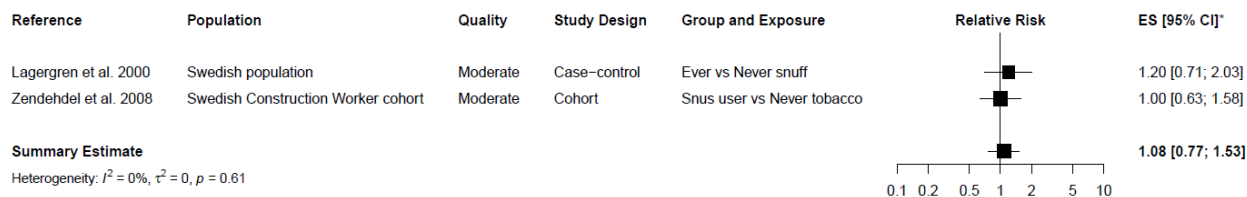
# Esophageal Cancer Incidence in Snus users compared to Smokers



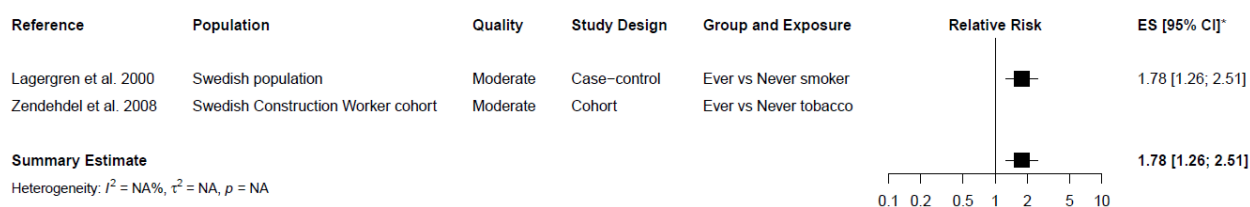
## Esophageal adenocarcinoma

*Preference for adjusted estimates when available*

### Esophageal Cancer Incidence in Snus users



### Esophageal Cancer Incidence in Smokers

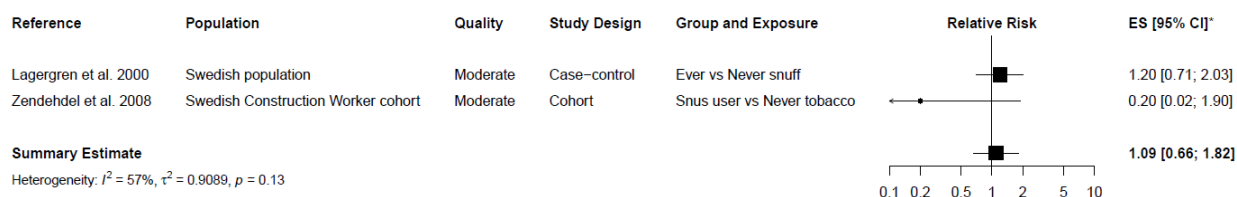


### Esophageal Cancer Incidence in Snus users compared to Smokers

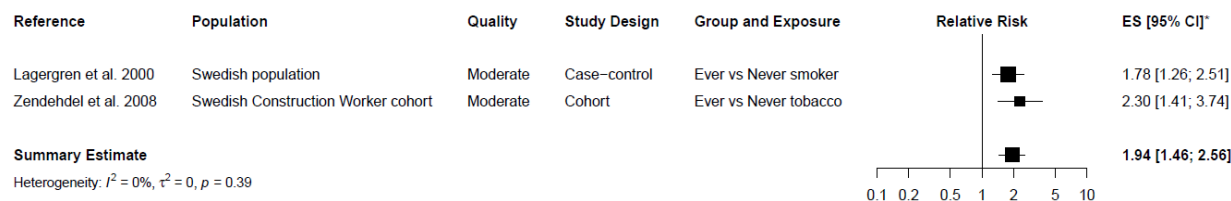


## Fixed-effects meta-analysis

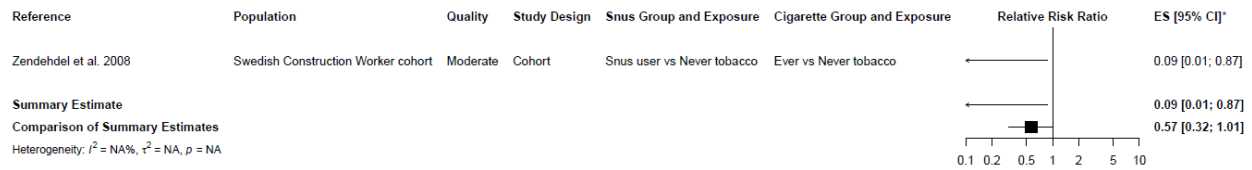
### Esophageal Cancer Incidence in Snus users



### Esophageal Cancer Incidence in Smokers



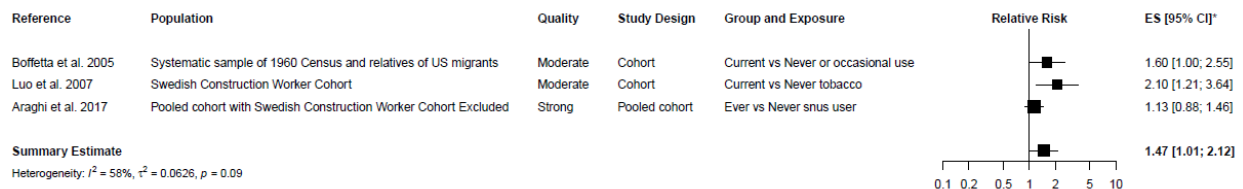
## Esophageal Cancer Incidence in Snus users compared to Smokers



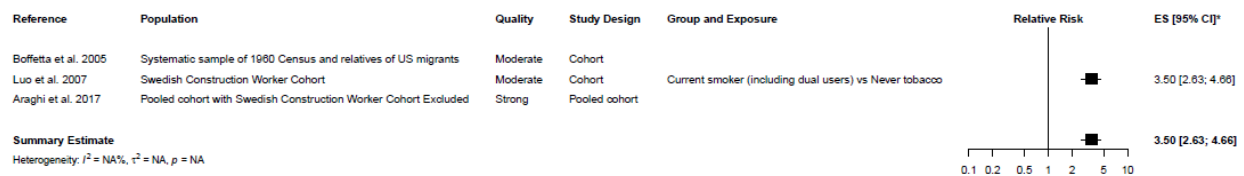
## Pancreatic Cancer

### Current exposure when available

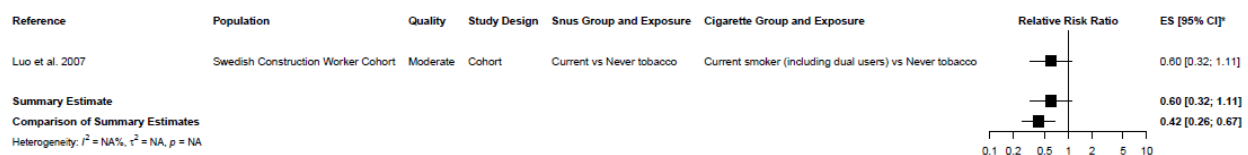
#### Pancreatic Cancer Incidence in Snus users



#### Pancreatic Cancer Incidence in Smokers

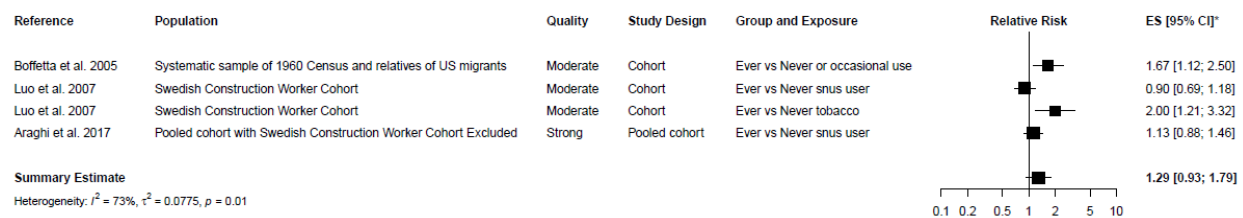


#### Pancreatic Cancer Incidence in Snus users compared to Smokers



### Adjusted effect estimates when available

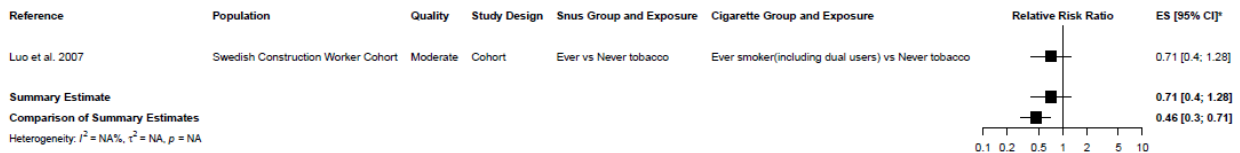
#### Pancreatic Cancer Incidence in Snus users



### Pancreatic Cancer Incidence in Smokers

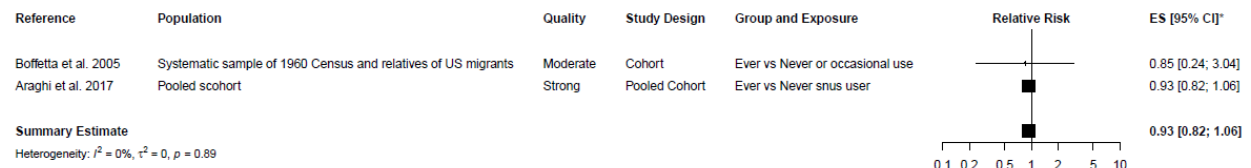


### Pancreatic Cancer Incidence in Snus users compared to Smokers



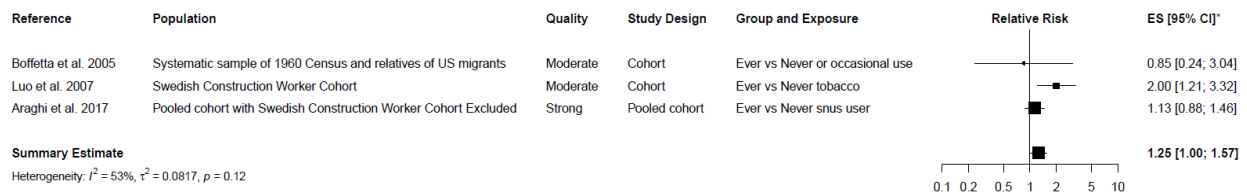
Exclude Luo et al. (2007) and use the Araghi et al. (2017) estimate with the CWC  
No studies have cigarette effect measures.

### Pancreatic Cancer Incidence in Snus users



## Fixed Effects

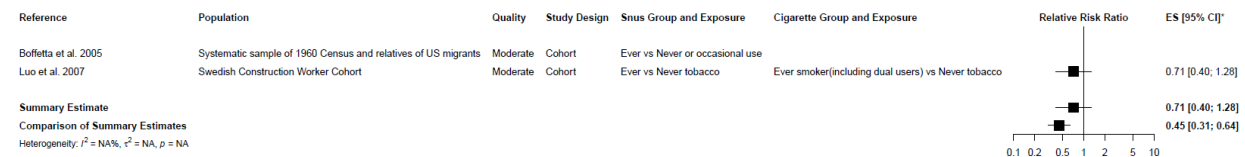
### Pancreatic Cancer Incidence in Snus users



### Pancreatic Cancer Incidence in Smokers



### Pancreatic Cancer Incidence in Snus users compared to Smokers



## Stomach Cancer and Cardia Stomach Cancer

### Stomach Cancer

Inclusion of Hansson et al. (1994)

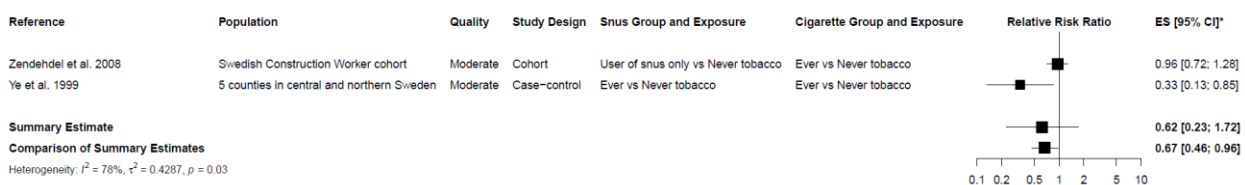
#### Stomach Cancer Incidence in Snus users



#### Stomach Cancer Incidence in Smokers



#### Stomach Cancer Incidence in Snus users compared to Smokers

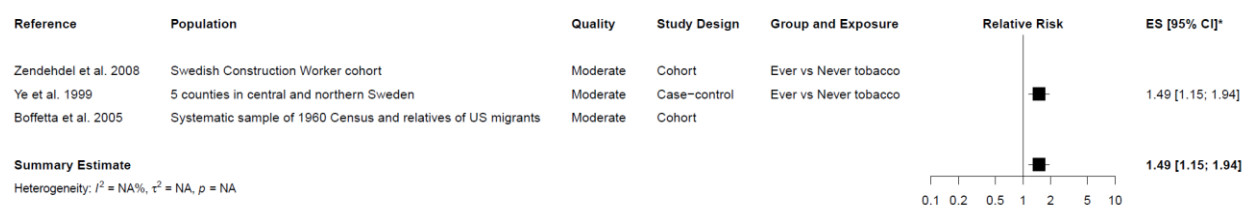


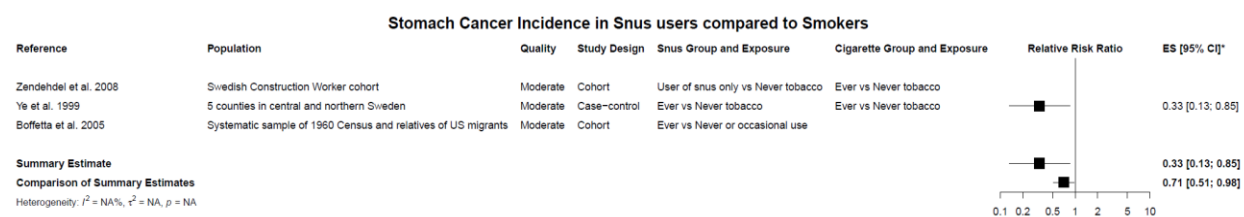
Preference for adjusted estimates when available

#### Stomach Cancer Incidence in Snus users

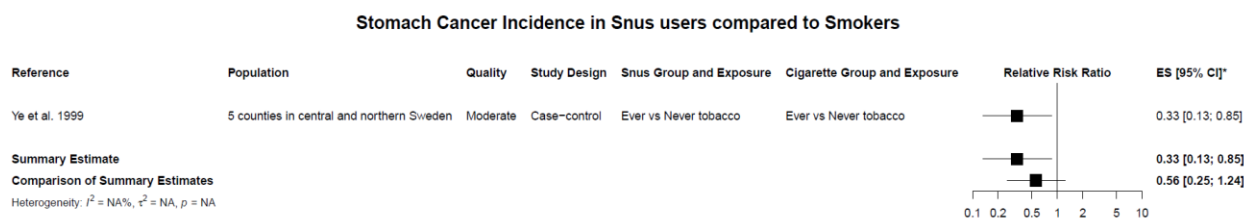
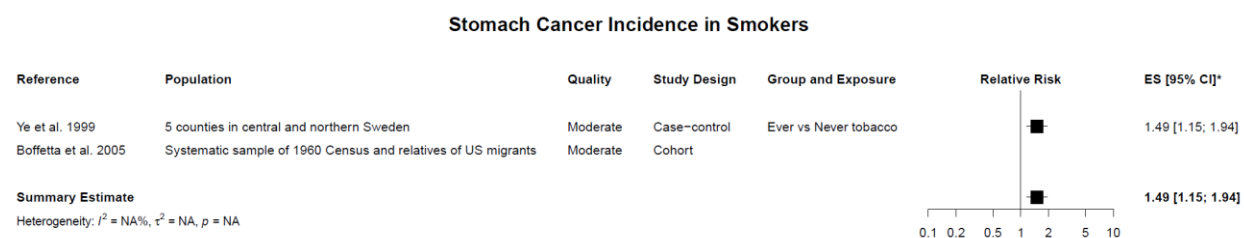
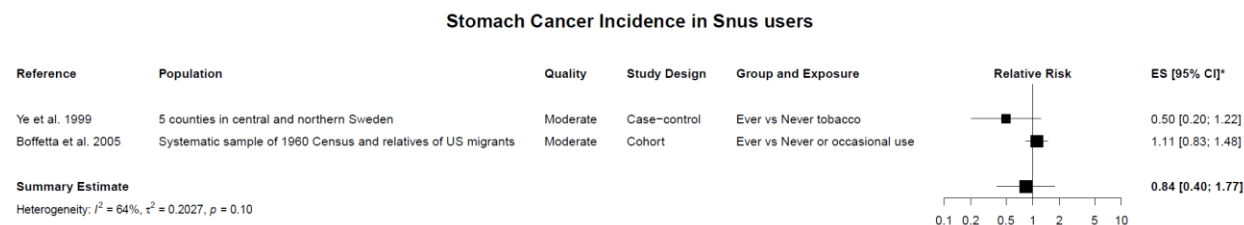


#### Stomach Cancer Incidence in Smokers

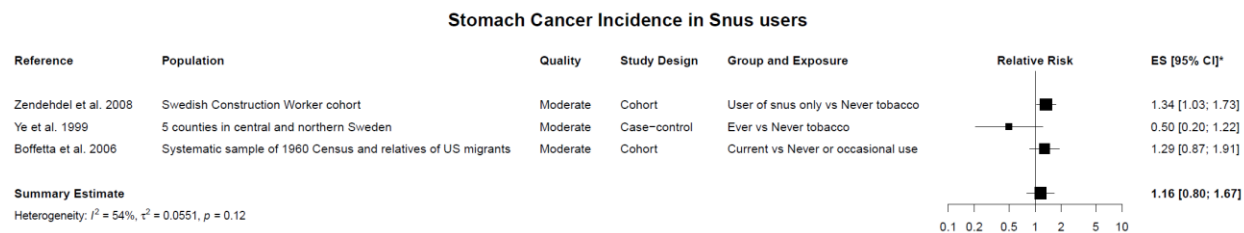




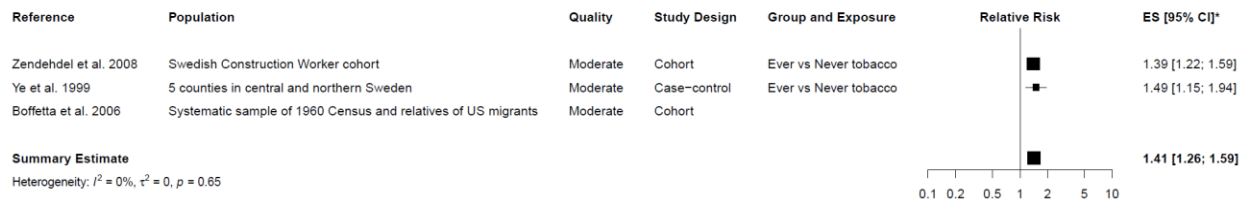
Exclusion of unclear exposure (Zende del et al. 2008)



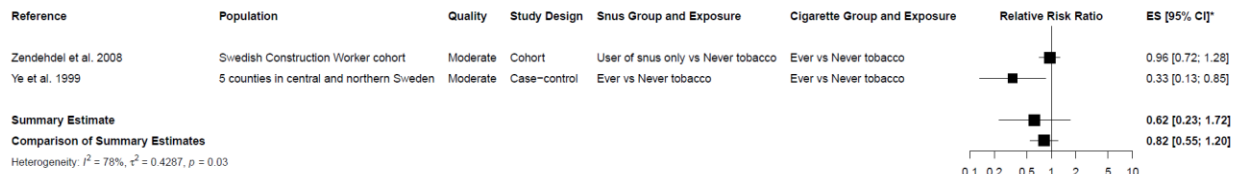
Preference for Current Snus Exposure Characterization when available



### Stomach Cancer Incidence in Smokers

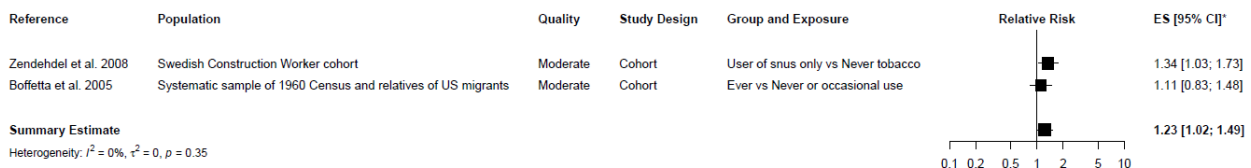


### Stomach Cancer Incidence in Snus users compared to Smokers

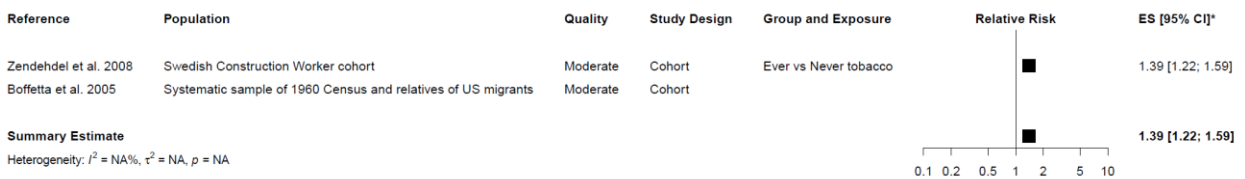


## Only Cohort Studies

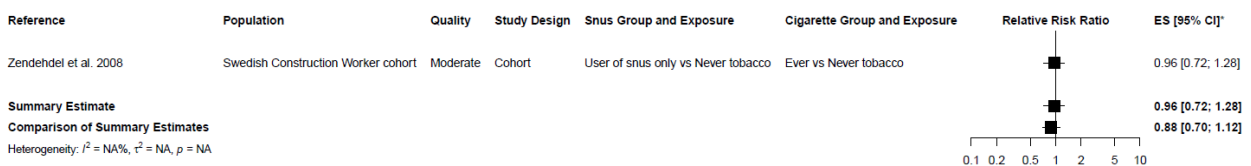
### Stomach Cancer Incidence in Snus users



### Stomach Cancer Incidence in Smokers

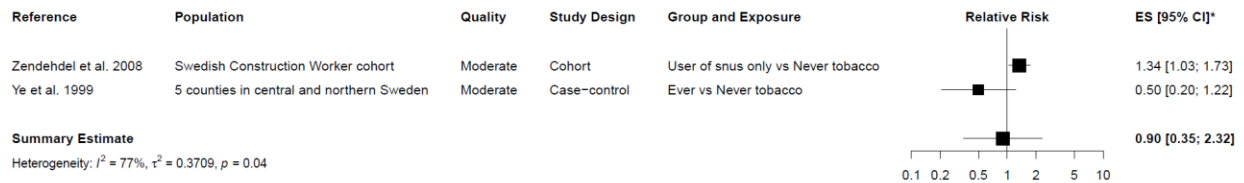


### Stomach Cancer Incidence in Snus users compared to Smokers

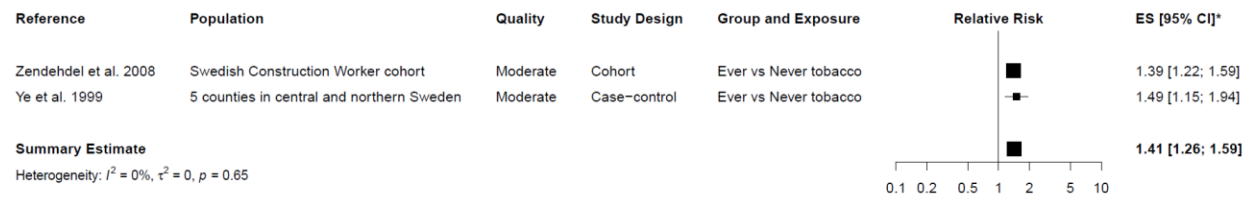


## Stratified Estimates Only

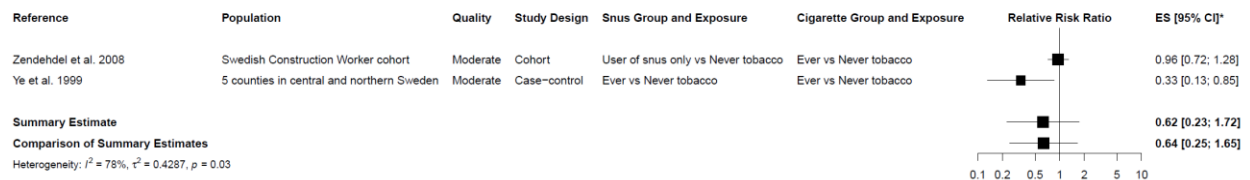
### Stomach Cancer Incidence in Snus users



### Stomach Cancer Incidence in Smokers



### Stomach Cancer Incidence in Snus users compared to Smokers



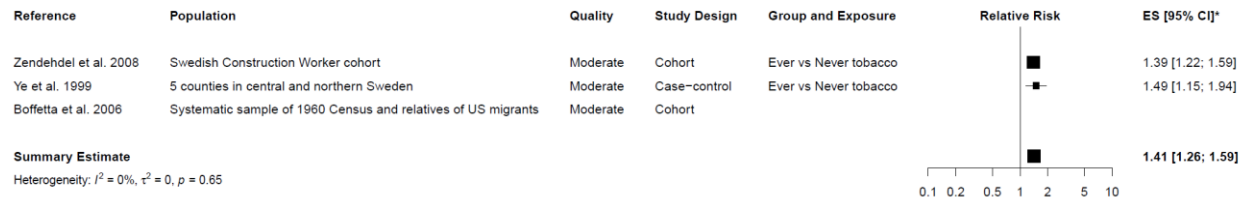
## Fixed-effect meta-analysis

### Stomach Cancer Incidence in Snus users

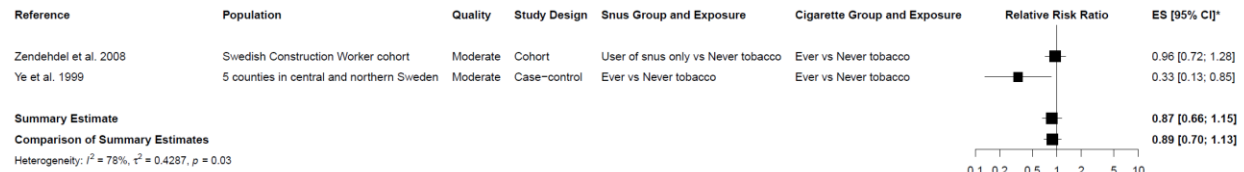




### Stomach Cancer Incidence in Smokers

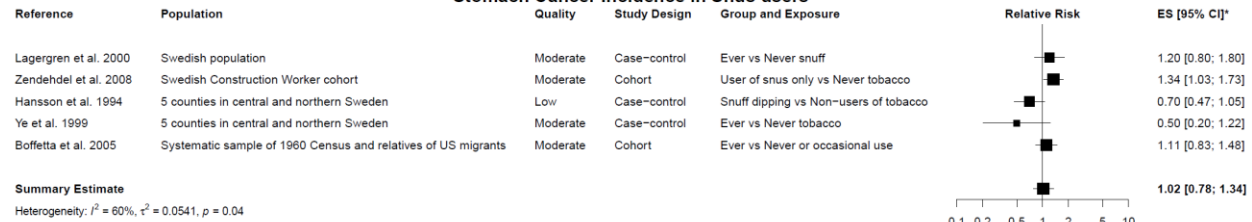


### Stomach Cancer Incidence in Snus users compared to Smokers

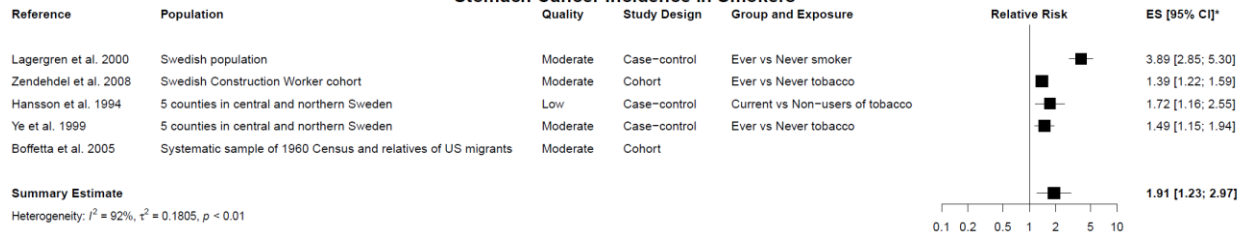


All studies identified in systematic review

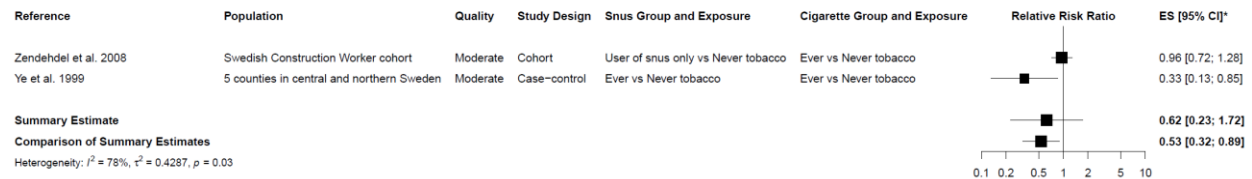
### Stomach Cancer Incidence in Snus users



### Stomach Cancer Incidence in Smokers



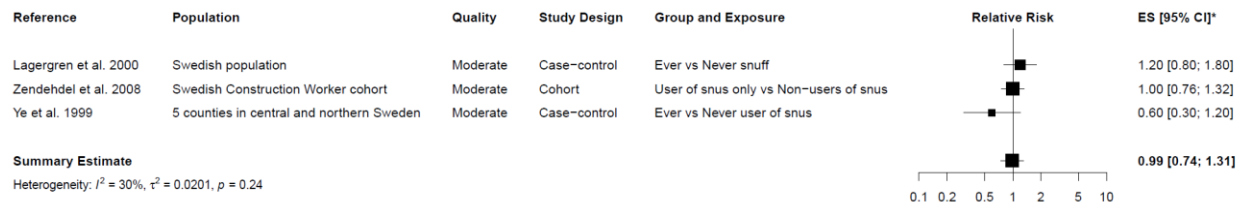
### Stomach Cancer Incidence in Snus users compared to Smokers



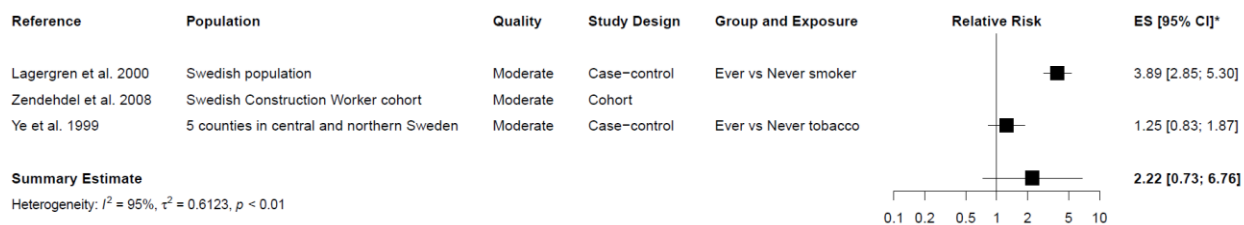
## Cardia Stomach Cancer

Preference for adjusted estimates when available

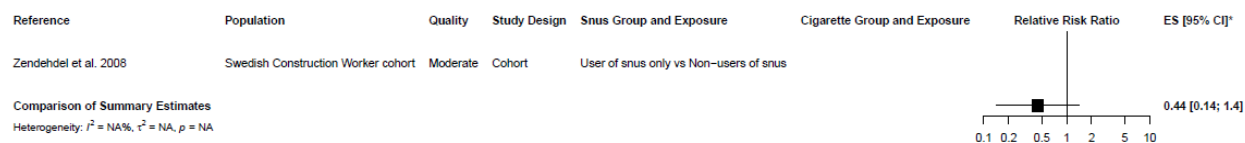
### Stomach Cancer Incidence in Snus users



### Stomach Cancer Incidence in Smokers

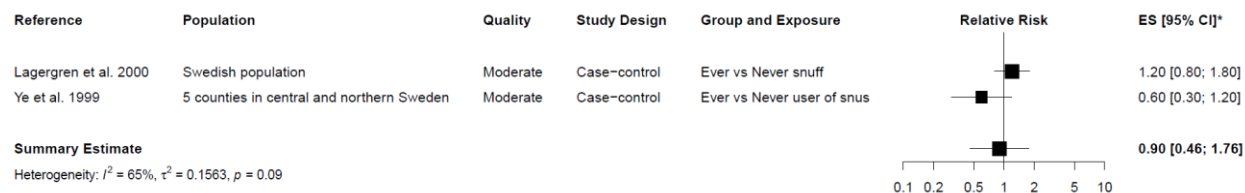


### Stomach Cancer Incidence in Snus users compared to Smokers







Exclusion of unclear snus exposure characterization in Zendejdel et al. 2008


### Stomach Cancer Incidence in Snus users



### Stomach Cancer Incidence in Smokers




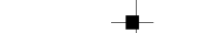
Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Lagergren et al. 2000	Swedish population	Moderate	Case-control	Ever vs Never smoker		3.89 [2.85; 5.30]
Zendeheidel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	Ever vs Never tobacco		2.10 [1.48; 2.97]
Ye et al. 1999	5 counties in central and northern Sweden	Moderate	Case-control	Ever vs Never tobacco		1.25 [0.83; 1.87]
<b>Summary Estimate</b>						2.19 [1.15; 4.16]
Heterogeneity: $I^2 = 90\%$ , $\tau^2 = 0.2879$ , $p < 0.01$						

### Stomach Cancer Incidence in Snus users compared to Smokers





Reference	Population	Quality	Study Design	Snus Group and Exposure	Cigarette Group and Exposure	Relative Risk Ratio	ES [95% CI]*	
Comparison of Summary Estimates								0.41 [0.16; 1.04]
Heterogeneity: $I^2 = \text{NA}\%$ , $\tau^2 = \text{NA}$ , $p = \text{NA}$								

Preference for current exposure when available



### Stomach Cancer Incidence in Snus users

Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Lagergren et al. 2000	Swedish population	Moderate	Case-control	Ever vs Never snuff		1.20 [0.80; 1.80]
Zendeheidel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	User of snus only vs Never tobacco		0.90 [0.40; 2.01]
Ye et al. 1999	5 counties in central and northern Sweden	Moderate	Case-control	Current vs Never user of snus		0.50 [0.21; 1.17]
<b>Summary Estimate</b>						0.91 [0.55; 1.49]
Heterogeneity: $I^2 = 41\%$ , $\tau^2 = 0.0815$ , $p = 0.18$						

### Stomach Cancer Incidence in Smokers

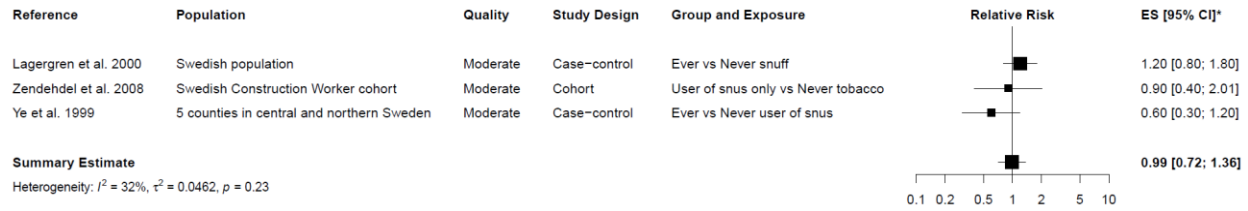
Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Lagergren et al. 2000	Swedish population	Moderate	Case-control	Ever vs Never smoker		3.89 [2.85; 5.30]
Zendeheidel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	Current vs Never tobacco		2.30 [1.60; 3.30]
Ye et al. 1999	5 counties in central and northern Sweden	Moderate	Case-control	Current vs Never tobacco		1.70 [0.97; 2.99]
<b>Summary Estimate</b>						2.58 [1.61; 4.14]
Heterogeneity: $I^2 = 76\%$ , $\tau^2 = 0.1302$ , $p = 0.01$						

### Stomach Cancer Incidence in Snus users compared to Smokers

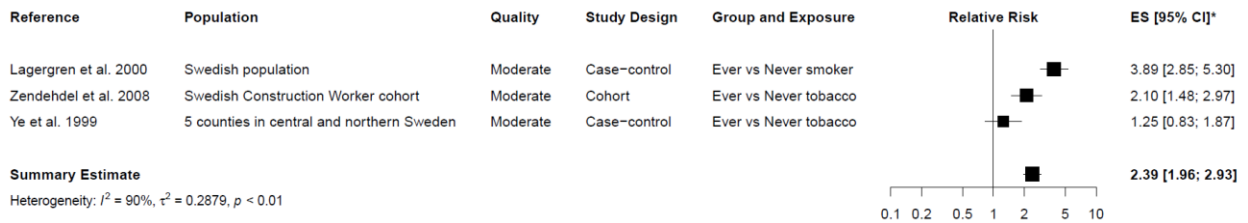
Reference	Population	Quality	Study Design	Snus Group and Exposure	Cigarette Group and Exposure	Relative Risk Ratio	ES [95% CI]*	
Zendeheidel et al. 2008	Swedish Construction Worker cohort	Moderate	Cohort	User of snus only vs Never tobacco	Current vs Never tobacco		0.39 [0.16; 0.95]	
<b>Summary Estimate</b>							0.39 [0.16; 0.95]	
<b>Comparison of Summary Estimates</b>								0.35 [0.18; 0.70]
Heterogeneity: $I^2 = \text{NA}\%$ , $\tau^2 = \text{NA}$ , $p = \text{NA}$								

## Fixed Effect Meta-Analysis

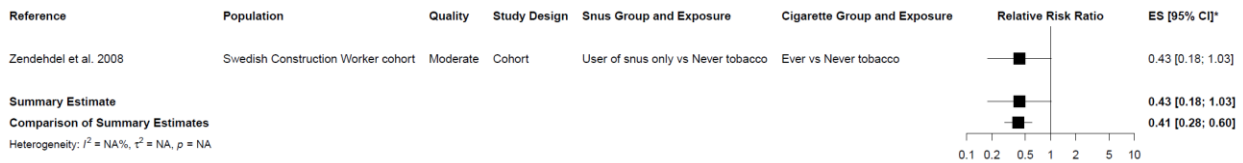
### Stomach Cancer Incidence in Snus users



### Stomach Cancer Incidence in Smokers



### Stomach Cancer Incidence in Snus users compared to Smokers



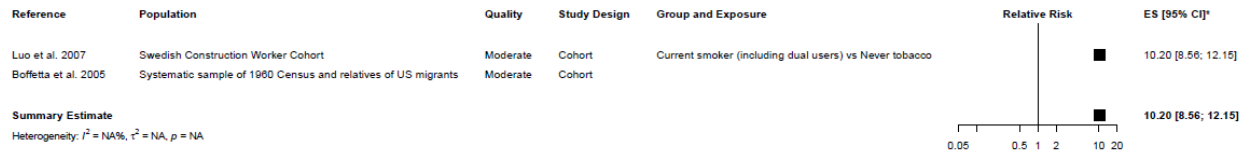
## Lung Cancer

Preference for Current Exposure when available

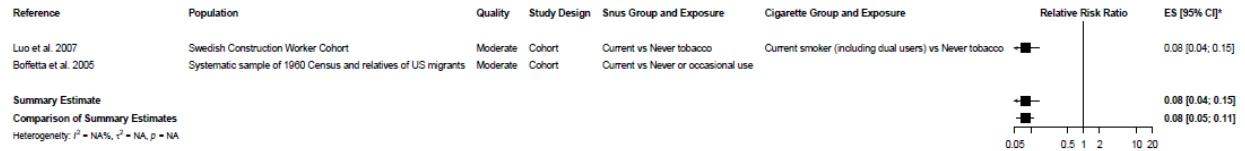
### Lung Cancer Incidence in Snus users



### Lung Cancer Incidence in Smokers



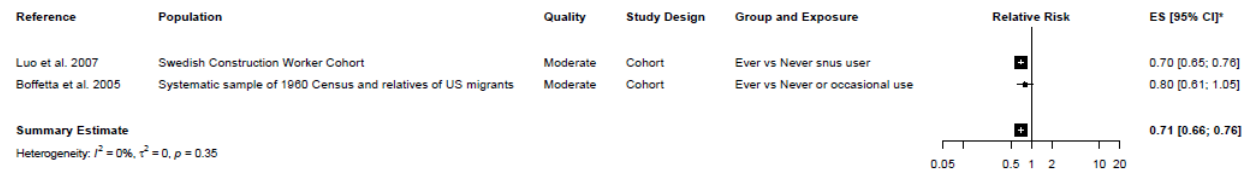
### Lung Cancer Incidence in Snus users compared to Smokers



Preference for Adjusted Estimates when available

Effects for smoking estimates adjusted for snus were not available. Comparisons could not be reasonably made between stratified smoking effects and adjusted snus effects.

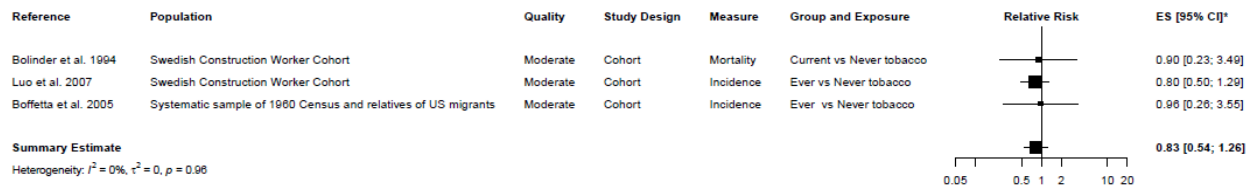
### Lung Cancer Incidence in Snus users



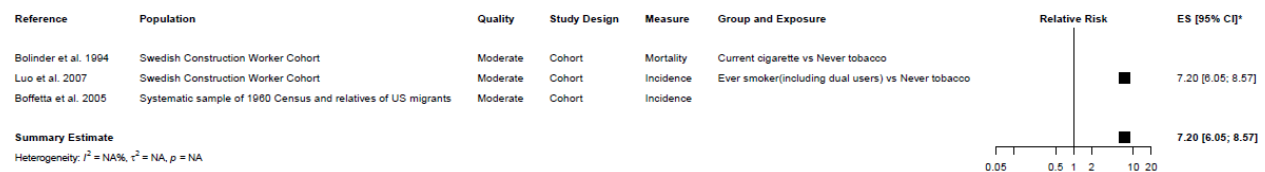
Including all studies (Using snus estimates for the entire cohort in Bolinder et al. 1994)

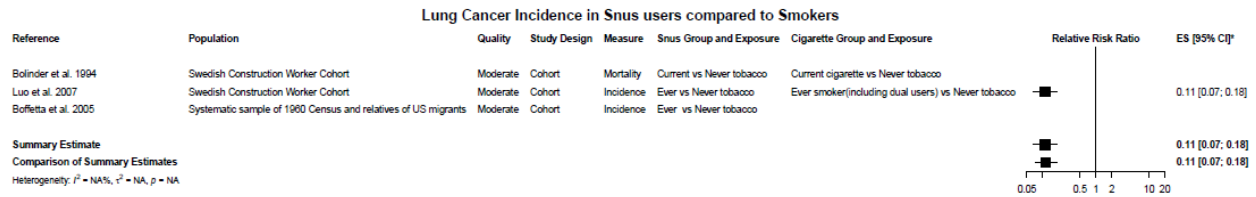
Bolinder et al. 1994 does not report estimates for smokers in the entire cohort

### Lung Cancer Incidence in Snus users



### Lung Cancer Incidence in Smokers





## Fixed Effect Meta-Analysis

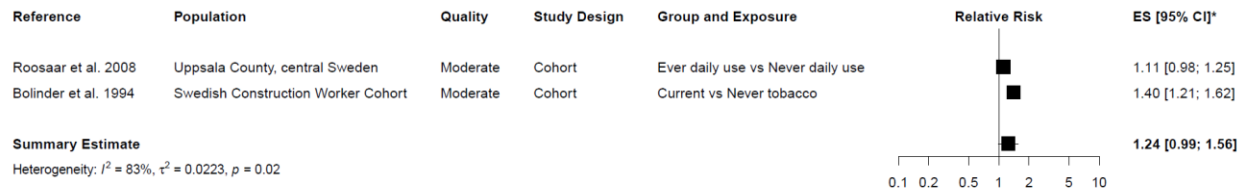
No changes

## Cardiovascular Effects

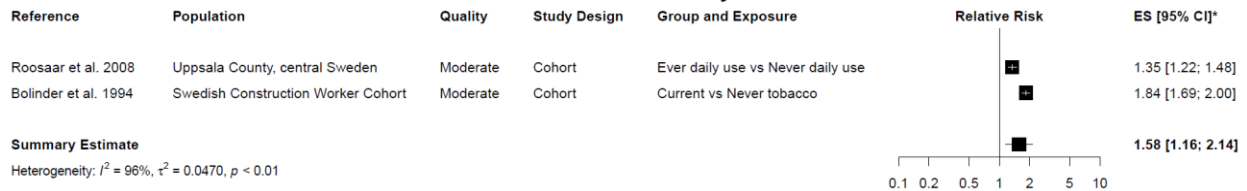
Cardiovascular disease

*Preference for adjusted estimates*

### Cardiovascular Disease Mortality in Snus users



### Cardiovascular Disease Mortality in Smokers



### Cardiovascular Disease Mortality in Snus users compared to Smokers

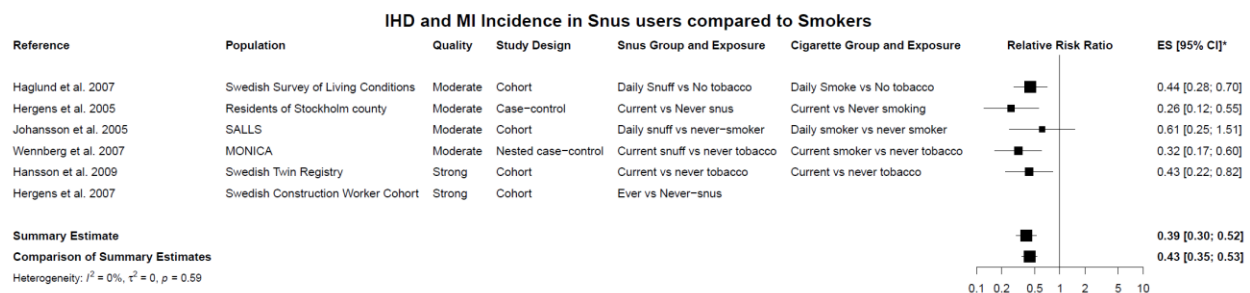
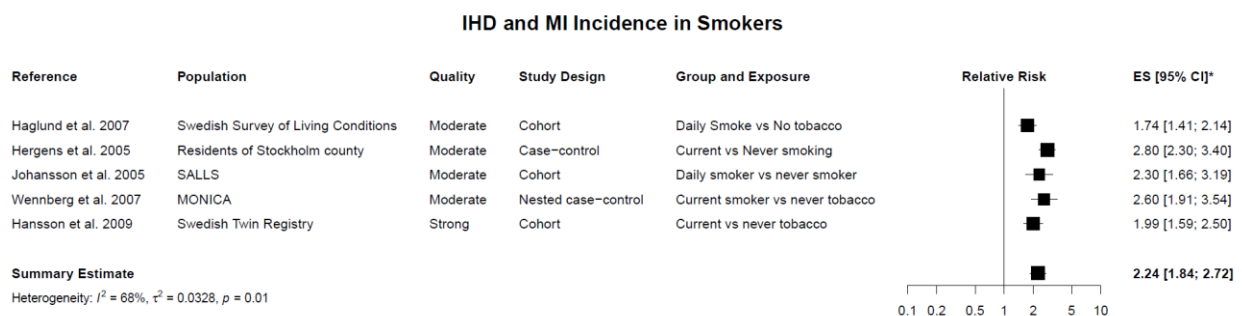
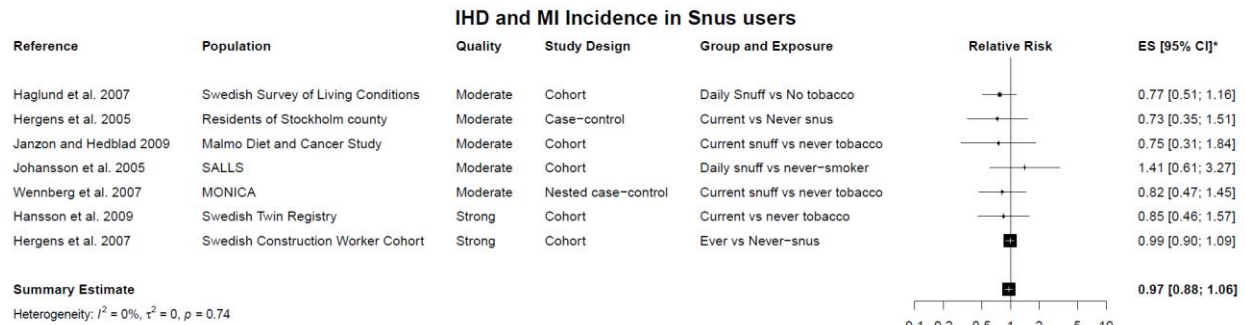


*Fixed-Effects meta-analysis*

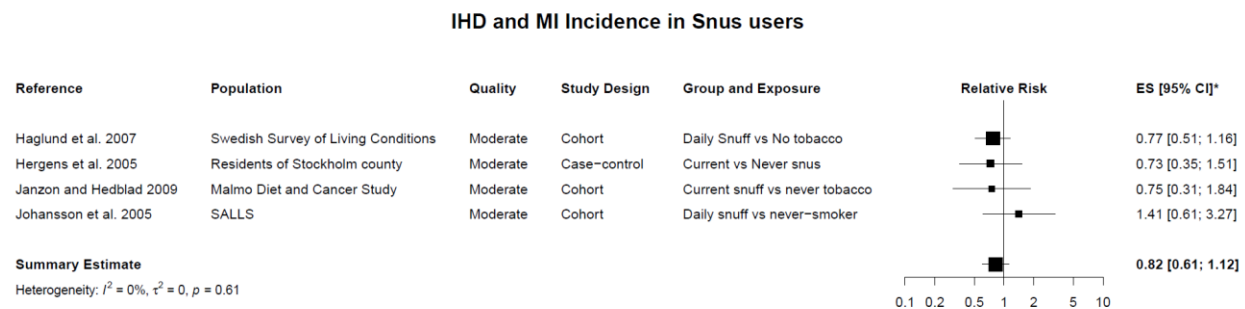
No changes

## IHD and MI Incidence:

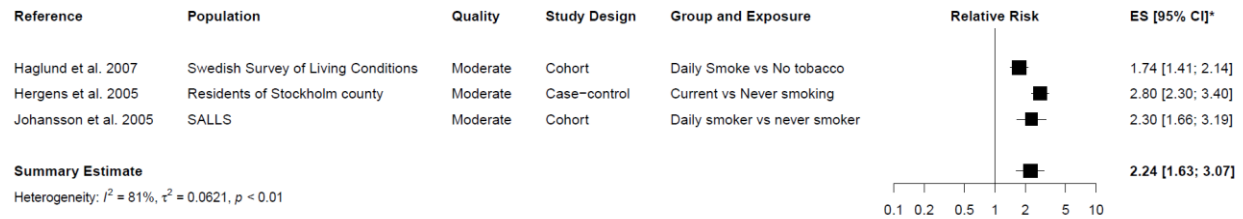
*Preference for ever exposure when available*



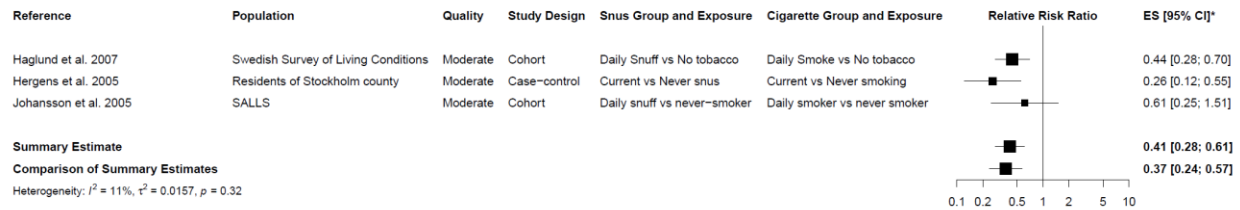
*Exclusion of studies with different outcome ascertainment*



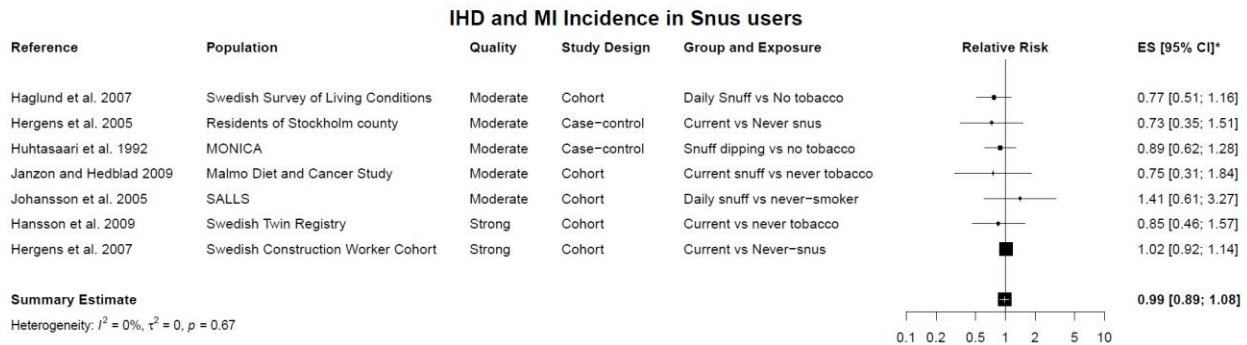
## IHD and MI Incidence in Smokers



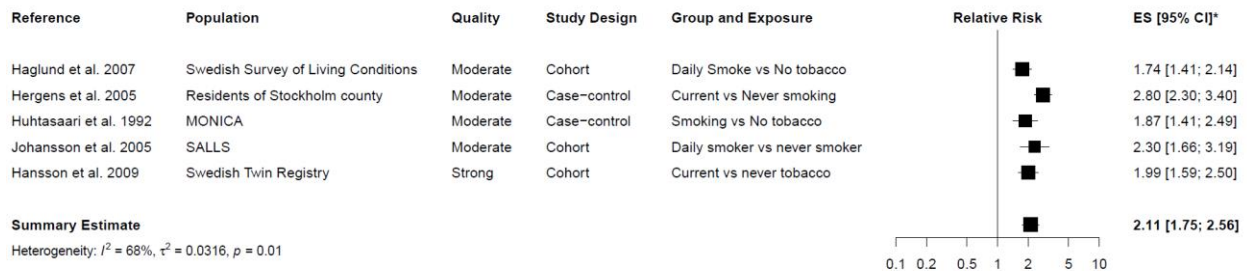
## IHD and MI Incidence in Snus users compared to Smokers



## MONICA cohort 1989-1991 preferred (Huhtasaari et al. 1992)

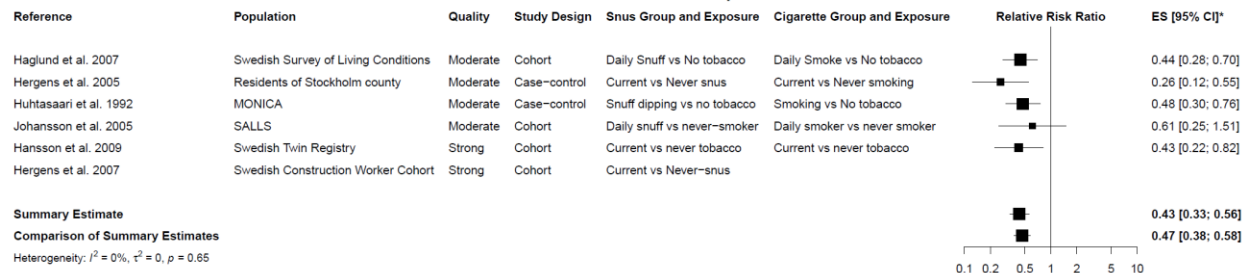


## IHD and MI Incidence in Smokers



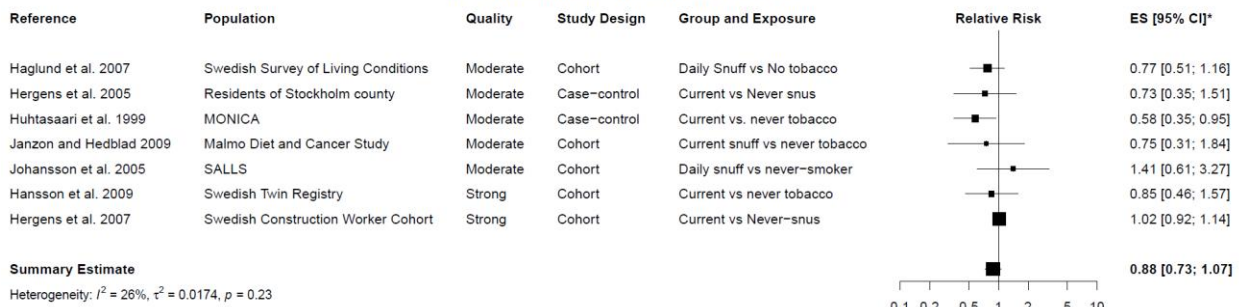


### IHD and MI Incidence in Snus users compared to Smokers

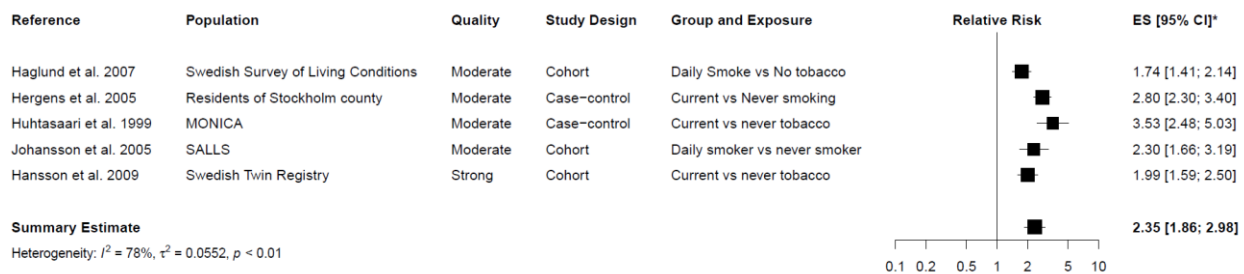


MONICA cohort 1991-1993 preferred (Huhtasaari et al. 1999)

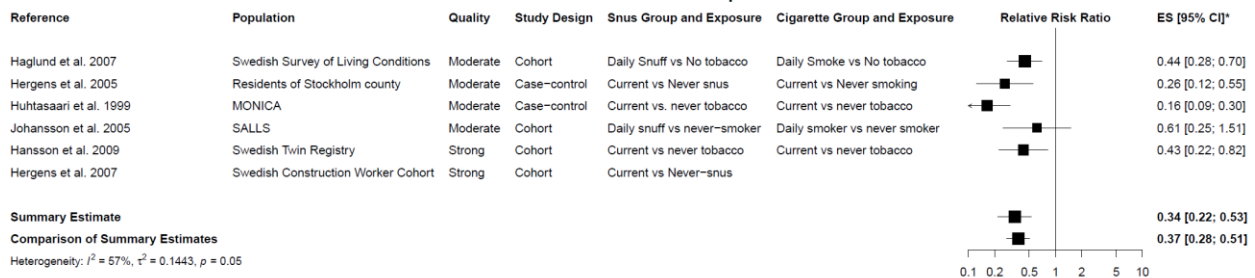
### IHD and MI Incidence in Snus users



### IHD and MI Incidence in Smokers

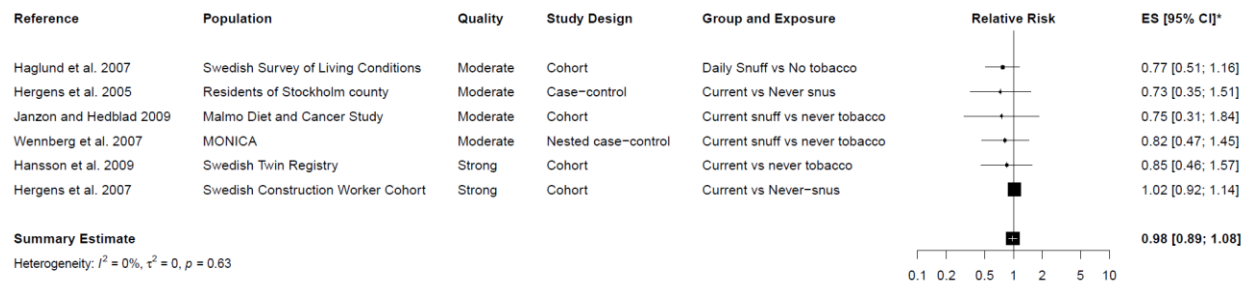


### IHD and MI Incidence in Snus users compared to Smokers

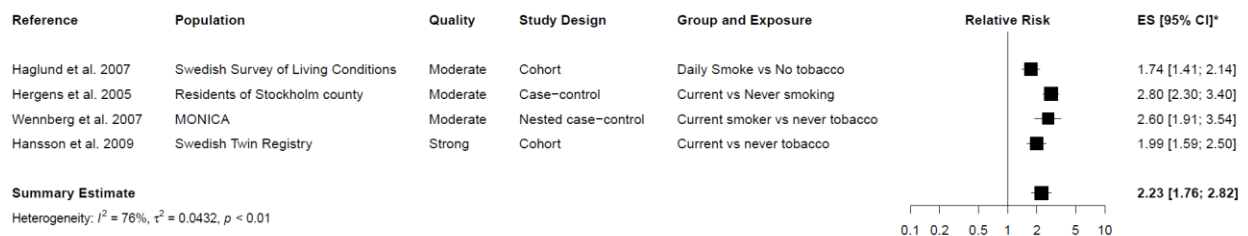


## Exclusion of possible duplicate study population (Johansson et al. 2005)

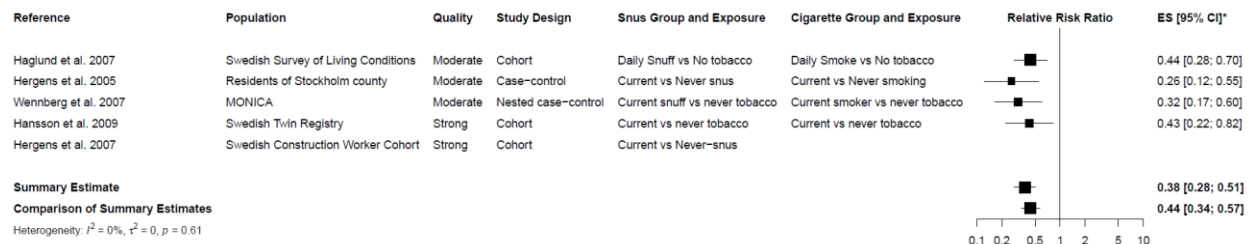
### IHD and MI Incidence in Snus users



### IHD and MI Incidence in Smokers

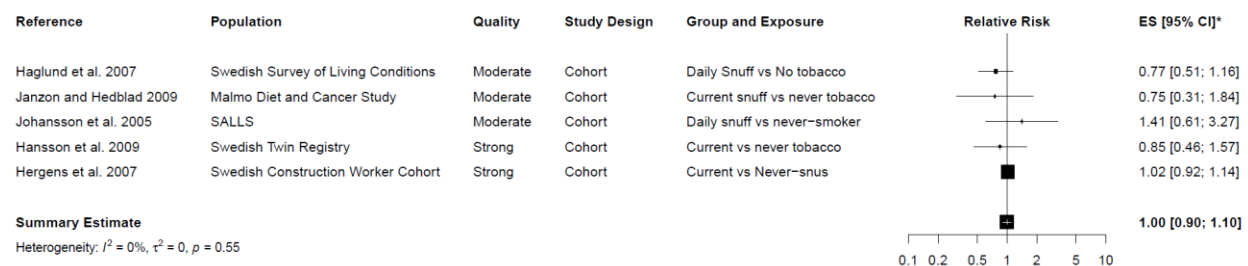


### IHD and MI Incidence in Snus users compared to Smokers

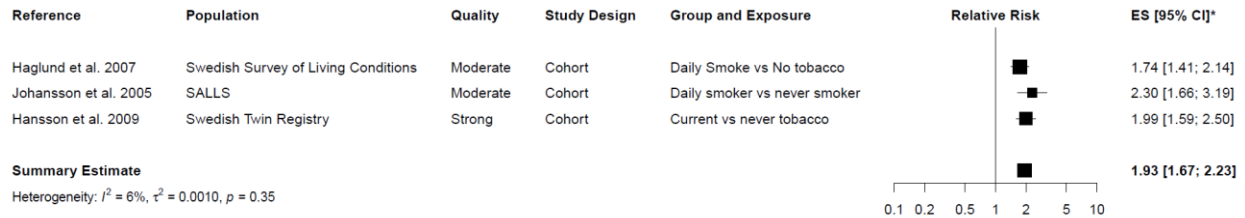


## Only cohort studies

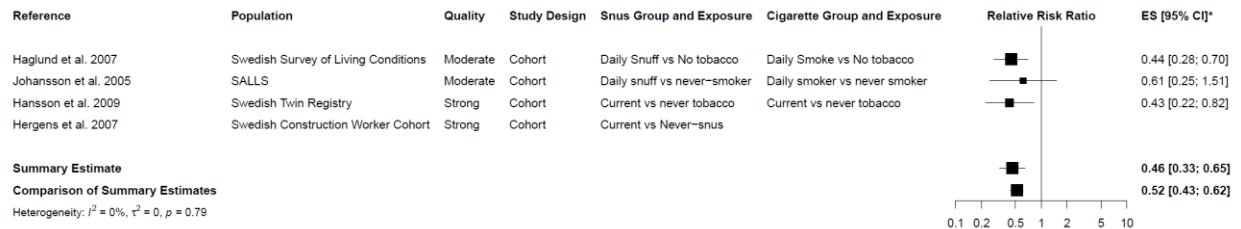
### IHD and MI Incidence in Snus users



## IHD and MI Incidence in Smokers

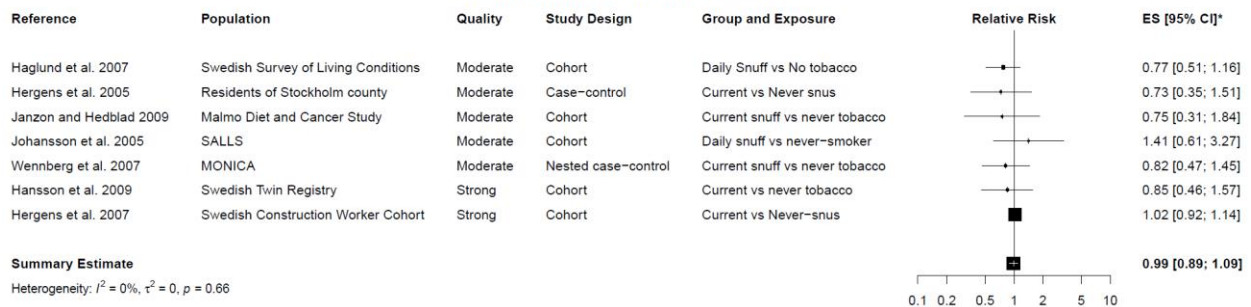


## IHD and MI Incidence in Snus users compared to Smokers

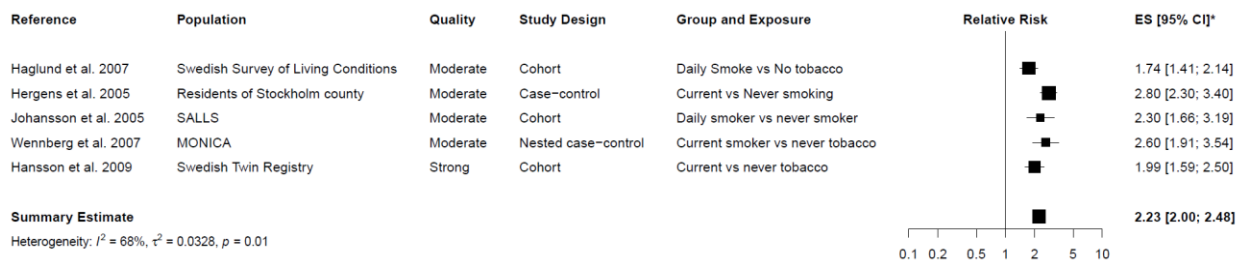


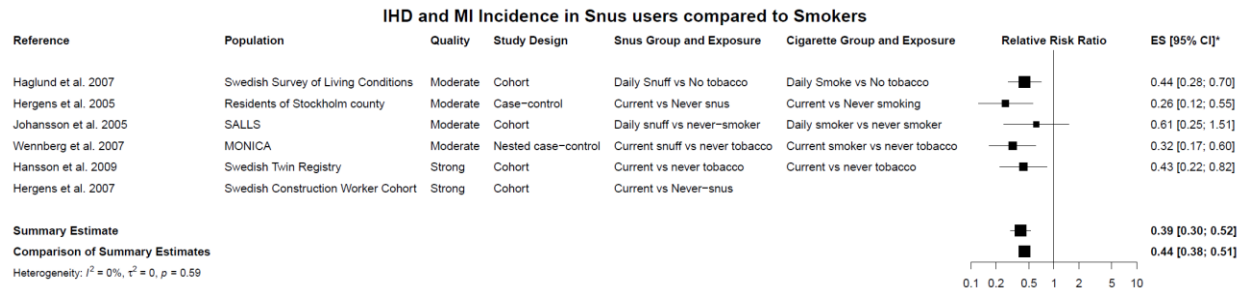
## Fixed-effects meta-analysis

### IHD and MI Incidence in Snus users

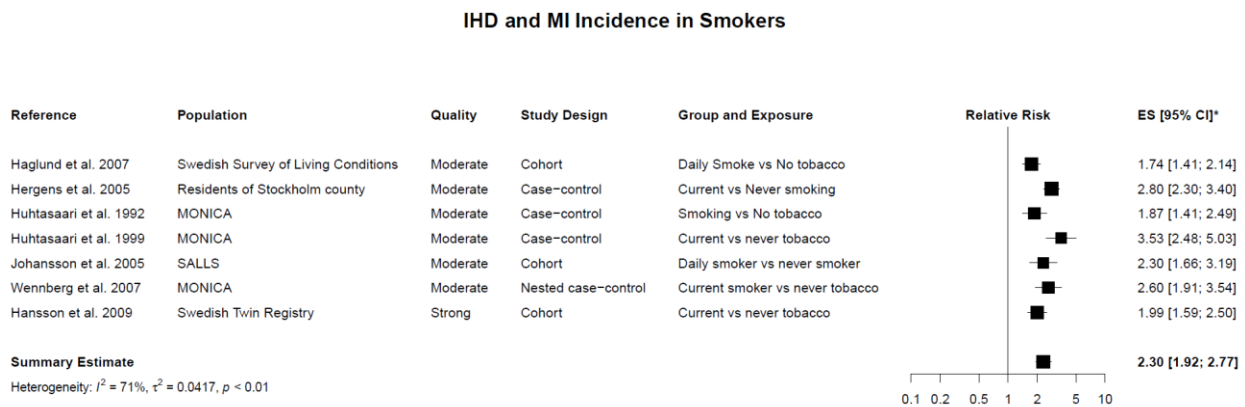
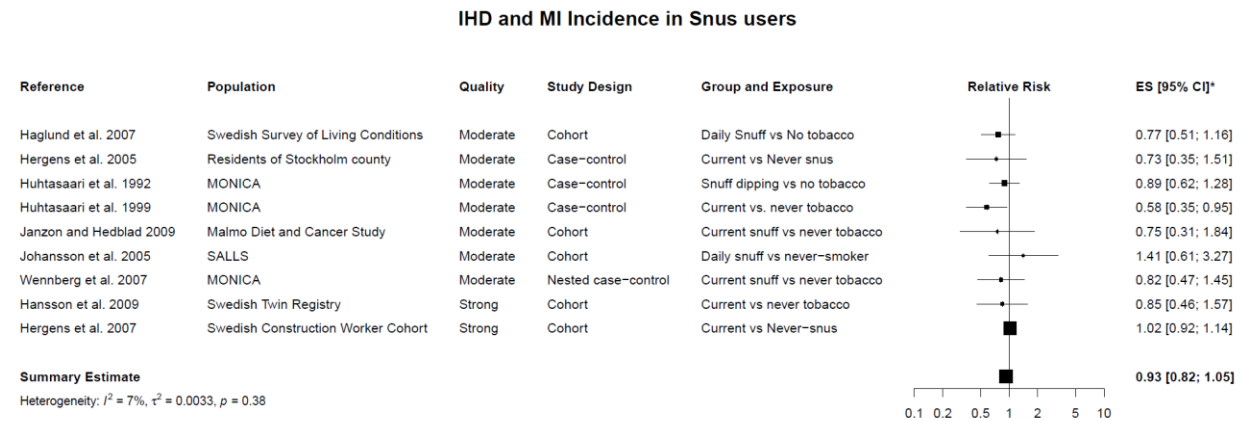


### IHD and MI Incidence in Smokers

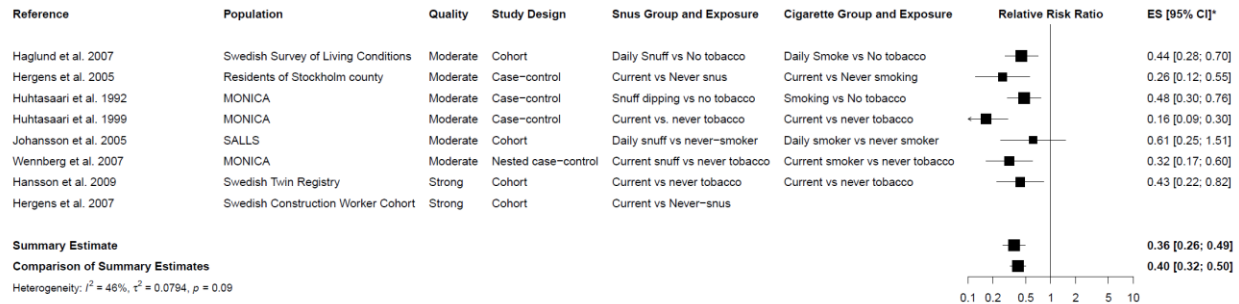




*Inclusion of all studies that look at IHD and MI Incidence*



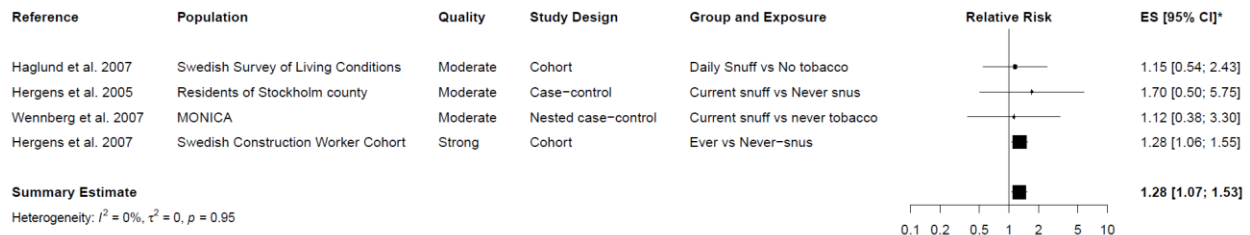
### IHD and MI Incidence in Snus users compared to Smokers



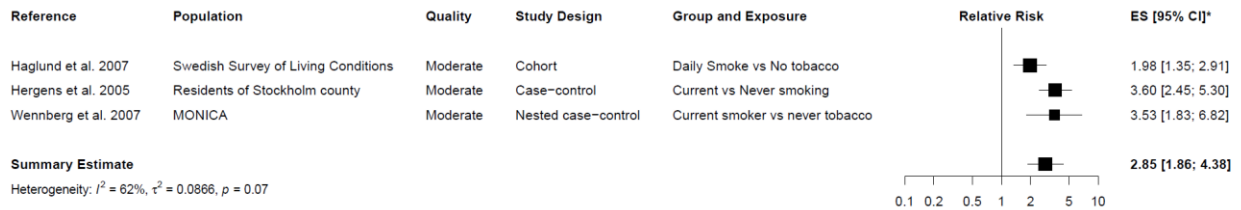
## IHD and MI Mortality:

*Preference for ever exposure when available*

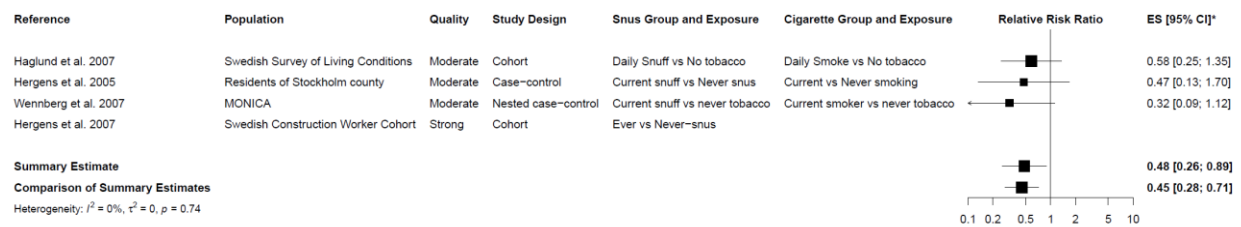
### IHD and MI Mortality in Snus users



### IHD and MI Mortality in Smokers

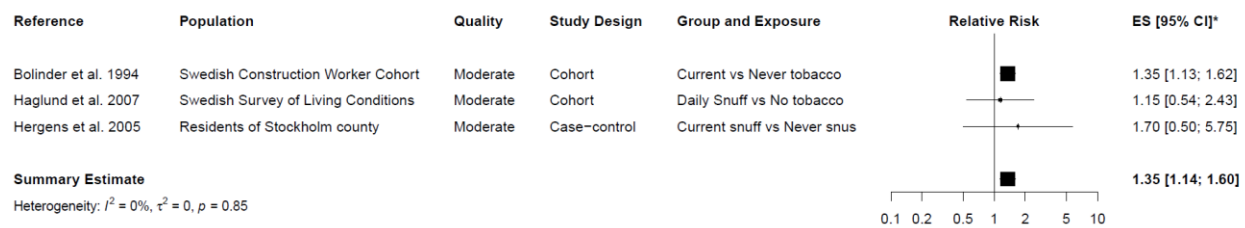


### IHD and MI Mortality in Snus users compared to Smokers

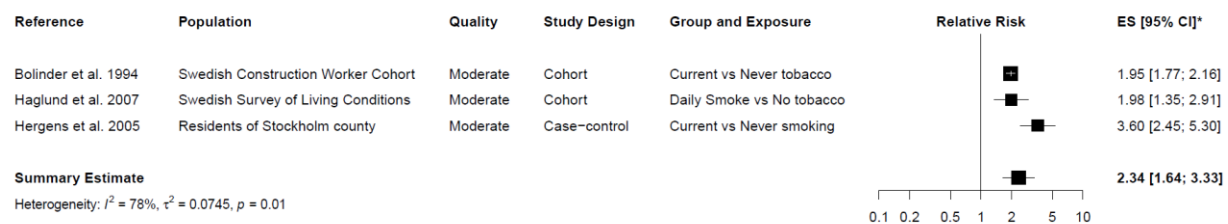


Exclusion of studies with different outcome ascertainment (Wennberg et al. 2007)

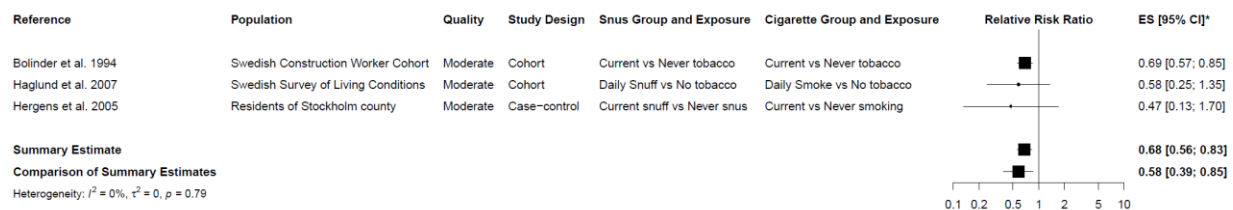
### IHD and MI Mortality in Snus users



### IHD and MI Mortality in Smokers

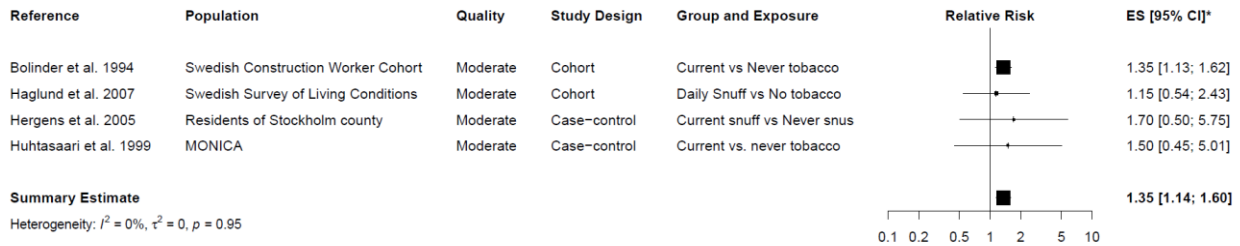


### IHD and MI Mortality in Snus users compared to Smokers

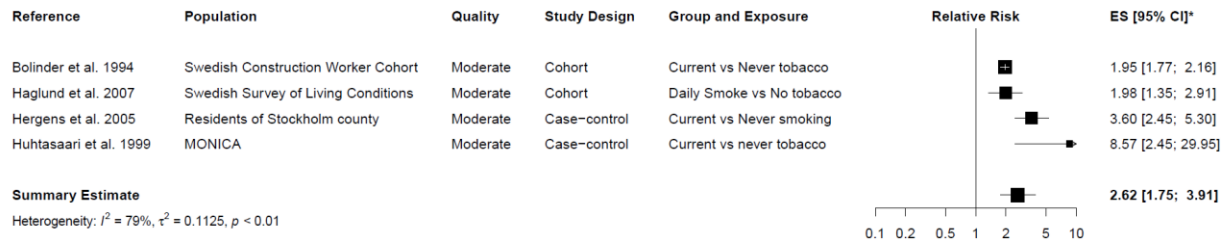


MONICA cohort 1991-1993 preferred (Huhtasaari et al. 1999)

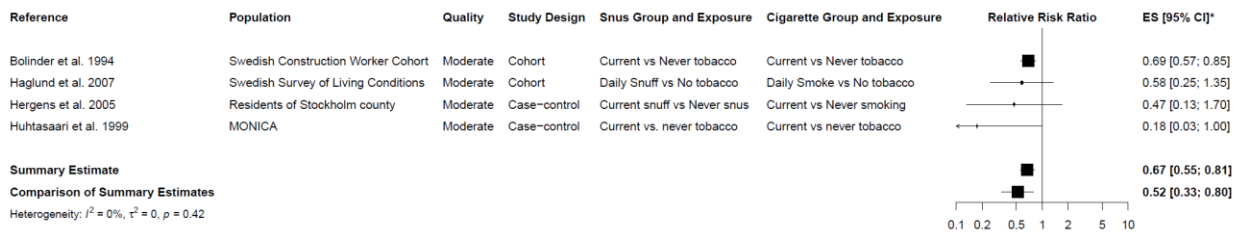
### IHD and MI Mortality in Snus users



### IHD and MI Mortality in Smokers

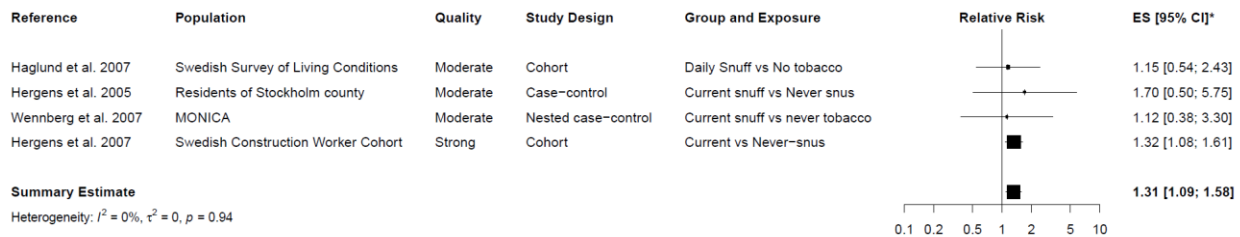


### IHD and MI Mortality in Snus users compared to Smokers



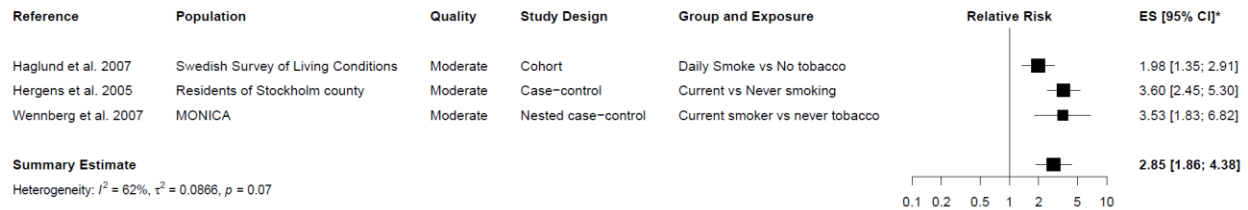
*Prefer latest update of Swedish construction worker cohort (Hergens et al. 2007)*

### IHD and MI Mortality in Snus users

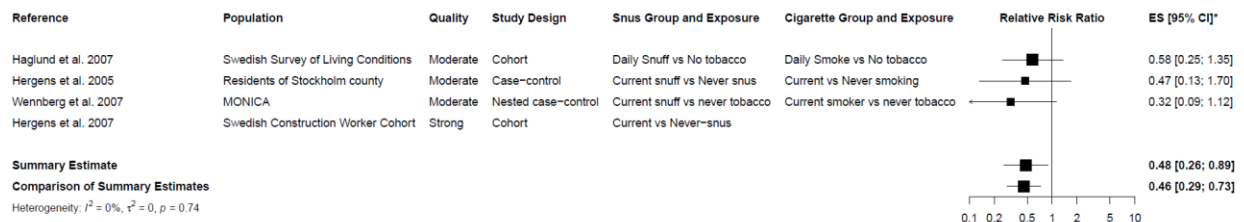




## IHD and MI Mortality in Smokers

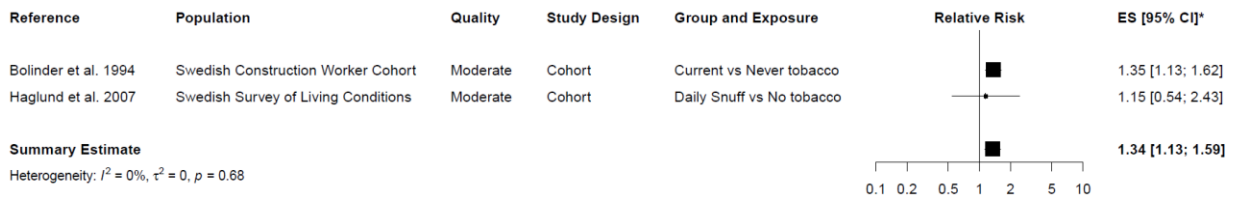


## IHD and MI Mortality in Snus users compared to Smokers

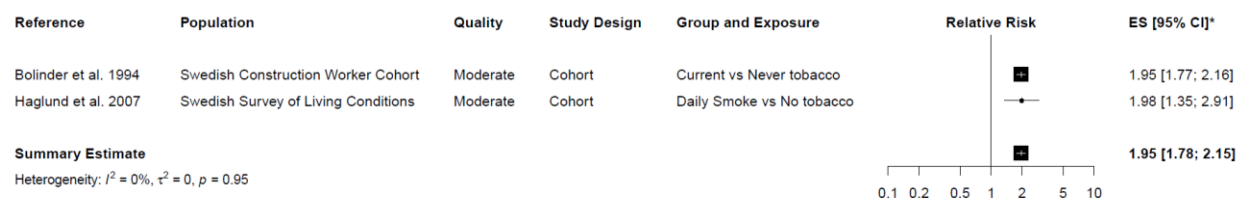


Only cohort studies

## IHD and MI Mortality in Snus users



## IHD and MI Mortality in Smokers



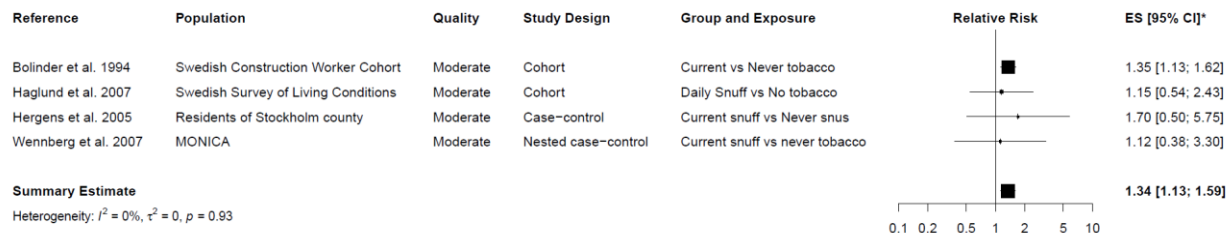
## IHD and MI Mortality in Snus users compared to Smokers



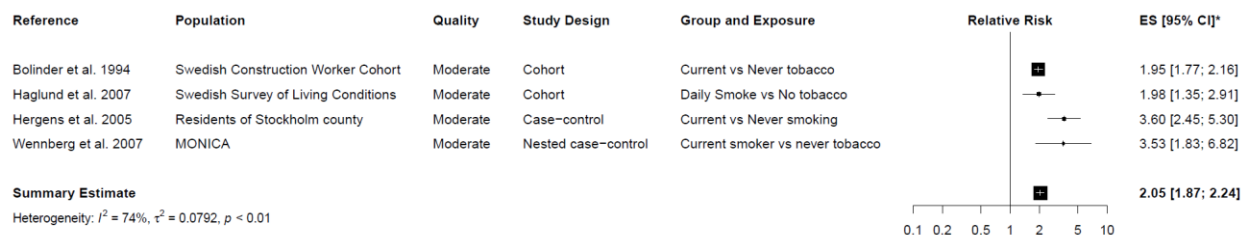


## Fixed-effects meta-analysis

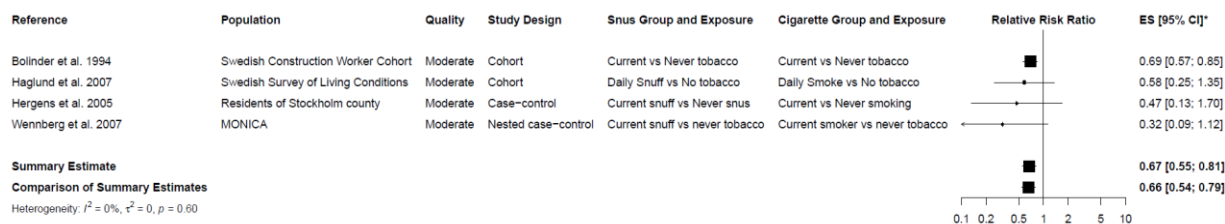
### IHD and MI Mortality in Snus users



### IHD and MI Mortality in Smokers

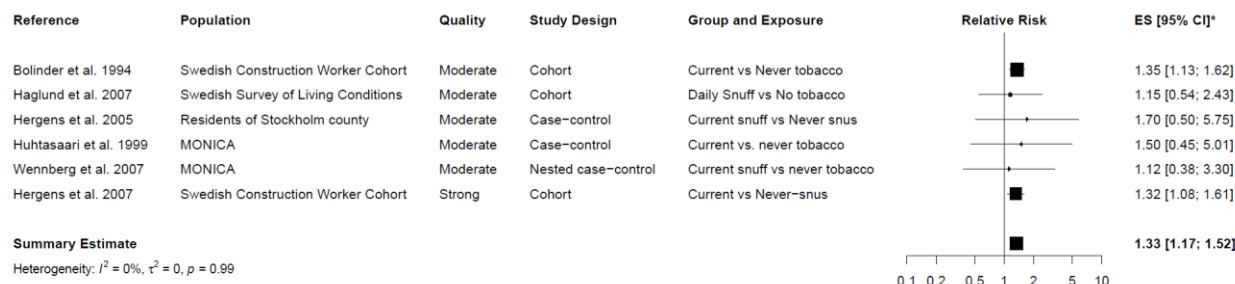


### IHD and MI Mortality in Snus users compared to Smokers

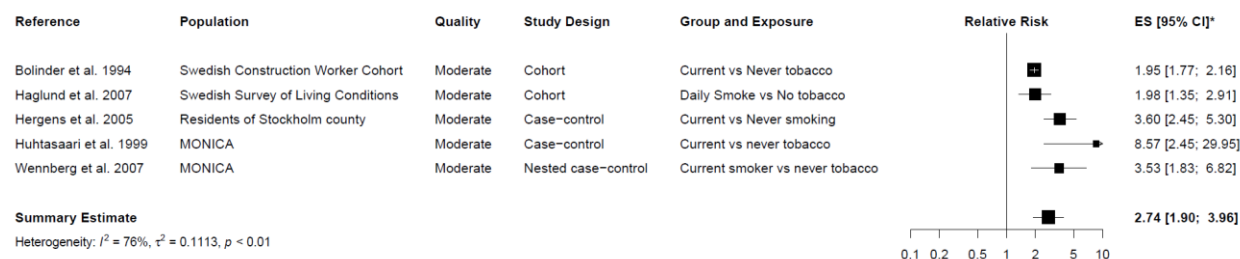


## Inclusion of all studies that look at IHD and MI Mortality

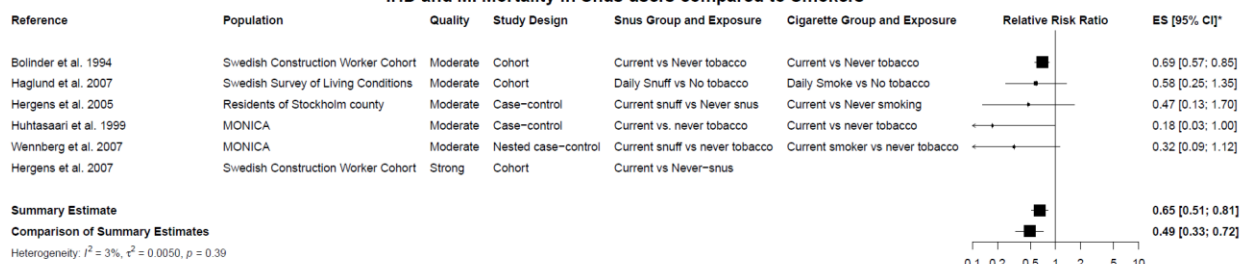
### IHD and MI Mortality in Snus users



## IHD and MI Mortality in Smokers



## IHD and MI Mortality in Snus users compared to Smokers

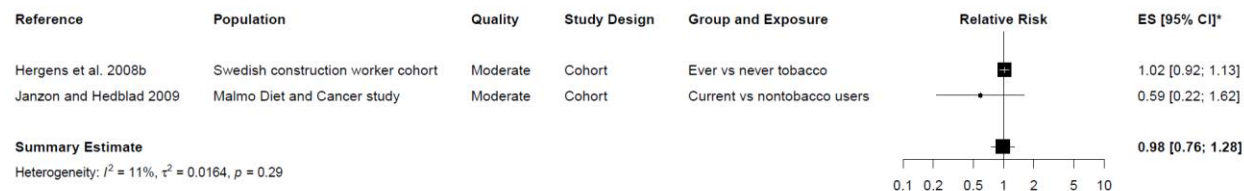


## Stroke Incidence

### Ischemic, Hemorrhagic, and Unspecified Incident stroke

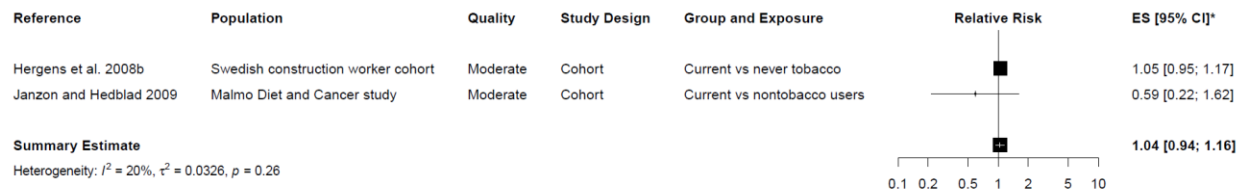
Preference for ever estimates in meta-analyses of ischemic, hemorrhagic and unspecified incident stroke using older estimates

## Stroke Incidence in Snus users



## Fixed-effects meta-analyses of ischemic, hemorrhagic and unspecified incident stroke using older estimates

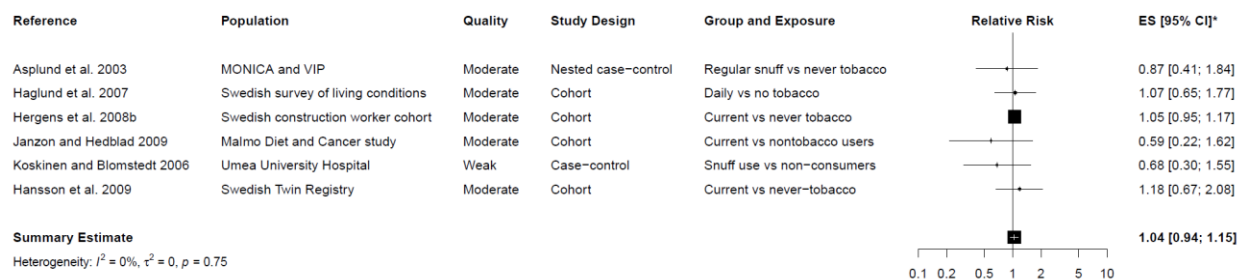
### Stroke Incidence in Snus users



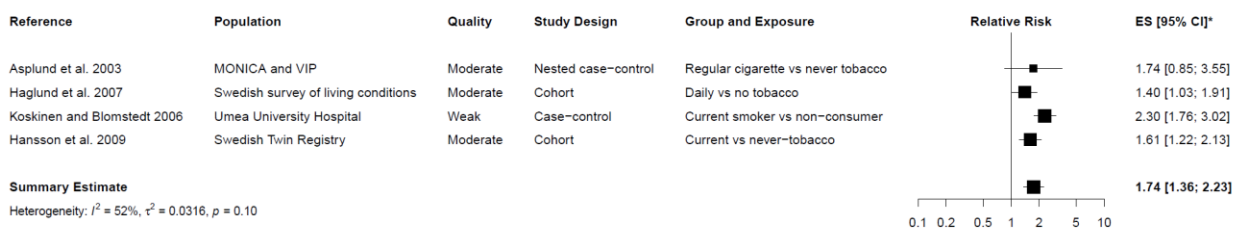
### Any stroke

Meta-analyses of any stroke using older estimates (i.e. all studies except Hansson et al. (2014))

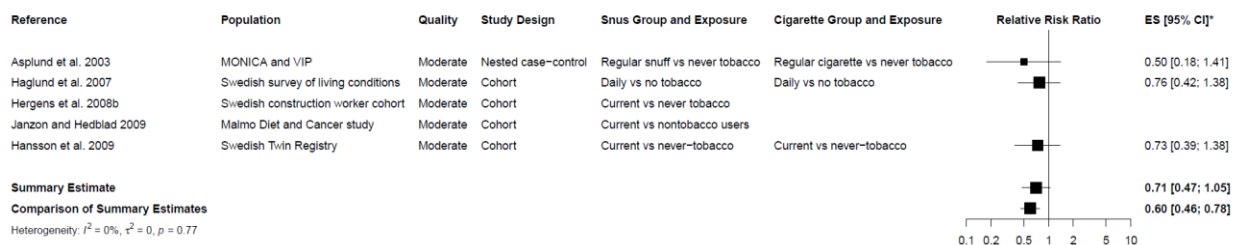
### Stroke Incidence in Snus users



### Stroke Incidence in Smokers

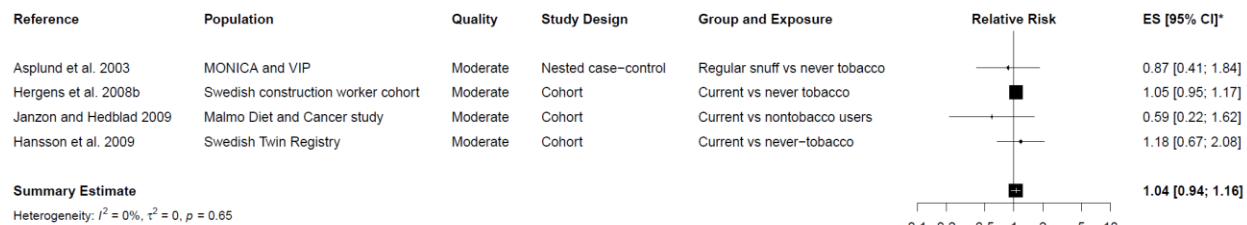


### Stroke Incidence in Snus users compared to Smokers

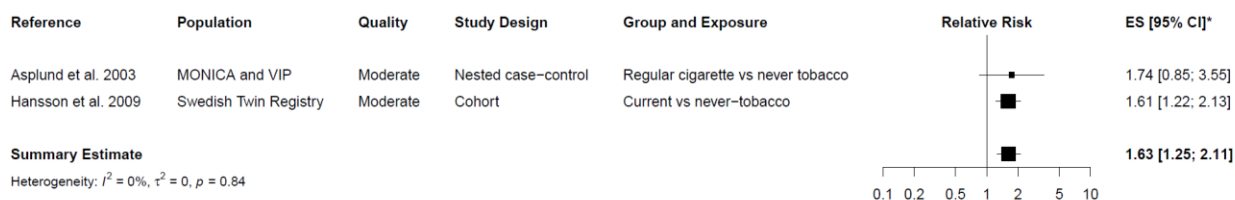


Meta-analyses of any stroke using older estimates only with slight variations in outcome specificity (Asplund et al. 2003; Hansson et al. 2009)

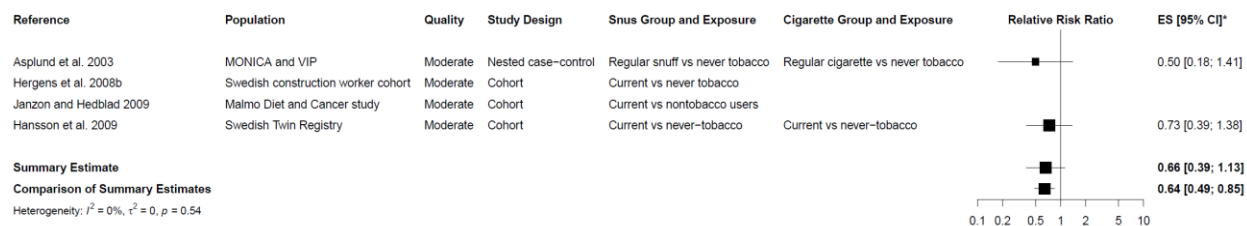
### Stroke Incidence in Snus users



### Stroke Incidence in Smokers

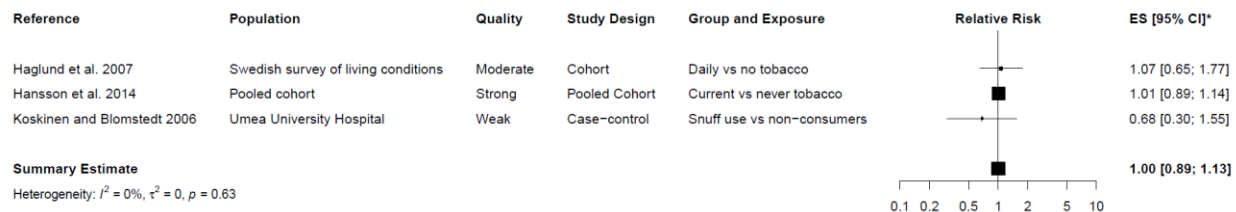


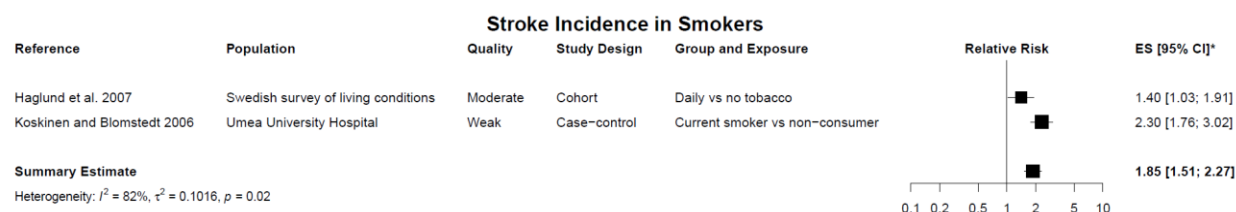
### Stroke Incidence in Snus users compared to Smokers



Fixed-effects meta-analyses of any stroke (Hansson et al. 2014; Haglund et al. 2007; Koskinen and Blomstedt 2006)

### Stroke Incidence in Snus users

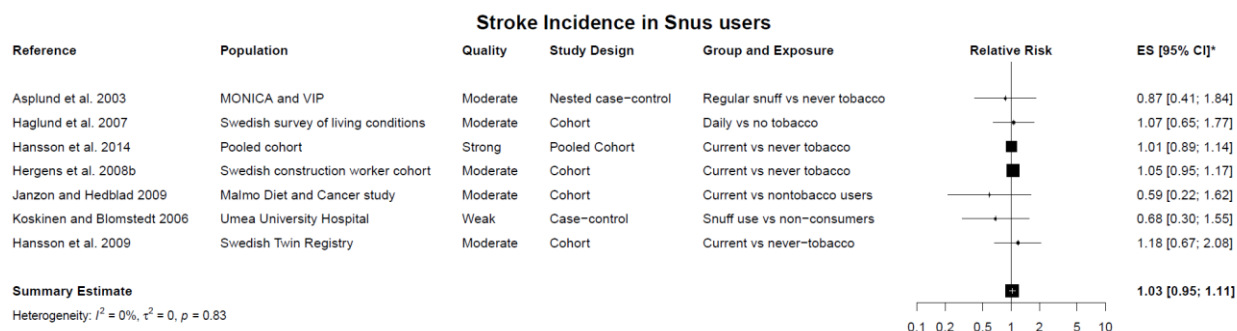




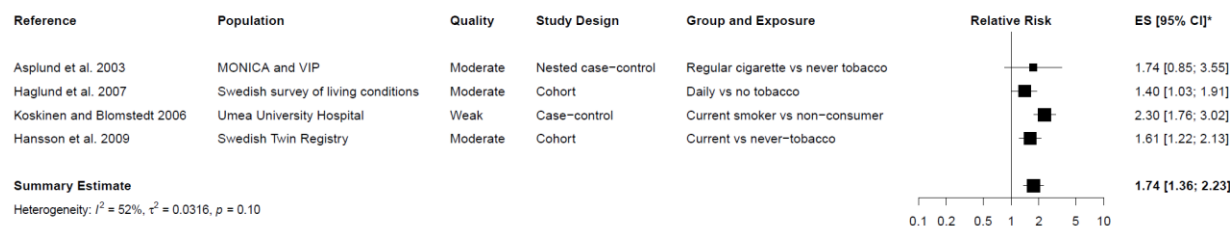
### Stroke incidence in Snus users compared to Smokers

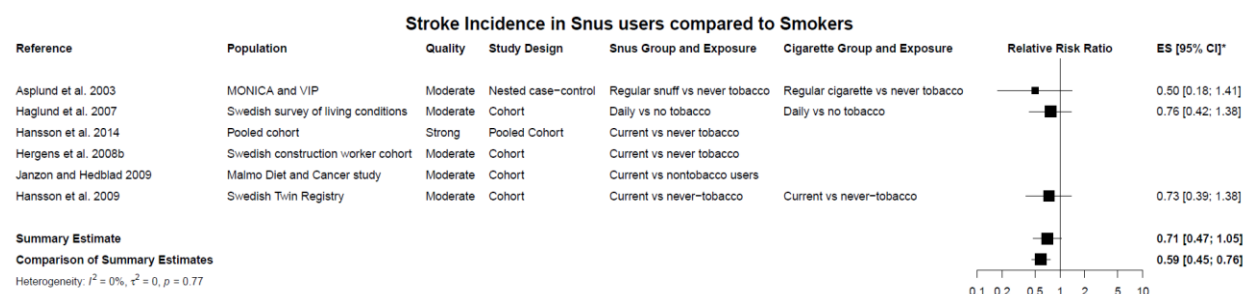


### All identified studies



### Stroke Incidence in Smokers



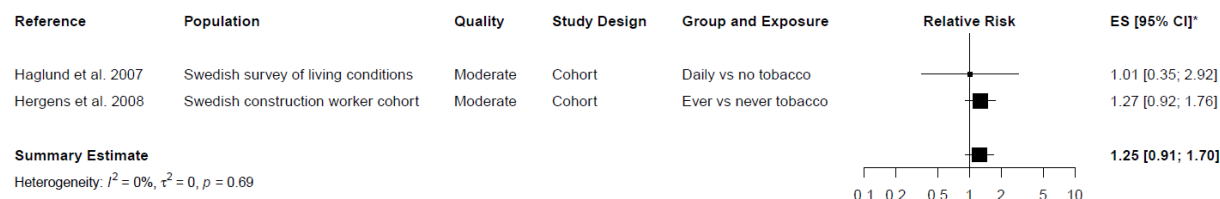


\*Koskinen and Blomstedt have non-exclusive exposure groups and consequently left out of risk comparison. Comparison of summary estimates confounded by presence of dual users

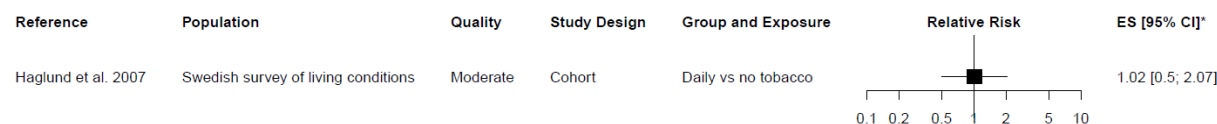
## Stroke Mortality

*Preference for ever estimates when available*

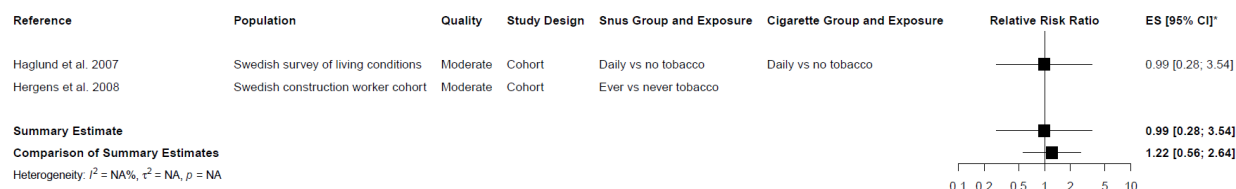
### Stroke Mortality in Snus users



### Stroke Mortality in Smokers

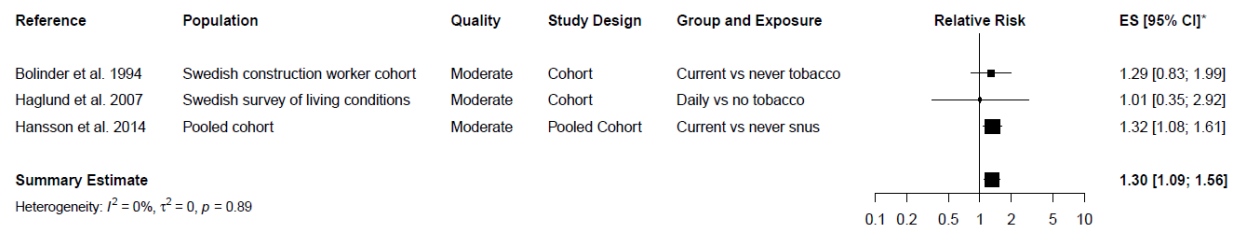


### Stroke Mortality in Snus users compared to Smokers

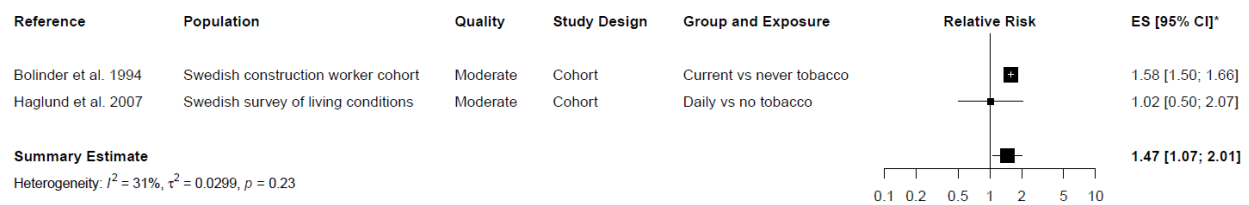


### Inclusion of Hansson et al. (2014)

#### Stroke Mortality in Snus users



#### Stroke Mortality in Smokers

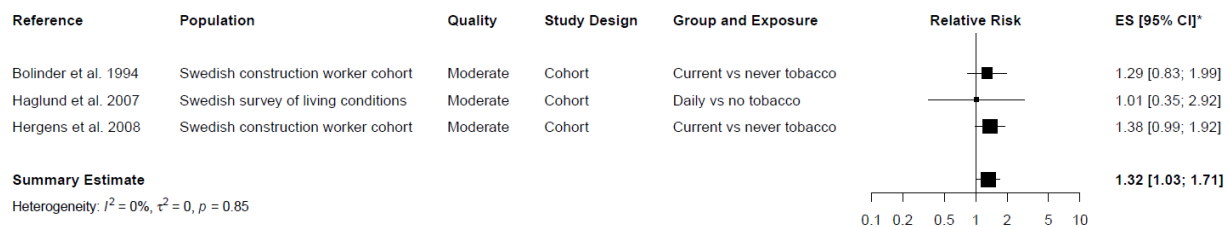


#### Stroke Mortality in Snus users compared to Smokers



### Inclusion of Hergens et al. (2008)

#### Stroke Mortality in Snus users



## Stroke Mortality in Smokers

Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Bolinder et al. 1994	Swedish construction worker cohort	Moderate	Cohort	Current vs never tobacco		1.58 [1.50; 1.66]
Haglund et al. 2007	Swedish survey of living conditions	Moderate	Cohort	Daily vs no tobacco		1.02 [0.50; 2.07]
<b>Summary Estimate</b>						1.47 [1.07; 2.01]
Heterogeneity: $I^2 = 31\%$ , $\tau^2 = 0.0299$ , $p = 0.23$						

## Stroke Mortality in Snus users compared to Smokers

Reference	Population	Quality	Study Design	Snus Group and Exposure	Cigarette Group and Exposure	Relative Risk Ratio	ES [95% CI]*
Bolinder et al. 1994	Swedish construction worker cohort	Moderate	Cohort	Current vs never tobacco	Current vs never tobacco		0.81 [0.53; 1.26]
Haglund et al. 2007	Swedish survey of living conditions	Moderate	Cohort	Daily vs no tobacco	Daily vs no tobacco		0.99 [0.28; 3.54]
Hergens et al. 2008	Swedish construction worker cohort	Moderate	Cohort	Current vs never tobacco			
<b>Summary Estimate</b>							0.83 [0.55; 1.26]
<b>Comparison of Summary Estimates</b>							0.90 [0.60; 1.36]
Heterogeneity: $I^2 = 0\%$ , $\tau^2 = 0$ , $p = 0.78$							

## Updated Swedish construction worker cohort

## Stroke Mortality in Snus users

Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Haglund et al. 2007	Swedish survey of living conditions	Moderate	Cohort	Daily vs no tobacco		1.01 [0.35; 2.92]
Hansson et al. 2014	Pooled cohort	Moderate	Pooled Cohort	Current vs never snus		1.32 [1.08; 1.61]
<b>Summary Estimate</b>						1.31 [1.07; 1.59]
Heterogeneity: $I^2 = 0\%$ , $\tau^2 = 0$ , $p = 0.63$						

## Stroke Mortality in Smokers

Reference	Population	Quality	Study Design	Group and Exposure	Relative Risk	ES [95% CI]*
Haglund et al. 2007	Swedish survey of living conditions	Moderate	Cohort	Daily vs no tobacco		1.02 [0.5; 2.07]

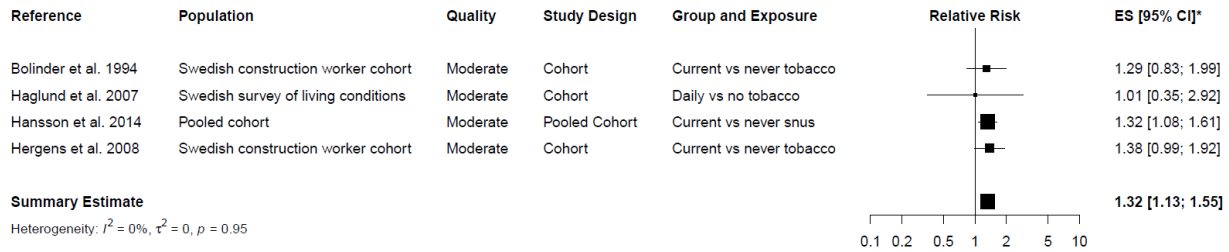
## Stroke Mortality in Snus users compared to Smokers

Reference	Population	Quality	Study Design	Snus Group and Exposure	Cigarette Group and Exposure	Relative Risk Ratio	ES [95% CI]*
Haglund et al. 2007	Swedish survey of living conditions	Moderate	Cohort	Daily vs no tobacco	Daily vs no tobacco		0.99 [0.28; 3.54]
Hansson et al. 2014	Pooled cohort	Moderate	Pooled Cohort	Current vs never snus			
<b>Summary Estimate</b>							0.99 [0.28; 3.54]
<b>Comparison of Summary Estimates</b>							1.28 [0.62; 2.67]
Heterogeneity: $I^2 = \text{NA}\%$ , $\tau^2 = \text{NA}$ , $p = \text{NA}$							

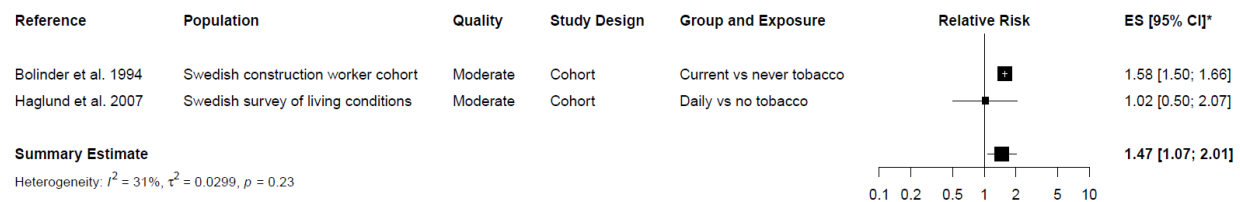


## All studies

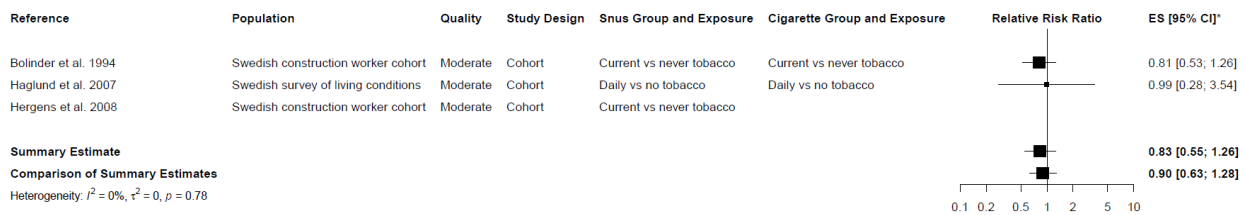
### Stroke Mortality in Snus users



### Stroke Mortality in Smokers

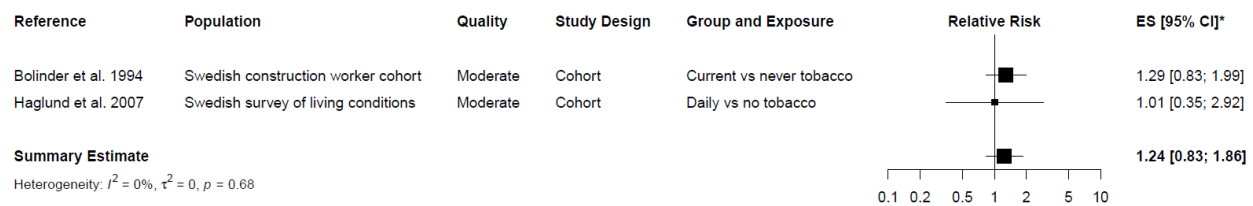


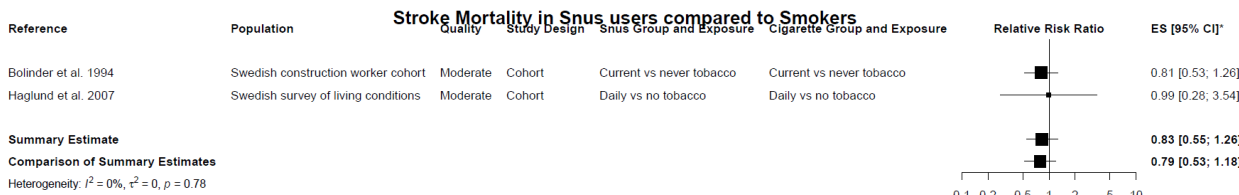
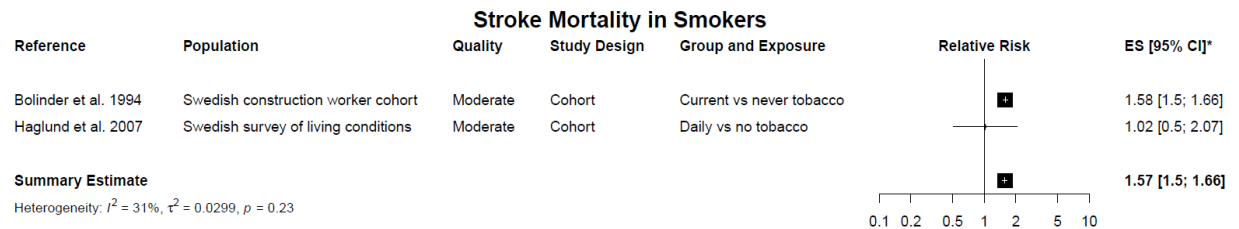
### Stroke Mortality in Snus users compared to Smokers



## Fixed-effects meta-analysis

### Stroke Mortality in Snus users

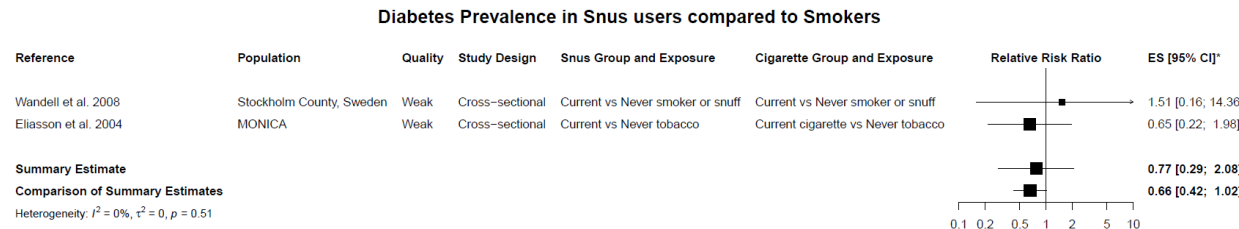
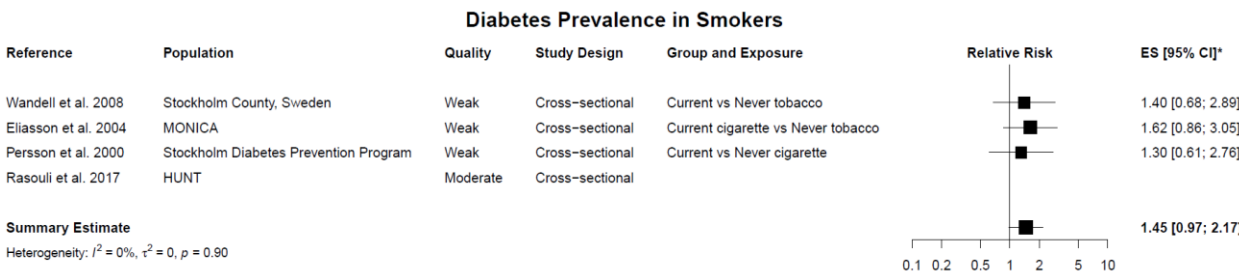
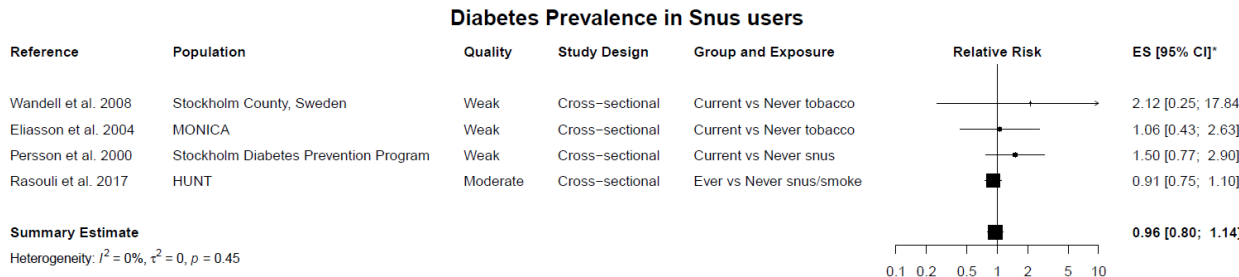




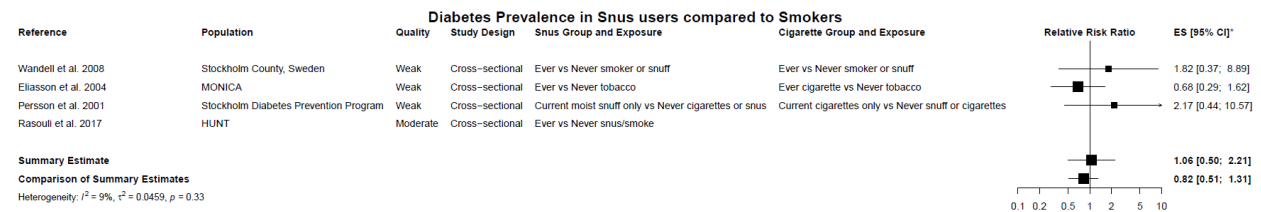
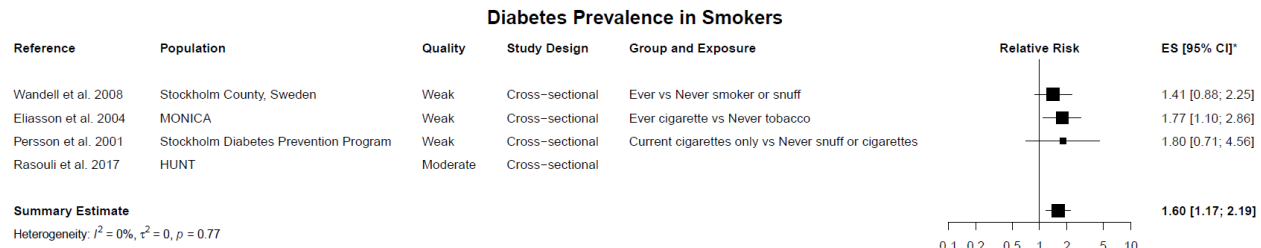
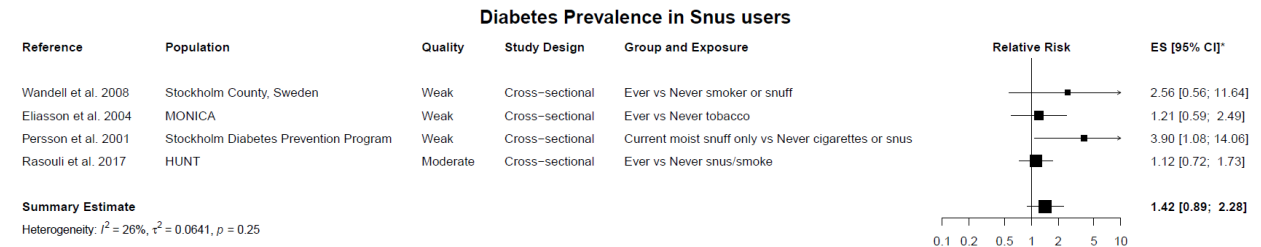
# Metabolic Effects

## Diabetes Prevalence

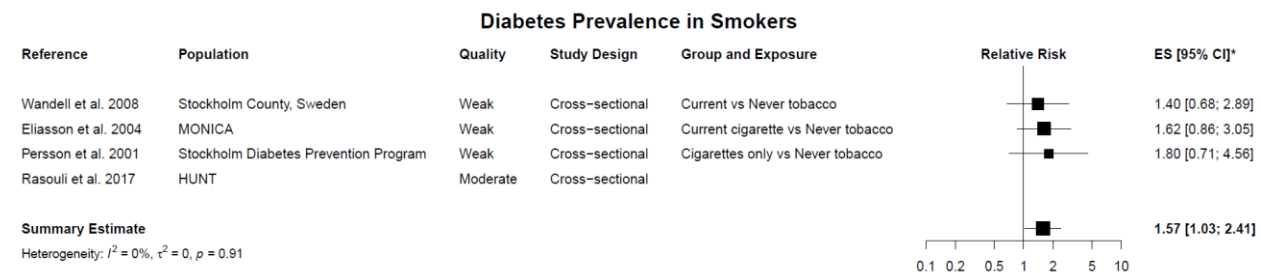
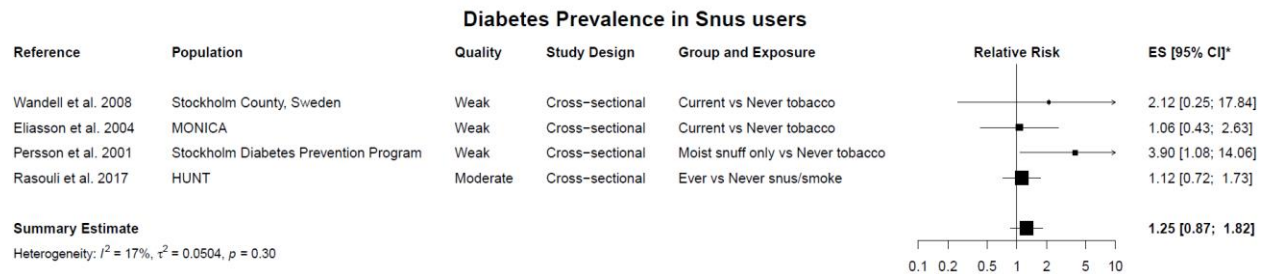
Preference for adjusted estimates when available



## Preference for ever exposure when available

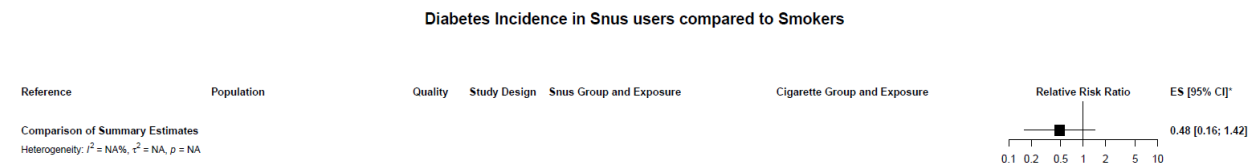
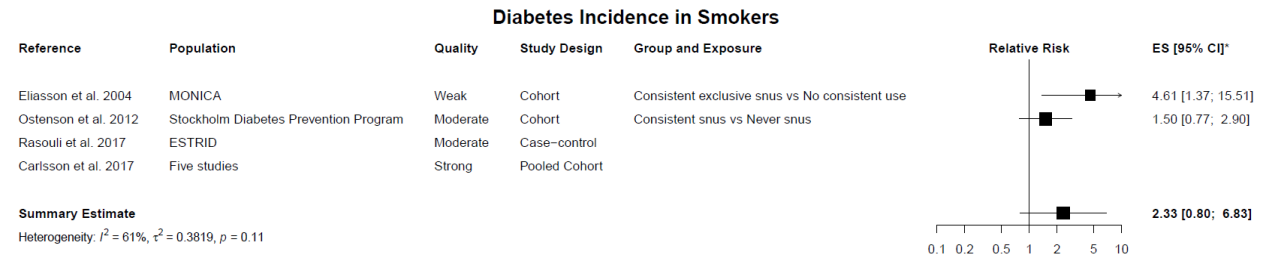
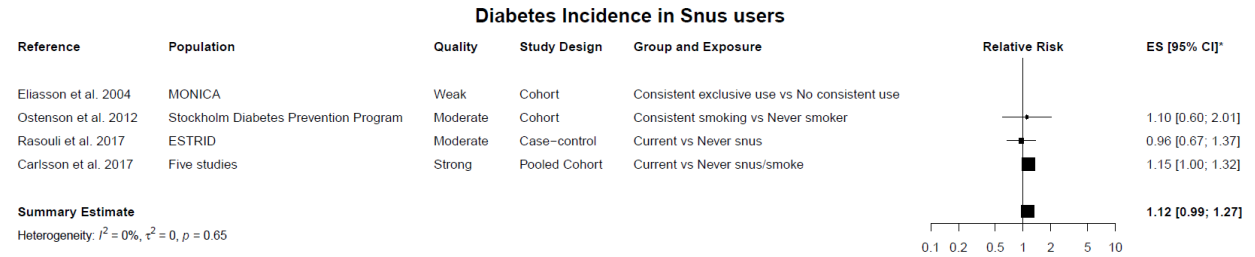


## Fixed-effect meta-analyses

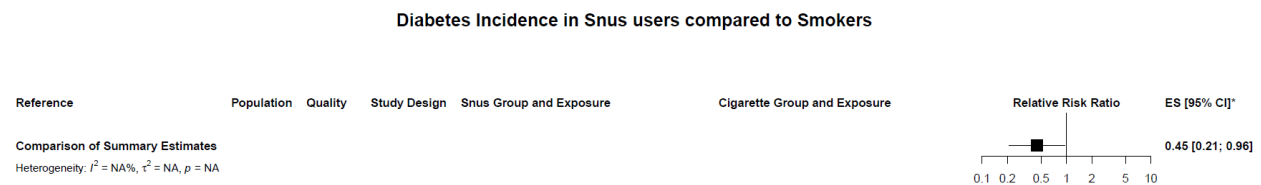
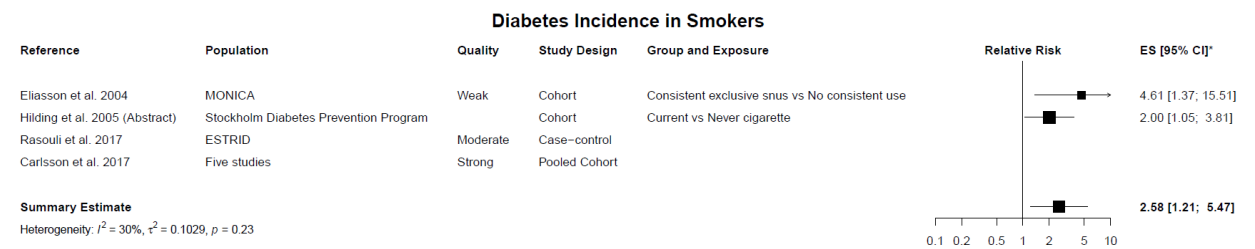
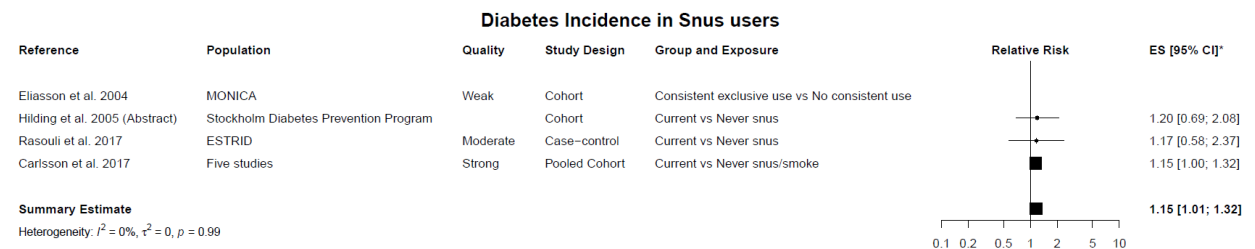


## Diabetes Incidence

Preference for adjusted estimates when available

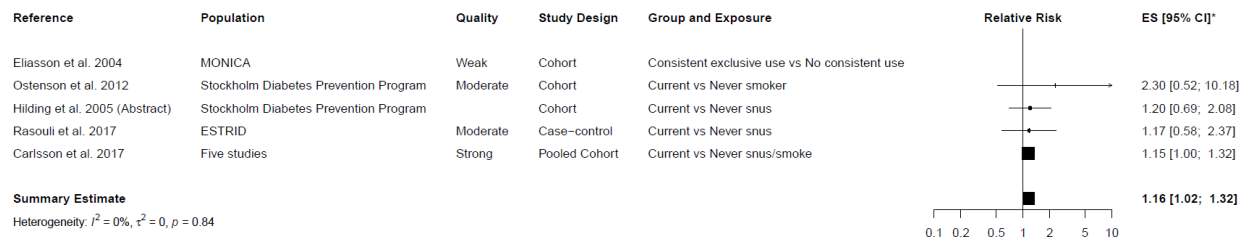


Inclusion of Hilding et al. (2005) instead of Ostenon et al. (2012)<sup>c</sup>

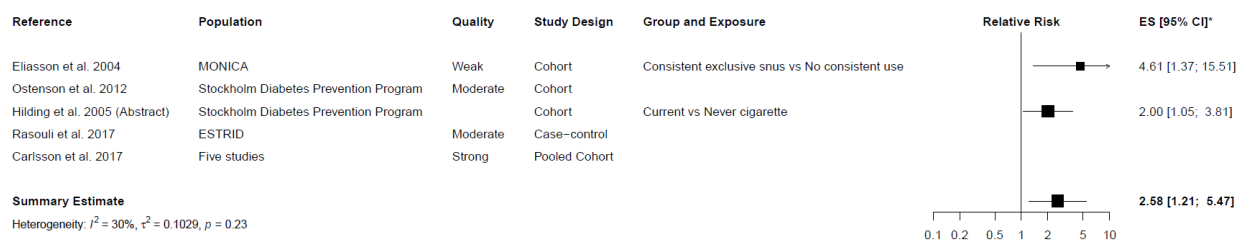


All studies (except Byhamre et al. 2017, which could not be combined)

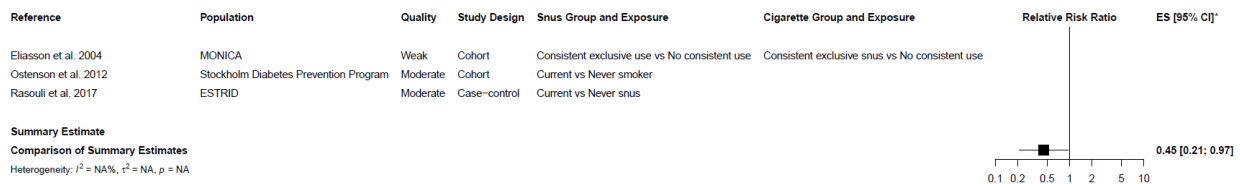
### Diabetes Incidence in Snus users



### Diabetes Incidence in Smokers

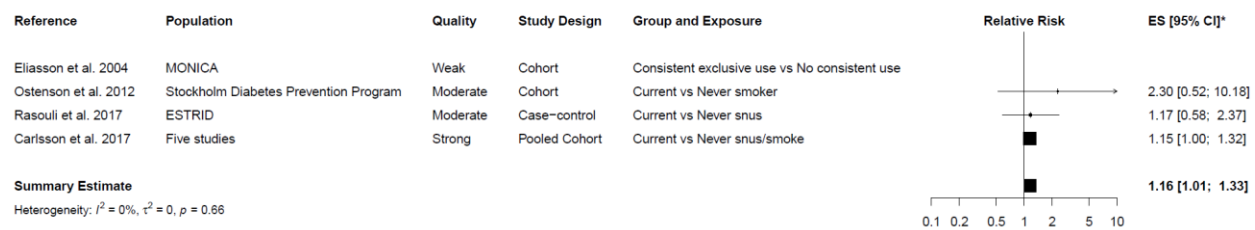


### Diabetes Incidence in Snus users compared to Smokers

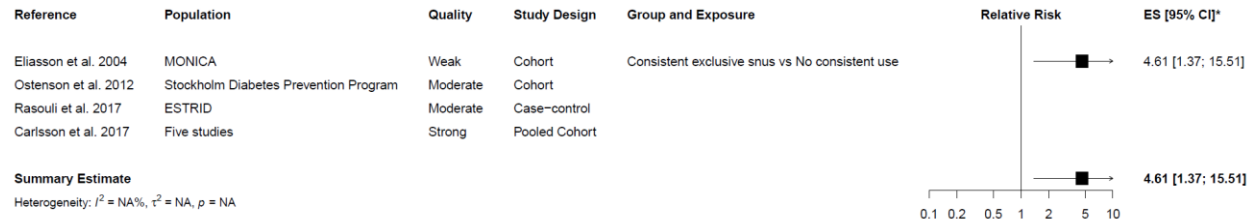


## Fixed Effects

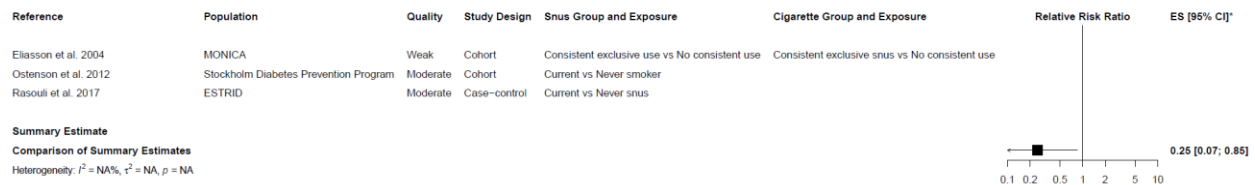
### Diabetes Incidence in Snus users



## Diabetes Incidence in Smokers



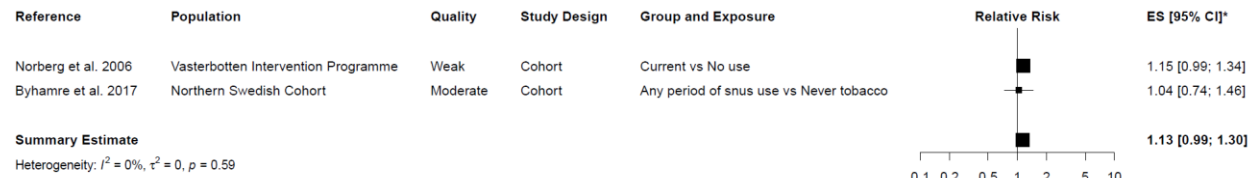
## Diabetes Incidence in Snus users compared to Smokers



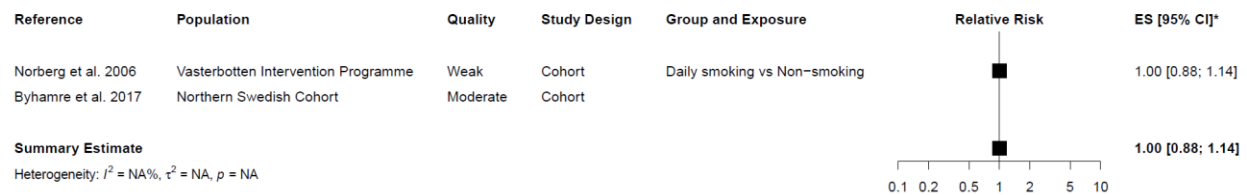
## Metabolic Syndrome Incidence

Alternative effect measure for Northern Swedish cohort (Replace estimate from Gustafsson et al. 2011 with Byhamre et al. 2017)

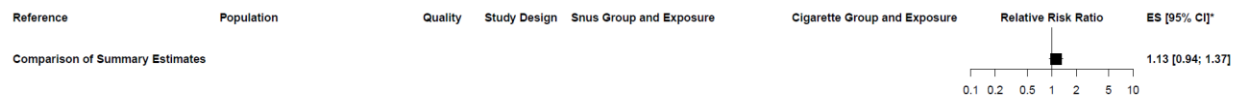
## Metabolic Syndrome Incidence in Snus users



## Metabolic Syndrome Incidence in Smokers

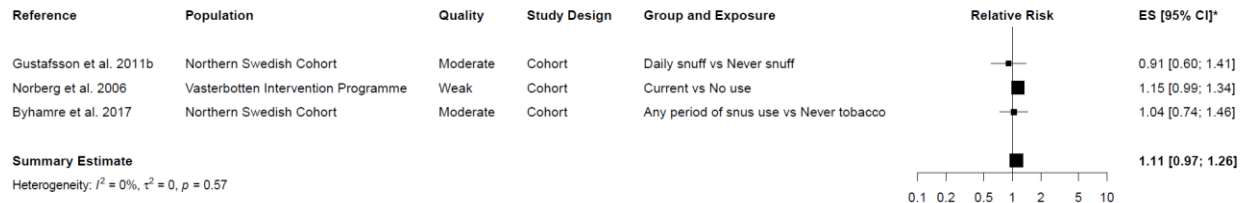


## Metabolic Syndrome Incidence in Snus users compared to Smokers

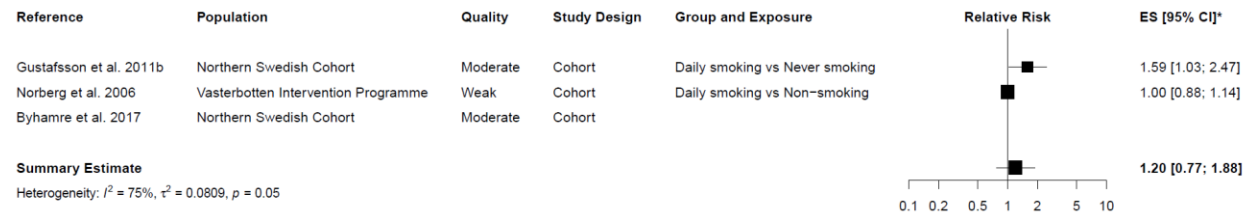


All studies: Inclusion of Byhamre et al. (2017)

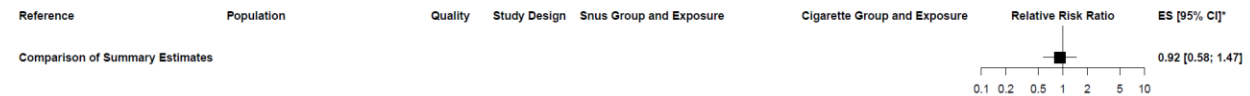
### Metabolic Syndrome Incidence in Snus users



### Metabolic Syndrome Incidence in Smokers

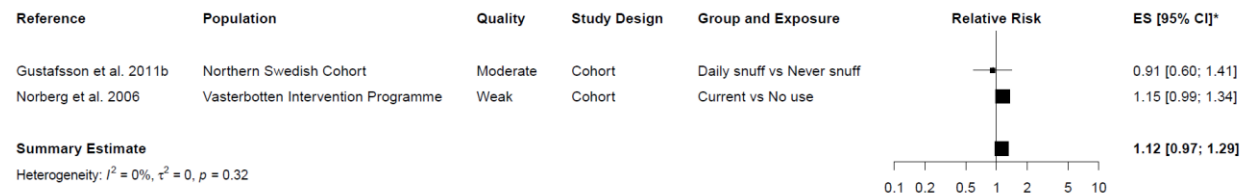


### Metabolic Syndrome Incidence in Snus users compared to Smokers

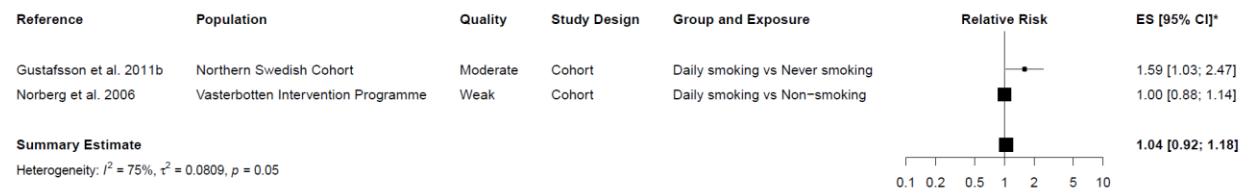


## Fixed-effect meta-analyses

### Metabolic Syndrome Incidence in Snus users



### Metabolic Syndrome Incidence in Smokers



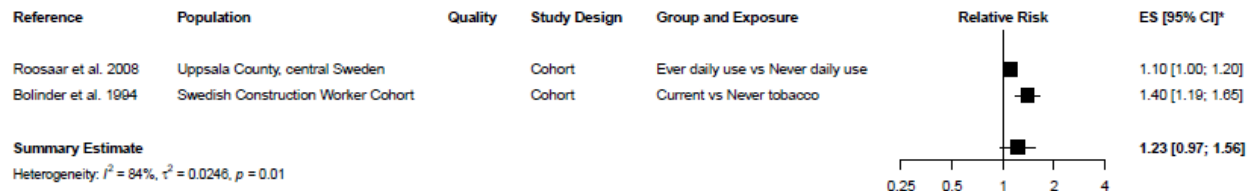
### Metabolic Syndrome Incidence in Snus users compared to Smokers



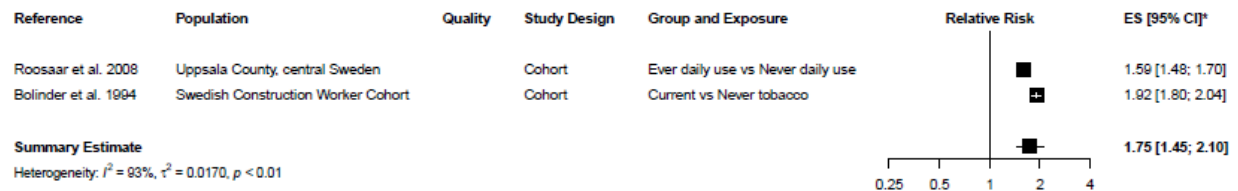
## All-cause mortality

Preference for adjusted estimates when available

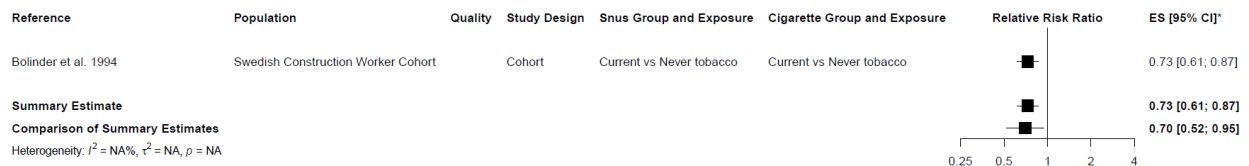
### All-cause Mortality in Snus users



### All-cause Mortality in Cigarette Users

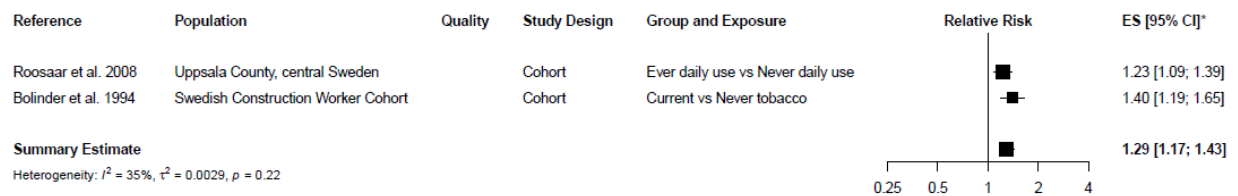


### All-cause Mortality in Snus users compared to Cigarette Users



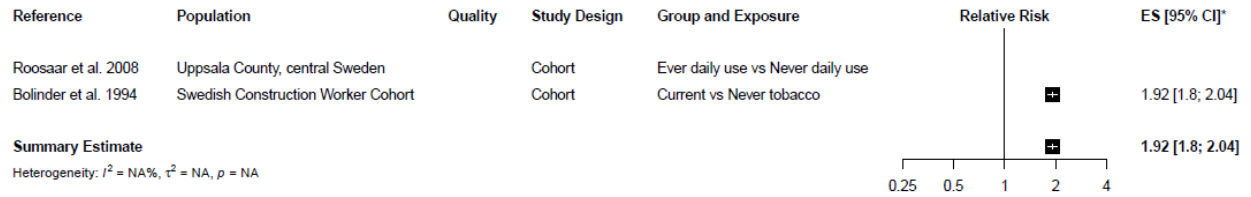
## Fixed-effect meta-analysis

### All-cause Mortality in Snus users





### All-cause Mortality in Cigarette Users



### All-cause Mortality in Snus users compared to Cigarette Users

