Appendix

Supplementary methods

Dietary data sampling

The modified diet history method of the MDC is a validated (1) dietary assessment method more thoroughly described elsewhere (2). The method consist of a combination of a 7-day food record, an extensive diet history questionnaire combined with an interview. During seven consecutive days, participants recorded cooks meals, cold beverages, drugs, natural remedies and dietary supplements. The diet history questionnaire was design to examine the general meal pattern, frequency and portion size of food consumed regularly. In the interview, the 7- day food record and the questionnaire were checked for overlap. The dietary data was converted into energy and nutrient intake using the MDC-nutrient database, which contains information mostly from the PC-KOST2- 93 from the National Food Agency in Sweden. Energy-adjusted intakes of food groups were calculated by regressing the intakes to the total non-alcohol energy intake. The alcohol intake was estimated using the 7-menu book.

Endpoint definition

Endpoints were retrieved by linking the ten digit Swedish personal identification number with three registers: the Swedish Hospital Discharge Register, the Swedish Cause of Death Register, and the Swedish Coronary Angiography and Angioplasty Registry (SCAAR) (3) (4). These registers have been previously described and validated for classifications of outcomes (4). CAD was defined as coronary artery revascularization, fatal or non-fatal myocardial infarction, or death due to ischemic heart disease.

Myocardial infarction was defined on the basis of the International Classification of Diseases (ICD) 9 code 410 or ICD-10 code I21. Death attributable to ischemic heart disease was defined as ICD-9 codes 412 and 414, or ICD-10 codes I22, I23, or I25. Coronary artery bypass surgery was identified from the national Swedish classification systems of surgical procedures and defined as procedure codes 3065, 3066, 3068, 3080, 3092, 3105, 3127, or 3158 in the Op6 system; or as procedure code FN in the KKÅ97 system. Percutaneous coronary intervention was identified from SCAAR (3). Fatal and non-fatal stroke was defined using codes 430, 431, 434 and 436 (ICD9) and I60, I61, I63, and I64 (ICD10). Cardiovascular mortality was defined as primary cause of death classified as ICD-9 codes 390 – 459 and ICD-10 codes I00 – I99.

Incident diabetes cases were retrieved from six different national and regional diabetes registers as described elsewhere (5). Prevalent diabetes mellitus at baseline was defined as a fasting whole blood glucose ≥ 6.1 mmol/L (corresponding to a plasma glucose of ≥ 7.0 mmol/L) or a history of physician diagnosis of diabetes mellitus or being on antidiabetic medication or having been registered in any of the six different national and regional diabetes registers.

Metabolite measurement

Profiling of plasma metabolites was performed using LC-MS using a UPLC-QTOF-MS System (Agilent Technologies 1290 LC, 6550 MS, Santa Clara, CA, USA) and has been described elsewhere (6).

Briefly, over-night fasted citrate venous plasma samples stored at -80 °C were thawed and extracted by addition of 120 μ l extraction solution (80:20 methanol/water) to 20 μ l plasma. The samples were then incubated at 4 °C for 1 hour at 1250 rpm. After 15 min centrifugation at 14 000g, 100 μ l supernatant was transferred into a glass vial for analysis. Extracted samples were separated on an Acquity UPLC BEH Amide column (1.7 μ m, 2.1 \ast 100mm; Waters Corporation, Milford, MA, USA).

Metabolites were identified by matching the measured mass-over charge ratio (m/z) and chromatographic retention times with an in-house metabolite library (eTable 1). Metabolite peak areas were integrated using Agilent Profinder B.06.00 (Agilent Technologies, Santa Clara, CA, USA).

Samples were analyzed in batches if 180 samples, where quality control samples were injected in the beginning and after every eight analytical samples in order to ensure high analytical repeatability. All metabolites were normalized to standard curves calculated from the quality control samples. Briefly, a low-order nonlinear locally estimated smoothing function was fitted to the signals from each metabolite in the quality control samples as a function of the injection order. Using this function, correction curves for each metabolites' analytical samples were interpolated, to which the metabolite measurements in the analytical samples were normalized (7).

Coefficients of variation (CV) were calculated using all quality control samples, and features with a CV over 20 % were excluded (bilirubin, methionine-S-oxide, sarcosine and uracil). The technical Intraclass Correlation Coefficients (ICC) were calculated as described by Sampson et al. (8) $\text{ICC} = 1 - \frac{1}{2}$ total variance
total variance

The average CV was 8.9 % and the average ICC 95.4%.

Supplementary figure 1: Metabolites correlations with food groups

Pearson correlation coefficients between circulating levels of the health conscious dietary biomarkers and dietary intake groups. Nonsignificant correlation P > 0.05 are colored as grey. Food groups are adjusted for total energy intake. N= 3236. SSB: Sugar sweetened beverages.

Supplementary figure 2: Kaplan Meier – Acetylornithine and endpoints

Supplementary figure 3: Kaplan Meier – Ergothioneine and endpoints
Coronary Artery Disease
Cardiovascular Mortality

Supplementary figure 5: Kaplan Meier – Pantothenic acid and endpoints
Coronary Artery Disease
Cardiovascular Mortality

Supplementary figure 6: Kaplan Meier – Proline betaine and endpoints

Supplementary figure 7: Kaplan Meier – Urobilin and endpoints
Coronary Artery Disease
Cardiovascular Mortality

Supplementary figure 2-6: The Kaplan-Meier plots show cumulative percentage of individuals free from events during follow up according to the quartiles of metabolite at baseline examination, 1 being the lowest quartile and 4 the highest. P values displayed were calculated using log rank test for trend. $N = 3236$.

Supplementary table 1: In-house metabolite library

Supplementary table 1: In-house metabolite library

Supplementary table 1: In-house metabolite library

The in-house metabolite library used when measuring metabolites with the liquid chromatography and mass spectrometry (LC-MS). M/Z: mass to charge ratio. CV: Coefficient of variation. ICC: Intraclass Correlation Coefficient RT: Retention time in minutes.

Supplementary table 2: Linear regressions between the health conscious dietary pattern and metabolites

Supplementary table 2: Linear regressions between the health conscious dietary pattern and metabolites

Supplementary table 2: Linear regressions between the health conscious dietary pattern and metabolites

Linear regression models between the HCFP and fasting metabolite levels, adjusted for age, sex, BMI, fasting glucose, fasting LDL cholesterol, fasting HDL cholesterol, fasting triglycerides, systolic blood pressure, anti-hypertensive treatment, season for dietary sampling, alcohol intake and smoking status. Beta represents a quintile increase or decrease in the five quintile scaled HCFP per SD increment of a metabolite with the 95 % confidence interval in paranthesis. The cut-off for significance $(P = 0.00044)$ was calculated using Bonferroni correction. N=2515.

Supplementary table 3: Sensitivity analysis physical activity in adjusted linear regressions

Linear regression models between the health conscious food pattern (HCFP) and circulating metabolite levels. Beta represents a quintile increase or decrease in the five quintile scaled HCFP per SD increment of a metabolite with the 95 % confidence interval in parenthesis.

Model 1: adjusted for age, sex, BMI, fasting glucose, fasting LDL cholesterol, fasting HDL cholesterol, fasting triglycerides, systolic blood pressure, anti-hypertensive treatment, season for dietary sampling, alcohol intake and smoking status.

Model 2: adjusted for all of the covariates in model 1 as well as physical activity

N= 2323 after exclusion of participants with incomplete data on physical activity.

Supplementary table 4: Fully adjusted cox regressions

Cox proportional hazard models comparing the health conscious dietary biomarker levels with risk for overall and cardiovascular mortality as well as for incident stroke, diabetes mellitus and coronary artery disease during the median follow time of 21.4 years. The models were adjusted for age, sex, BMI, fasting glucose, fasting LDL cholesterol, fasting HDL cholesterol, fasting triglycerides, systolic blood pressure, anti-hypertensive treatment, alcohol intake and smoking status. The hazard ratio is calculated as the increase or decrease in risk per one standard deviation increment of metabolite levels with 95% confidence interval. The proportional hazard was tested using the schoenfeld residual test. $N = 3236$.

CAD: Coronary heart disease, CVD-mortality: Cardiovascular mortality, T2DM – Type II diabetes mellitus, PH: proportional hazard

Supplementary table 5: Sensitivity analysis physical activity in adjusted cox regressions

Cox regression models created using metabolite levels as the independent variable and the endpoint as the independent. The continuous hazard ratio (HR) is expressed per one standard deviation increment of metabolite with the 95 % Confidence interval in parenthesis

Model 1: adjusted for age, sex, BMI, fasting glucose, fasting LDL cholesterol, fasting HDL cholesterol, fasting triglycerides, systolic blood pressure, anti-hypertensive treatment, season for dietary sampling, alcohol intake and smoking status.

Model 2: adjusted for all of the covariates in model 1 as well as physical activity.

N= 2993 after exclusion of participants with incomplete data on physical activity.

Supplementary table 6: Associations between risk factors and quartiles of ergothioneine

Values are displayed as mean ± SD

Beta coefficients is calculated using the quartile of ergothioneine as the independent variable and the respective clinical parameter as the dependent variable. Pearson chi square test was used to calculate the χ^2 for the categorical variables. Q1 is the quartile with lowest ergothioneine level at baseline, and Q4 the highest.

AHT: antihypertensive treatment. DBP: diastolic blood pressure. HDL: HDL cholesterol. LDL: LDL cholesterol. SBP: systolic blood pressure. df: degrees of freedom

Supplementary material references

1. Callmer E, Riboli E, Saracci R, Akesson B, Lindgarde F. Dietary assessment methods evaluated in the Malmo food study. J Intern Med. 1993;233(1):53-7.

2. Wirfalt E, Mattisson I, Johansson U, Gullberg B, Wallstrom P, Berglund G. A methodological report from the Malmo Diet and Cancer study: development and evaluation of altered routines in dietary data processing. Nutr J. 2002;1:3.

3. Lagerqvist B, James SK, Stenestrand U, Lindback J, Nilsson T, Wallentin L. Long-term outcomes with drug-eluting stents versus bare-metal stents in Sweden. N Engl J Med. 2007;356(10):1009-19.

4. Ludvigsson JF, Andersson E, Ekbom A, et al. External review and validation of the Swedish national inpatient register. BMC Public Health. 2011;11:450.

5. Enhorning S, Sjogren M, Hedblad B, Nilsson PM, Struck J, Melander O. Genetic vasopressin 1b receptor variance in overweight and diabetes mellitus. Eur J Endocrinol. 2016;174(1):69-75.

6. Ottosson F, Ericson U, Almgren P, et al. Postprandial Levels of Branch Chained and Aromatic Amino Acids Associate with Fasting Glycaemia. J Amino Acids. 2016;2016:8576730.

7. Dunn WB, Broadhurst D, Begley P, et al. Procedures for large-scale metabolic profiling of serum and plasma using gas chromatography and liquid chromatography coupled to mass spectrometry. Nat Protoc. 2011;6(7):1060-83.

8. Sampson JN, Boca SM, Shu XO, et al. Metabolomics in epidemiology: sources of variability in metabolite measurements and implications. Cancer Epidemiol Biomarkers Prev. 2013;22(4):631-40.