Supplemental Material

Table S1. Search Strategy.

Search #	Medline 1946 to June 03, 2019	Embase 1946 to June 03, 2019	Cochrane Through to June 03, 2019
1	Vegetables/	exp vegetable/	Vegetables/
2	vegetable*.tw,kf.	vegetable*.tw,kw.	vegetable*.ti,ab,hw.
3	Vegetable Products/	1 or 2	1 or 2
4	or/1-3	fruit.mp.	fruit.mp.
5	fruit.mp.	exp Fruit/	Fruit/
6	exp Fruit/	4 or 5	4 or 5
7	5 or 6	3 or 6	3 or 6
8	4 or 7	cardiovascular disease/	cardiovascular diseases/
9	cardiovascular disease/	cardiovascular.tw,kw.	exp myocardial ischemia/
10	exp myocardial ischemia/	exp heart muscle ischemia/	cardiovascular.ti,ab,hw.
11	cardiovascular.tw,kf.	isch?em*.tw,kw.	isch?em*.ti,ab,hw.
12	isch?em*.tw,kf.	coronary.tw,kw.	coronary.ti,ab,hw.
13	coronary.tw,kf.	myocard*.tw,kw.	myocard*.ti,ab,hw.
14	myocard*.tw,kf.	angina.tw,kw.	angina.ti,ab,hw.
15	angina.tw,kf.	exp cerebrovascular disease/	exp cerebrovascular disorders/
16	exp cerebrovascular disorders/	stroke.tw,kw.	stroke*.ti,ab,hw.
17	stroke*.tw,kf.	cerebral vascular.tw,kw.	cerebral vascular.ti,ab,hw.
18	cerebral vascular.tw,kf.	cerebrovascular.tw,kw.	cerebrovascular.ti,ab,hw.
19	cerebrovascular.tw,kf.	Or / 8-18	Or / 8-
20	Or / 9-19	exp cohort analysis/	
21	exp cohort studies/	exp longitudinal study/	
22	cohort*.tw.	exp prospective study/	
23	controlled clinical trial.pt.	exp follow up/	
24	Epidemiologic methods/	cohort$.tw.	
25	limit 24 to yr=1971-1988	Or / 20-24	
26	Or / 21- 25	7 and 19	
27	8 and 20	25 and 26	
28	26 and 27		

Table S2. Confounding Variables Among 117 Studies of Fruit and Vegetables and Cardiovascular Disease Outcomes.

Study	Adriouch, 2018[42]	Appleby, 2002[43]	Atkins, 2014[44]	Bahadoran, 2017[45]	Bazzano, 2002[46]	Belin, 2011[47]	Bendinelli, 2011[48]	Berard, 2017[49]	Bhupathiraju, 2013[50]	Bingham, 2008[51]	Blekkenhorst, 2017[52]
No. of variables fully adjusted model	13	3	8	2	10	10	12	5	13	9	10
No. of multivariable models presented	1	1	2	2	2	1	2	1	2	1	8
Timing of measurement of confounding variables	BL	BL	BL	BL	BL, 1982-84, 86, 87, 92	BL	BL	BL	1984-86, q2y	BL	BL
Pre-specified primary confounding variables											
Age	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables											
Sex		✓	✓		✓		✓	✓		✓	N/A
Smoking	✓	✓	✓		✓	✓	✓		✓	✓	✓
BMI	✓		✓			✓			✓		✓
Physical activity	✓		✓		✓	✓	✓		✓	✓	✓
Alcohol	✓				✓		✓		✓	✓	✓
Blood pressure	✓					✓	✓			✓	
Energy	✓		✓		✓	✓	✓	✓	✓	✓	
Diabetes					✓	✓	✓				✓
Cholesterol						✓	✓			✓	✓
Other Confounding variables											
Education	✓				✓	✓	✓	✓			
Socioeconomic status			✓								✓
Menopause and/or hormone Use	✓						✓		✓		
Region/location											
Randomization treatment											✓
Ethnicity/nationality	✓				✓	✓					
Marital status											
Study center								✓			
Survey season	✓										
Employment status											
Follow-up duration											
Dietary Intake											
Vitamin/supplement					✓				✓		
Fruit and/or vegetable	✓										
Saturated fat											
Whole grains											
Fish/shellfish									✓		
Meat							✓				
Red meat									✓		
Dietary pattern score			✓	✓							
Processed meat											
Coffee											
Fibre											
Folate											
Sodium											
Vitamin E											
Disease History											
MI or family history of MI									✓		
CHD or family history of CHD											
CVD or family history of CVD				✓							
Medications											
ASA											✓
Other confounding variables not listed:	Sleep, WC								Cereal fibre, Trans fat	Weight	GFR

Table S2. *Page 2/11*

Study	Bos, 2014[53]	Buijsse, 2008[54]	BuilCosiales, 2016[56]	BuilCosiales, 2017[55]	Cassidy, 2012[57]	Collin, 2019[58]	Conrad, 2018[59]	Dauchet, 2004[60]	Dauchet, 2010[61]	Du, 2016[62]
No. of variables fully adjusted model	7	15	17	14	13	12	10	10	12	13
No. of multivariable models presented	1	4	1	3	1	4	1	1	1	2
Timing of measurement of confounding variables	BL	BL	BL	1999, q2y	1976, q2y	BL	BL	BL	BL	BL
Pre-specified primary confounding variables										
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables										
Sex	✓	✓	✓	✓	✓	✓	✓			✓
Smoking	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BMI	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical activity		✓	✓		✓	✓		✓	✓	✓
Alcohol		✓	✓	✓	✓	✓				✓
Blood pressure	✓		✓	✓	✓			✓	✓	
Energy		✓	✓	✓	✓	✓				
Diabetes	✓		✓		✓			✓	✓	
Cholesterol					✓			✓	✓	
Other Confounding variables										
Education			✓	✓		✓	✓	✓	✓	✓
Socioeconomic status		✓				✓	✓			✓
Menopause and/or hormone Use					✓					
Region/location						✓				✓
Randomization treatment			✓							
Ethnicity/nationality							✓			
Marital status				✓						
Study center			✓					✓	✓	
Survey season										✓
Employment status								✓	✓	
Follow-up duration										
Dietary Intake										
Vitamin/supplement					✓				✓	
Fruit and/or vegetable			✓							
Saturated fat		✓				✓				
Whole grains			✓	✓						
Fish/shellfish										
Meat										✓
Red meat										
Dietary pattern score										
Processed meat										
Coffee										
Fibre		✓				✓				
Folate		✓								
Sodium										
Vitamin E										
Disease History										
MI or family history of MI										
CHD or family history of CHD	✓		✓	✓						
CVD or family history of CVD										
Medications										
ASA					✓					
Other confounding variables not listed:		Vitamin C, trans/PUFA, α-tocopherol	Olive oil, Statins	Dyslipidemia, Legumes, Olive oil			Cardiomet-abolic meds, added sugar, SFA:M/PUFA		Dyslipidemi	Dairy, Preserved vegetables

Table S2. *Page 3/11*

Study	Du, 2017[63]	Elwood, 2013[64]	Eriksen, 2015[65]	Fitzgerald, 2012[66]	Fraser, 1992[67]	Gardener, 2011[68]	Gaziano, 1995[69]	Genkinger, 2004[70]	Gillman, 1995[71]	Goetz, 2016[72]	Goetz, 2016[73]
No. of variables fully adjusted model	12	3	9	10	6	7	6	6	7	12	10
No. of multivariable models presented	14	1	1	1	1	1	1	2	1	1	1
Timing of measurement of confounding variables	BL	1979, q5y	BL	BL	BL	qy.	1976, qy	BL	BL	BL	BL
Pre-specified primary confounding variables											
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables											
Sex	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Smoking	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
BMI	✓		✓					✓	✓		
Physical activity	✓			✓	✓	✓			✓	✓	✓
Alcohol	✓		✓	✓						✓	
Blood pressure			✓								
Energy				✓	✓	✓		✓		✓	✓
Diabetes				✓			✓		✓		
Cholesterol			✓				✓	✓	✓		
Other Confounding variables											
Education	✓			✓		✓				✓	✓
Socioeconomic status	✓	✓	✓							✓	✓
Menopause and/or hormone Use				✓							
Region/location	✓									✓	✓
Randomization treatment				✓							
Ethnicity/nationality						✓					✓
Marital status											
Study center											
Survey season	✓										
Employment status			✓								
Follow-up duration											
Dietary Intake											
Vitamin/supplement											
Fruit and/or vegetable											
Saturated fat											
Whole grains											
Fish/shellfish											
Meat	✓										
Red meat											
Dietary pattern score											✓
Processed meat											
Coffee											
Fibre											
Folate											
Sodium											
Vitamin E											
Disease History											
MI or family history of MI											
CHD or family history of CHD											
CVD or family history of CVD											
Medications											
ASA											
Other confounding variables not listed:	Preserved vegetables				Weight		Functional status			Trans FA MUFA:SFA, %E sweets	

Table S2. *Page 4/11*

Study	Gunge, 2017[74]	Gunnell, 2013[75]	Hansen, 2010[77]	Hansen, 2017[76]	Harriss, 2007[78]	Hertog, 1997[79]	Hirvonen, 2000[81]	Hirvonen, 2001[80]	Hjartaker, 2015[82]	Hodgson, 2016[83]	Holmberg, 2009[84]
No. of variables fully adjusted model	18	10	11	13	15	13	10	11	9	15	0
No. of multivariable models presented	4	1	2	2	2	1	1	1	1	2	0
Timing of measurement of confounding variables	BL	BL	BL	BL	BL	BL, q5y	BL	BL	BL	BL	BL
Pre-specified primary confounding variables											
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Pre-specified secondary confounding variables											
Sex	✓	✓	✓	✓	✓				✓	✓	
Smoking	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
BMI	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Physical activity	✓	✓	✓	✓	✓		✓	✓	✓	✓	
Alcohol	✓		✓	✓		✓			✓	✓	
Blood pressure	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Energy	✓			✓	✓	✓				✓	
Diabetes				✓	✓		✓	✓		✓	
Cholesterol	✓	✓	✓	✓		✓	✓	✓		✓	
Other Confounding variables											
Education	✓		✓	✓	✓		✓	✓			
Socioeconomic status						✓			✓	✓	
Menopause and/or hormone Use	✓										
Region/location					✓						
Randomization treatment							✓	✓		✓	
Ethnicity/nationality					✓						
Marital status								✓			
Study center											
Survey season		✓		✓							
Employment status											
Follow-up duration	✓										
Dietary Intake											
Vitamin/supplement									✓		
Fruit and/or vegetable	✓				✓						
Saturated fat			✓								
Whole grains	✓		✓								
Fish/shellfish	✓										
Meat					✓						
Red meat	✓										
Dietary pattern score					✓						
Processed meat	✓										
Coffee									✓		
Fibre											
Folate											
Sodium											
Vitamin E						✓					
Disease History											
MI or family history of MI											
CHD or family history of CHD				✓		✓	✓	✓			
CVD or family history of CVD					✓					✓	
Medications											
ASA										✓	
Other confounding variables not listed:	WC	Charlson index, DM hospitalization		Weight		Vitamin C, B-carotene, Dietary fat				Cancer	

Table S2. *Page 5/11*

Study	Iso, 2007[85]	Jacques, 2015[86]	Johnsen, 2003[87]	Joshipura, 1999[88]	Joshipura, 2009[89]	Keli, 1996[90]	Kim, 2013[91]	Knekt, 1994[94]	Knekt, 1996[93]	Knekt, 2000[92]	Kobylecki, 2015[95]
No. of variables fully adjusted model	3	5	13	12	14	7	0	5	6	17	12
No. of multivariable models presented	1	2	2	1	198-86, q2y	1	0	2	1	1	3
Timing of measurement of confounding variables	BL	1991, q3-4y	BL	1980-6, q2y	1980-6, q2y	1960-73, 77, 85	BL	BL	BL	BL	BL
Pre-specified primary confounding variables											
Age	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Pre-specified secondary confounding variables											
Sex	✓	✓	✓	✓					✓		✓
Smoking		✓	✓	✓	✓	✓		✓	✓	✓	✓
BMI		✓	✓	✓	✓				✓	✓	✓
Physical activity			✓	✓	✓						✓
Alcohol			✓	✓	✓	✓					✓
Blood pressure			✓	✓	✓	✓		✓	✓	✓	✓
Energy		✓	✓	✓	✓	✓		✓		✓	
Diabetes			✓		✓					✓	
Cholesterol			✓	✓	✓	✓		✓	✓	✓	✓
Other Confounding variables											
Education			✓								
Socioeconomic status											✓
Menopause and/or hormone Use				✓	✓						
Region/location	✓									✓	
Randomization treatment											
Ethnicity/nationality											
Marital status											
Study center											
Survey season											
Employment status											
Follow-up duration											
Dietary Intake											
Vitamin/supplement				✓	✓						✓
Fruit and/or vegetable											
Saturated fat										✓	
Whole grains					✓						
Fish/shellfish						✓					
Meat											
Red meat			✓								
Dietary pattern score											
Processed meat											
Coffee											
Fibre										✓	
Folate											
Sodium											
Vitamin E										✓	
Disease History											
MI or family history of MI				✓							
CHD or family history of CHD					✓						
CVD or family history of CVD											
Medications											
ASA					✓						
Other confounding variables not listed:			Ω-3-FA							Occupation, Vit C/E,Querc P/MUFA	Maximal oxygen intake, CRP

Table S2. *Page 6/11*

Study	Kondo, 2019[96]	Kvaavik, 2010[97]	Lai, 2015[98]	Larsson, 2009[99]	Larsson, 2013[100]	Leenders, 2013[102]	Leenders, 2014[101]	Lin, 2007[103]	Lin, 2017[104]	Liu, 2000[106]
No. of variables fully adjusted model	7	8	8	14	16	11	11	13	6	8
No. of multivariable models presented	1	2	2	2	2	1	1	2	1	3
Timing of measurement of confounding variables	BL	BL	BL	BL	BL	BL	BL	1990, q2y	BL	BL
Pre-specified primary confounding variables										
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables										
Sex	✓	✓	✓	✓	✓	✓	✓		✓	
Smoking	✓		✓	✓	✓	✓	✓	✓		
BMI		✓	✓	✓	✓	✓	✓	✓	✓	
Physical activity			✓	✓	✓	✓	✓	✓		✓
Alcohol	✓		✓	✓	✓	✓	✓	✓		✓
Blood pressure		✓		✓	✓			✓	✓	✓
Energy	✓			✓	✓			✓		
Diabetes		✓		✓	✓	✓	✓	✓	✓	✓
Cholesterol				✓				✓		✓
Other Confounding variables										
Education					✓	✓	✓		✓	
Socioeconomic status		✓	✓							
Menopause and/or hormone Use								✓		
Region/location										
Randomization treatment				✓						✓
Ethnicity/nationality										
Marital status										
Study center						✓	✓			
Survey season										
Employment status										
Follow-up duration										
Dietary Intake										
Vitamin/supplement								✓		✓
Fruit and/or vegetable	✓		✓		✓	✓	✓			
Saturated fat										
Whole grains										
Fish/shellfish	✓									
Meat						✓	✓			
Red meat					✓					
Dietary pattern score										
Processed meat					✓					
Coffee					✓					
Fibre										
Folate				✓						
Sodium	✓									
Vitamin E								✓		
Disease History										
MI or family history of MI					✓					
CHD or family history of CHD		✓								
CVD or family history of CVD				✓					✓	
Medications										
ASA					✓			✓		
Other confounding variables not listed:		Respiratory diseases		Magnesium						

Table S2. *Page 7/11*

Study	Liu, 2001[105]	Mann, 1997[107]	Manuel, 2015[108]	Miller, 2017[109]	Mink, 2007[110]	Mizrahi, 2009[111]	Mori, 2018[112]	Mytton, 2018[113]	Nagura, 2009[114]	Nakamura, 2008[115]
No. of variables fully adjusted model	11	5	1	17	11	8	16	16	16	15
No. of multivariable models presented	2	1	1	1	2	1	3	2	3	3
Timing of measurement of confounding variables	BL	BL	BL	BL	BL	BL	BL	BL	BL	BL
Pre-specified primary confounding variables										
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables										
Sex	✓	✓		✓		✓	✓	✓	✓	✓
Smoking	✓	✓		✓	✓	✓	✓	✓	✓	✓
BMI	✓	✓			✓	✓	✓		✓	✓
Physical activity	✓			✓	✓	✓	✓	✓	✓	✓
Alcohol	✓						✓	✓	✓	✓
Blood pressure	✓			✓	✓	✓	✓	✓	✓	✓
Energy				✓	✓	✓	✓	✓		✓
Diabetes	✓			✓	✓		✓	✓	✓	✓
Cholesterol	✓			✓		✓		✓		
Other Confounding variables										
Education				✓	✓			✓	✓	✓
Socioeconomic status		✓								
Menopause and/or hormone Use					✓					✓
Region/location				✓						
Randomization treatment	✓									
Ethnicity/nationality										
Marital status					✓					✓
Study center				✓			✓			
Survey season										
Employment status							✓			
Follow-up duration										
Dietary Intake										
Vitamin/supplement	✓						✓			
Fruit and/or vegetable				✓			✓		✓	
Saturated fat									✓	✓
Whole grains										
Fish/shellfish										
Meat										
Red meat				✓						
Dietary pattern score										
Processed meat										
Coffee							✓			
Fibre				✓						
Folate										
Sodium							✓		✓	✓
Vitamin E										
Disease History										
MI or family history of MI								✓		
CHD or family history of CHD										
CVD or family history of CVD										
Medications										
ASA										
Other confounding variables not listed:				Waist:hip, bread, white meat	Waist:hip		Green tea	Family hx of diabetes/ stroke	Sleep, stress, Ω-3 FA, diet cholesterol	Dietary protein

Table S2. *Page 8/11*

Study	Nechuta, 2010[116]	Neelakantan, 2018[117]	Ness, 2005[118]	Nothlings, 2008[119]	Okuda, 2015[120]	Oude Griep, 2010[121]	Oude Griep, 2011[123]	Oude Griep, 2011[122]	Oyebode, 2014[124]	Pham, 2007[125]
No. of variables fully adjusted model	7	12	8	11	11	12	15	15	8	9
No. of multivariable models presented	2	1	2	2	3	3	3	3	2	1
Timing of measurement of confounding variables	BL	BL	BL	BL	BL	BL	BL	BL	2001, qy	BL
Pre-specified primary confounding variables										
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables										
Sex	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Smoking		✓		✓	✓	✓	✓	✓	✓	✓
BMI	✓	✓			✓		✓	✓	✓	✓
Physical activity	✓	✓							✓	
Alcohol				✓	✓	✓	✓	✓	✓	✓
Blood pressure		✓		✓						✓
Energy		✓	✓	✓	✓	✓	✓	✓		
Diabetes		✓		✓			✓	✓		✓
Cholesterol							✓	✓		
Other Confounding variables										
Education	✓	✓				✓	✓	✓	✓	
Socioeconomic status	✓		✓						✓	
Menopause and/or hormone Use						✓	✓	✓		
Region/location			✓							
Randomization treatment										
Ethnicity/nationality		✓								
Marital status	✓									
Study center										
Survey season			✓							
Employment status										
Follow-up duration										
Dietary Intake										
Vitamin/supplement						✓	✓	✓		
Fruit and/or vegetable		✓								✓
Saturated fat										
Whole grains		✓				✓	✓	✓		
Fish/shellfish		✓			✓	✓	✓	✓		
Meat					✓					
Red meat										
Dietary pattern score										
Processed meat						✓	✓	✓		
Coffee										
Fibre										
Folate										
Sodium					✓					
Vitamin E										
Disease History										
MI or family history of MI				✓		✓	✓	✓		
CHD or family history of CHD										
CVD or family history of CVD										
Medications										
ASA										
Other confounding variables not listed:		Sleep, nuts, legumes, dairy	Child food expenditure, Townsend	Cancer hx, insulin tx, Waist:Hip	Dairy, soy					Blood transfusion

Table S2. *Page 9/11*

Study	Rebello, 2014[126]	Rissanen, 2003[127]	Saglimbene, 2017[128]	Sahyoun, 1996[129]	Sauvaget, 2003[130]	Scheffers, 2019[131]	Sesso, 2003[132]	Sesso, 2003[134]	Sesso, 2007[133]	Shah, 2018[135]	Sharma, 2013[136]
No. of variables fully adjusted model	20	10	N/A	4	13	12	16	16	18	10	7
No. of multivariable models presented	3	4	N/A	3	4	4	2	2	4	2	1
Timing of measurement of confounding variables	BL	BL	N/A	BL	BL	BL	BL	BL	BL	BL	BL
Pre-specified primary confounding variables											
Age	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Pre-specified secondary confounding variables											
Sex		✓		✓	✓	✓				✓	
Smoking	✓	✓			✓	✓	✓	✓	✓	✓	✓
BMI	✓	✓			✓	✓	✓	✓	✓	✓	
Physical activity	✓					✓	✓	✓	✓	✓	✓
Alcohol	✓				✓	✓	✓	✓	✓	✓	✓
Blood pressure	✓	✓			✓	✓	✓	✓	✓	✓	
Energy	✓							✓	✓		✓
Diabetes		✓			✓		✓	✓	✓	✓	
Cholesterol		✓				✓	✓	✓	✓	✓	
Other Confounding variables											
Education	✓				✓	✓					✓
Socioeconomic status											
Menopause and/or hormone Use	✓						✓	✓	✓		
Region/location					✓						
Randomization treatment							✓	✓	✓		
Ethnicity/nationality	✓										✓
Marital status											
Study center											
Survey season	✓										
Employment status											
Follow-up duration		✓									✓
Dietary Intake											
Vitamin/supplement		✓									
Fruit and/or vegetable							✓	✓	✓		
Saturated fat	✓						✓	✓			
Whole grains											
Fish/shellfish											
Meat											
Red meat	✓										
Dietary pattern score						✓					
Processed meat											
Coffee											
Fibre							✓	✓	✓		
Folate							✓	✓	✓		
Sodium											
Vitamin E							✓				
Disease History											
MI or family history of MI					✓		✓	✓	✓		
CHD or family history of CHD											
CVD or family history of CVD										✓	
Medications											
ASA											
Other confounding variables not listed:	Sleep, bread, legumes, soy egg, PUFA	Maximal oxygen		Functional status, Health	Birth cohort, animal prod, radiation				Vitamin C, flavonoid, potassium		

Table S2. *Page 10/11*

Study	Sharma, 2014[137]	Simila, 2013[138]	Sonestedt, 2015[139]	Sotomayer, 2019[140]	Steffen, 2003[141]	Stefler, 2016[142]	Strandhagen, 2000[143]	Takachi, 2008[144]	Tanaka, 2013[145]	Tucker, 2005[147]	Tognon, 2014[146]
No. of variables fully adjusted model	5	2	14	16	12	12	5	11	21	10	6
No. of multivariable models presented	1	1	3	4	3	1	2	2	3	3	1
Timing of measurement of confounding variables	BL	BL	BL	BL	BL	BL	BL	BL	BL	1961, biennially	BL
Pre-specified primary confounding variables											
Age		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables											
Sex			✓	✓	✓	✓	✓	✓	✓	✓	✓
Smoking	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
BMI	✓		✓	✓	✓			✓	✓	✓	✓
Physical activity	✓		✓	✓	✓	✓		✓	✓	✓	✓
Alcohol	✓		✓	✓	✓	✓		✓	✓	✓	
Blood pressure				✓	✓		✓	✓	✓		
Energy			✓		✓	✓		✓	✓	✓	
Diabetes	✓			✓				✓	✓		
Cholesterol				✓	✓		✓		✓		
Other Confounding variables											
Education			✓	✓	✓	✓					✓
Socioeconomic status				✓							
Menopause and/or hormone Use											
Region/location											
Randomization treatment		✓									
Ethnicity/nationality					✓						
Marital status						✓					
Study center								✓			
Survey season			✓								
Employment status											
Follow-up duration				✓						✓	
Dietary Intake											
Vitamin/supplement						✓		✓		✓	
Fruit and/or vegetable			✓			✓					
Saturated fat									✓	✓	
Whole grains			✓								
Fish/shellfish											
Meat			✓								
Red meat											
Dietary pattern score					✓						
Processed meat											
Coffee			✓								
Fibre											
Folate											
Sodium									✓		
Vitamin E											
Disease History											
MI or family history of MI											
CHD or family history of CHD											
CVD or family history of CVD											
Medications											
ASA											
Other confounding variables not listed:			Fermented milk	eGFR, proteinuria, primary renal disease, hsCRP		Birth cohort, house score			†		

Table S2. *Page 11/11*

Study	Von Ruesten, 2013[148]	Vormund, 2015[149]	Wang, 2016[150]	Watkins, 2000[151]	Whiteman, 1999[152]	Yamada, 2011[153]	Yokoyama, 2000[154]	Yoshizaki, 2019[155]	Yu, 2014[156]	Zhang, 2011[157]	Zhang, 2011[158]
No. of variables fully adjusted model	11	8	7	17	3	11	9	17	13	17	11
No. of multivariable models presented	2	3	1	1	1	2	1	3	2	1	1
Timing of measurement of confounding variables	BL, q2-3y	BL	BL	BL	BL	BL	BL	BL	BL	BL	BL
Pre-specified primary confounding variables											
Age	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pre-specified secondary confounding variables											
Sex	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Smoking	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BMI	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Physical activity	✓			✓		✓	✓	✓	✓	✓	✓
Alcohol	✓		✓	✓		✓	✓	✓		✓	✓
Blood pressure	✓			✓		✓	✓	✓	✓	✓	✓
Energy								✓	✓	✓	
Diabetes				✓				✓	✓	✓	✓
Cholesterol	✓					✓	✓	✓	✓	✓	✓
Other Confounding variables											
Education	✓			✓		✓			✓	✓	
Socioeconomic status									✓	✓	
Menopause and/or hormone Use										✓	
Region/location		✓	✓			✓					
Randomization treatment											
Ethnicity/nationality		✓		✓							
Marital status		✓		✓		✓					
Study center							✓				
Survey season		✓	✓								
Employment status				✓			✓				
Follow-up duration											
Dietary Intake											
Vitamin/supplement	✓								✓	✓	
Fruit and/or vegetable	✓							✓			✓
Saturated fat										✓	
Whole grains											
Fish/shellfish								✓	✓		
Meat								✓			
Red meat				✓					✓		
Dietary pattern score											
Processed meat											
Coffee				✓							
Fibre											
Folate											
Sodium								✓			
Vitamin E											
Disease History											
MI or family history of MI											
CHD or family history of CHD							✓			✓	
CVD or family history of CVD											
Medications											
ASA				✓							
Other confounding variables not listed:				Stroke, Diuretics				Mental stress		Occupation, stroke	Stroke

ASA - acetylsalicylic acid; BL - baseline; CHD – coronary heart disease; CRP – C-reactive protein; CVD – cardiovascular disease; GFR – glomerular filtration rate; FA – fatty acid; MI – myocardial infarction; M/PUFA - mono/poly-unsaturated fatty acids; Querc – quercetin supplement; q*X*y - confounding variables measured once every *X* years; WC – waist circumference.

*Tanaka et al. (2013) adjusted for the following additional confounding variables: dyslipidemia, HbA1c, oral antihyperglycemic agents, insulin, retinopathy, dietary cholesterol, dietary fat and Ω-3 and Ω-6 FA.

Table S3: Newcastle-Ottawa Scale (NOS) for Assessing the Quality of Cohort Studies

Study	Selection*	Outcome†	Comparability‡	Total§
Adriouch, 2018[42]	3	2	2	7
Appleby, 2002[43]	1	1	1	3
Atkins, 2014[44]	3	3	1	7
Bahadoran, 2017[45]	2	1	0	3
Bazzano, 2002[46]	2	3	1	6
Belin, 2011[47]	3	3	2	8
Bendinelli, 2011[48]	3	3	2	8
Berard, 2017[49]	3	3	1	7
Bhupathiraju, 2013[50]	2	2	1	5
Bingham, 2008[51]	2	0	2	4
Blekkenhorst, 2017[52]	2	3	2	7
Bos, 2014[53]	2	3	2	7
Buijsse, 2008[54]	3	3	1	7
Buil-Cosiales, 2016[56]	3	3	2	8
Buil-Cosiales, 2017[55]	3	1	2	6
Cassidy, 2012[57]	2	2	2	6
Collin, 2019[58]	3	3	1	7
Conrad, 2018[59]	3	3	1	7
Dauchet, 2004[60]	3	3	2	8
Dauchet, 2010[61]	4	3	2	9
Du, 2016[62]	4	3	1	8
Du, 2017[63]	4	3	1	8
Elwood, 2013[64]	3	3	1	7
Eriksen, 2015[65]	3	3	2	8
Fitzgerald, 2012[66]	2	2	1	5
Fraser, 1992[67]	2	3	2	7
Gardener, 2011[68]	4	2	1	7
Gaziano, 1995[69]	2	3	1	6
Genkinger, 2004[70]	3	3	1	7
Gillman, 1995[71]	3	3	2	8
Goetz, 2016[72]	3	2	1	6
Goetz, 2016[73]	3	3	1	7
Gunge, 2017[74]	3	3	2	8

Study	Selection*	Outcome†	Comparability‡	Total§
Gunnell, 2013[75]	3	1	2	6
Hansen, 2010[77]	3	3	2	8
Hansen, 2017[76]	2	3	2	7
Harriss, 2007[78]	3	3	2	8
Hertog, 1997[79]	2	3	2	7
Hirvonen, 2000[81]	2	3	2	7
Hirvonen, 2001[80]	2	3	2	7
Hjartaker, 2015[82]	2	3	1	6
Hodgson, 2016[83]	2	3	2	7
Holmberg, 2009[84]	2	3	0	5
Iso, 2007[85]	2	2	1	5
Jacques, 2015[86]	3	3	1	7
Johnsen, 2003[87]	3	2	2	7
Joshipura, 1999[88]	2	2	2	6
Joshipura, 2009[89]	2	3	2	7
Keli, 1996[90]	4	3	1	8
Kim, 2013[91]	1	3	0	4
Knekt, 1994[94]	4	3	1	8
Knekt, 1996[93]	2	3	2	7
Knekt, 2000[92]	4	3	2	9
Kobylecki, 2015[95]	3	3	2	8
Kondo, 2019[96]	3	3	1	7
Kvaavik, 2010[97]	4	3	1	8
Lai, 2015[98]	3	3	1	7
Larsson, 2009[99]	2	3	2	7
Larsson, 2013[100]	3	3	2	8
Leenders, 2013[102]	3	3	2	8
Leenders, 2014[101]	3	3	2	8
Lin, 2007[103]	2	2	2	6
Lin, 2017[104]	3	3	1	7
Liu, 2000[106]	2	3	2	7
Liu, 2001[105]	2	3	2	7
Mann, 1997[107]	2	3	1	6
Manuel, 2015[108]	4	3	1	8
Miller, 2017[109]	3	3	2	8

Study	Selection*	Outcome†	Comparability‡	Total§
Mink, 2007[110]	3	3	2	8
Mizrahi, 2009[111]	4	3	2	9
Mori, 2018[112]	3	3	2	8
Mytton, 2018[113]	3	3	2	8
Nagura, 2009[114]	3	3	2	8
Nakamura, 2008[115]	2	3	2	7
Nechuta, 2010[116]	3	3	1	7
Neelakantan, 2018[117]	3	3	2	8
Ness, 2005[118]	3	3	1	7
Nothlings, 2008[119]	2	3	1	6
Okuda, 2015[120]	3	3	1	7
Oude Griep, 2010[121]	3	3	1	7
Oude Griep, 2011[123]	2	3	2	7
Oude Griep, 2011[122]	2	3	2	7
Oyebode, 2014[124]	3	3	1	7
Pham, 2007[125]	3	3	2	8
Rebello, 2014[126]	3	3	1	7
Rissanen, 2003[127]	2	3	2	7
Saglimbene, 2017[128]	1	0	0	1
Sahyoun, 1996[129]	1	3	1	5
Sauvaget, 2003[130]	2	3	2	7
Scheffers, 2019[131]	3	3	2	8
Sesso, 2003[132]	2	3	2	7
Sesso, 2003[134]	2	3	2	7
Sesso, 2007[133]	3	2	2	7
Shah, 2018[135]	3	3	2	8
Sharma, 2013[136]	3	2	0	5
Sharma, 2014[137]	3	2	0	5
Simila, 2013[138]	2	3	1	6
Sonestedt, 2015[139]	4	3	2	9
Sotomayer, 2019[140]	1	3	2	6
Steffen, 2003[141]	4	3	2	9
Stefler, 2016[142]	2	3	1	6
Strandhagen, 2000[143]	2	3	1	6
Takachi, 2008[144]	3	3	2	8

Study	Selection*	Outcome†	Comparability‡	Total§
Tanaka, 2013[145]	2	3	2	7
Tognon, 2014[146]	3	3	1	7
Tucker, 2005[147]	2	3	1	6
Von Ruesten, 2013[148]	3	2	2	7
Vormund, 2015[149]	3	3	1	7
Wang, 2016[150]	1	3	1	5
Watkins, 2000[151]	3	3	2	8
Whiteman, 1999[152]	3	3	1	7
Yamada, 2011[153]	2	3	2	7
Yokoyama, 2000[154]	2	3	2	7
Yoshizaki, 2019[155]	3	3	2	8
Yu, 2014[156]	3	3	2	8
Zhang, 2011[157]	3	3	2	8
Zhang, 2011[158]	3	2	2	7

*Maximum 4 points awarded for representativeness of exposed cohort, selection of non-exposed cohort, exposure assessment, and demonstration outcome not present at baseline.

†Maximum 3 points awarded for outcome assessment, follow-up length, and adequacy of follow-up.

‡Maximum 2 points awarded for adjusting for the pre-specified primary confounding variable (age) and 5 of the 7 pre-specified secondary confounding variables (sex, family history of CVD, smoking, body mass index, blood pressure (or hypertension/medications), cholesterol (or dyslipidemia/medications) and presence of diabetes mellitus.

§A maximum of 9 points could be awarded.

Table S4. GRADE Assessment for Fruits and Vegetables and Cardiovascular Disease Incidence

Quality Assessment								Study Event Rates (%)	Relative Risk (95% CI)	Certainty
No. of Cohorts	Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Publication Bias	Other			
Fruit and Vegetable Consumption on Cardiovascular Disease Incidence (follow-up median 10 years)										
12	observational	not serious	not serious	not serious	serious[1]	undetected	dose-response gradient[2]	24,310/501,744 (4.9%)	0.93 (0.89, 0.96)	⊕⊕◯◯ **LOW**
Fruit Consumption on Cardiovascular Disease Incidence (follow-up median 10 years)										
16	observational	not serious	not serious	not serious	not serious	undetected	dose-response gradient[3]	27,204/577,323 (4.7%)	0.91 (0.88, 0.95)	⊕⊕◯◯ **LOW**
Vegetable Consumption on Cardiovascular Disease Incidence (follow-up median 11 years)										
14	observational	not serious	not serious	not serious	serious[4]	undetected	none	22,810/539,683 (4.2%)	0.94 (0.90, 0.97)	⊕◯◯◯ **VERY LOW**
Berries Consumption on Cardiovascular Disease Incidence (follow-up median 10 years)										
1	observational	not serious	not serious[5]	serious[6]	serious[7]	undetected[8]	none	1,004/38,176 (2.6%)	1.27 (0.95, 1.71)	⊕◯◯◯ **VERY LOW**
Citrus Fruit Consumption on Cardiovascular Disease Incidence (follow-up median 10 years)										
6	observational	not serious	not serious	not serious	serious[9]	undetected[8]	dose-response gradient[10]	6,220/222,525 (2.8%)	0.88 (0.80, 0.96)	⊕⊕◯◯ **LOW**
Fruit Juice Consumption on Cardiovascular Disease Incidence (follow-up median 15 years)										
5	observational	not serious	not serious	not serious	serious[11]	undetected[8]	none	8,056/167,879 (4.8%)	1.00 (0.93, 1.07)	⊕◯◯◯ **VERY LOW**
Pommes Consumption on Cardiovascular Disease Incidence (follow-up median 8 years)										
5	observational	not serious	not serious	serious[12]	not serious	undetected[8]	dose-response gradient[13]	2,578/149,437 (1.7%)	0.76 (0.66, 0.88)	⊕⊕◯◯ **LOW**
Allium Vegetables Consumption on Cardiovascular Disease Incidence (follow-up median 7 years)										
2	observational	not serious	serious[14]	serious[15]	serious[16]	undetected[8]	none	808/40,814 (2.0%)	0.79 (0.57, 1.10)	⊕◯◯◯ **VERY LOW**
Cruciferous Vegetables Consumption on Cardiovascular Disease Incidence (follow-up median 9 years)										
7	observational	not serious	serious[17]	not serious	serious[18]	undetected[8]	none	6,824/273,878 (2.5%)	0.99 (0.90, 1.08)	⊕◯◯◯ **VERY LOW**
Green Leafy Vegetables Consumption on Cardiovascular Disease Incidence (follow-up median 7 years)										
5	observational	not serious	not serious	not serious	serious[19]	undetected[8]	dose-response gradient[20]	5,732/211,902 (2.7%)	0.87 (0.76, 0.99)	⊕⊕◯◯ **LOW**
Tomatoes Consumption on Cardiovascular Disease Incidence (follow-up median 9 years)										
2	observational	not serious	not serious	serious[21]	serious[22]	undetected[8]	none	841/55,452 (1.5%)	0.97 (0.78, 1.20)	⊕◯◯◯ **VERY LOW**

[1] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.89) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.96) crosses the MID.

[2] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between total fruit and vegetable intake and incident CVD ($p<0.001$).

[3] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and incident CVD ($p=0.004$).

[4] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.90) includes the MID of 5% while the upper bound of the 95% CI (RR, 0.97) crosses the MID.

[5] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available.

[6] Downgrade for serious indirectness as evidence is based on 1 cohort of female health-professionals residing in the USA and may not be generalizable to different populations.

[7] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.95 to 1.27) includes both clinically important benefit ($RR\leq0.95$) and harm ($RR\geq1.05$).

[8] No downgrade for publication bias as publication bias could not be assessed due to lack of power for assessing funnel plot asymmetry and small study effects (i.e. <10 observations available).

[9] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.80) includes the MID of 5% while the upper bound of the 95% CI (RR, 0.96) crosses the MID.

[10] Upgrade for a dose-response gradient, as the MKSPLINE analysis revealed a significant non-linear inverse relationship between citrus fruit intake and CVD incidence ($p=0.033$).

[11] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.93 to 1.07) includes both clinically important benefit ($RR<0.95$) and harm ($RR\geq1.05$).

[12] Downgrade for serious indirectness as evidence is based on a predominately (>78%) female population and may not be generalizable to different populations.

[13] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between pommes intake and incident CVD ($p=0.043$).

[14] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity ($I^2=85\%$, $p=0.01$), which could not be explored through sensitivity due to only 2 observations available.

[15] Downgrade for serious indirectness as evidence is based on a predominately (97%) female populations of which most are health professionals, and may not be generalizable to different populations.

[16] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.57) includes the MID of 5% while the upper bound of the 95% CI (RR, 1.10) crosses the MID.

[17] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity ($I^2=52\%$, $p=0.04$). Although the removal of Buil-Cosiales et al. 2016 during sensitivity analysis did partially explain the heterogeneity ($I^2=27\%$, $p=0.22$), the presence of residual heterogeneity could not be excluded.

[18] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.90 to 1.08) includes both clinically important benefit ($RR\leq0.95$) and harm ($RR\geq1.05$).

[19] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.76) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.99) crosses the MID.

[20] Upgrade for a dose-response gradient, as the MKSPLINE analysis revealed a significant non-linear inverse relationship between green leafy vegetables intake and CVD mortality ($p=0.01$)

[21] Downgrade for serious indirectness as evidence is based on a predominately (88%) female population and may not be generalizable to different populations.

[22] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.78 to 1.20) includes both clinically important benefit ($RR\leq0.95$) and harm ($RR\geq1.05$).

Table S5. GRADE Assessment for Fruits and Vegetables and Cardiovascular Disease Mortality

Quality Assessment								Study Event Rates (%)	Relative Risk (95% CI)	Certainty
No. of Cohorts	Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Publication Bias	Other			
Fruit and Vegetable Consumption on Cardiovascular Disease Mortality (follow-up median 11 years)										
14	observational	not serious	serious[1]	not serious	not serious	undetected	dose-response gradient[2]	17,439/798,391 (2.2%)	0.89 (0.85, 0.93)	⊕⊕○○ **LOW**
Fruit Consumption on Cardiovascular Disease Mortality (follow-up median 11 years)										
27	observational	not serious	serious[3]	not serious	not serious	undetected	dose-response gradient[4]	39,623/1,581,506 (2.5%)	0.88 (0.86, 0.91)	⊕⊕○○ **LOW**
Vegetable Consumption on Cardiovascular Disease Mortality (follow-up median 10 years)										
21	observational	not serious	serious[5]	not serious	not serious	undetected	dose-response gradient[6]	33,516/1,101,435 (3.0%)	0.87 (0.85, 0.90)	⊕⊕○○ **LOW**
Apricot Consumption on Cardiovascular Disease Mortality (follow-up median 1.5 years)										
1	observational	serious[7]	not serious[8]	serious[9]	not serious	undetected[10]	none	515/9,757 (5.3%)	1.84 (1.27, 2.67)	⊕○○○ **VERY LOW**
Bananas Consumption on Cardiovacular Disease Mortality 16(follow-up median 20.3 years)										
1	observational	not serious	not serious[8]	serious[12]	serious[13]	undetected[10]	none	4,595/9,766 (47.1%)	1.06 (0.87, 1.29)	⊕○○○ **VERY LOW**
Berries Consumption on Cardiovascular Disease Mortality (follow-up median 16 years)										
4	observational	not serious	not serious	serious[14]	serious[15]	undetected[10]	none	7,401/112,892 (6.6%)	0.97 (0.92, 1.03)	⊕○○○ **VERY LOW**
Citrus Fruit Consumption on Cardiovascular Disease Mortality (follow-up median 17 years)										
3	observational	not serious	not serious[16]	serious[17]	serious[18]	undetected[10]	none	7,197/74,716 (9.6%)	0.95 (0.90, 1.02)	⊕○○○ **VERY LOW**
Dried Fruit Consumption on Cardiovascular Disease Mortality (follow-up median 17 years)										
2	observational	not serious	not serious	not serious	serious[19]	undetected[10]	none	447/31,757 (1.4%)	0.93 (0.63, 1.37)	⊕○○○ **VERY LOW**
Fruit Juice Consumption on Cardiovascular Disease Mortality (follow-up median 17 years)										
1	observational	not serious	not serious[8]	serious[20]	serious[21]	undetected[10]	none	286/30,458 (0.9%)	0.81 (0.58, 1.13)	⊕○○○ **VERY LOW**
Grapes Consumption on Cardiovascular Disease Mortality (follow-up median 16.7 years)										
3	observational	not serious	not serious[22]	serious[23]	serious[24]	undetected[10]	none	7,197/74,716 (9.6%)	0.90 (0.81, 1.01)	⊕○○○ **VERY LOW**
Pommes Consumption on Cardiovascular Disease Mortality (follow-up median 16 years)										
5	observational	not serious	not serious	serious[25]	not serious	undetected[10]	none	7,947/85,929 (9.2%)	0.86 (0.80, 0.92)	⊕○○○ **VERY LOW**
Allium Vegetables Consumption on Cardiovascular Disease Mortality (follow-up median 15 years)										
1	observational	not serious	not serious[8]	serious[26]	not serious	undetected[10]	none	238/1,226 (19.4%)	0.33 (0.22, 0.49)	⊕○○○ **VERY LOW**
Carrots Consumption on Cardiovacular Disease Mortality (follow-up median 18 years)										

2	observational	not serious	not serious	serious[27]	serious[28]	undetected[10]	none	4,792/10,325 (46.4%)	0.92 (0.85, 1.01)	⊕◯◯◯ **VERY LOW**
Celery Consumption on Cardiovascular Disease Mortality (follow-up median 16 years)										
1	observational	not serious	not serious[8]	serious[29]	serious[30]	undetected[10]	none	2,316/34,492 (6.7%)	0.91 (0.83, 1.01)	⊕◯◯◯ **VERY LOW**
Cruciferous Vegetables Consumption on Cardiovascular Disease Mortality (follow-up median 12 years)										
7	observational	not serious	serious[31]	not serious	not serious	undetected[10]	none	13,081/187,730 (7.0%)	0.85 (0.82, 0.89)	⊕◯◯◯ **VERY LOW**
Green Leafy Vegetables Consumption on Cardiovascular Disease Mortality (follow-up median 21 years)										
5	observational	not serious	serious[32]	not serious	not serious	undetected[10]	none	6,661/40,893 (16.3%)	0.87 (0.81, 0.94)	⊕⊕◯◯ **LOW**
Tomatoes Consumption on Cardiovascular Disease Mortality (follow-up median 16 years)										
3	observational	not serious	not serious	serious[33]	serious[34]	undetected[9]	none	7,072/45,557 (15.5%)	0.98 (0.93, 1.04)	⊕◯◯◯ **VERY LOW**

[1] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=68%, p<0.001) which could not be explained by sensitivity analyses.

[2] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit and vegetable intake and CVD mortality (p<0.011). The MKSPLINE procedure indicated a departure from linearity (p<0.001) at a threshold of 4 servings/day as observed by visual inspection.

[3] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=79%, p<0.001), which could not be explained by sensitivity analyses.

[4] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and CVD mortality (p=0.005).

[5] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=59%, p<0.001), which could not be explained by sensitivity analyses.

[6] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and CVD mortality (p<0.001).

[7] Downgrade for serious risk of bias as the effect estimate is based on Saglimbene et al. 2017, which presented with a high risk of bias (Newcastle-Ottawa Score: 1/9)

[8] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available

[9] Downgrade for serious indirectness as evidence is based on 1 cohort of patients receiving hemodialysis and may not be generalizable to different populations.

[10] No downgrade for publication bias as publication bias could not be assessed due to lack of power for assessing funnel plot asymmetry and small study effects (i.e. <10 observations available).

[11] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available

[12] Downgrade for serious indirectness as evidence is based on 1 male cohort and may not be generalizable to different populations

[13] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.87 to 1.29) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[14] Downgrade for serious indirectness as evidence is based on a predominately (91%) female population and may not be generalizable to different populations.

[15] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.92) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 1.03) crosses the MID.

[16] No downgrade for inconsistency as the presence of inter-study heterogeneity (I^2=62%, p=0.05) was explained by the removal of Lai et al. 2015 (I^2=0%, p=0.63) during sensitivity analysis.

[17] Downgrade for serious indirectness as the evidence is based on a predominately (87%) female population and may not be generalizable to different populations.

[18] Downgrade for serious imprecision, as upper bound of the 95% CIs (RR 1.02) crosses the MID (RR<0.95).

[19] Downgrade for serious imprecision, as upper bound of the 95% CIs (RR 1.37) crosses the MID (RR<0.95).

[20] Downgrade for serious indirectness as evidence is based on 1 female cohort residing in the United Kingdom and may not be generalizable to different populations.
[21] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.58 to 1.13) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).
[22] No downgrade for inconsistency as the presence of inter-study heterogeneity (I^2=61%, p=0.08) was explained by the removal of Lai et al. 2015 (I^2=0%, p=0.93) during sensitivity analysis.
[23] Downgrade for serious indirectness as evidence is based on a predominately (87%) female population and may not be generalizable to different populations.
[24] Downgrade for serious imprecision, as the upper bound of the 95% CIs (RR, 1.01) crosses the MID (RR<0.95).
[25] Downgrade for serious indirectness as evidence is based on a predominately (87%) female population and may not be generalizable to different populations.
[26] Downgrade for serious indirectness as evidence is based on 1 female cohort and may not be generalizable to different populations.
[27] Downgrade for serious indirectness as evidence is based on 2 male cohorts and may not be generalizable to different populations.
[28] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.85) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 1.01) crosses the MID.
[29] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available
[30] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.76) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.99) crosses the MID.
[31] Downgrade for serious inconsistency as there was evidence for substantial inter-study heterogeneity (I^2=86%, p<0.00001), which could not be explained by sensitivity analyses.
[32] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=88%, p<0.00001), which could not be explained by sensitivity analyses.
[33] Downgrade for serious indirectness as evidence is based on only 3 isolated geographical regions (Norway and Massachusetts and Iowa, USA) and may not be generalizable to different populations.
[34] Downgrade for serious imprecision, as the upper bound of the 95% CIs (RR, 1.04) includes crosses the MID (RR<0.95).

Table S6. GRADE Assessment for Fruits and Vegetables and Coronary Heart Disease Incidence

Quality Assessment								Study Event Rates (%)	Relative Risk (95% CI)	Certainty
No. of Cohorts	**Design**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication Bias**	**Other**			
Fruit and Vegetable Consumption on Coronary Heart Disease Incidence (follow-up median 10 years)										
19	observational	not serious	not serious	not serious	not serious	undetected	dose-response gradient[1]	17,987/619,182 (2.9%)	0.88 (0.83, 0.92)	⊕⊕⊕◯ **MODERATE**
Fruit Consumption on Coronary Heart Disease Incidence (follow-up median 10 years)										
20	observational	not serious	not serious	not serious	not serious	undetected	dose-response gradient[2]	23,856/1,170,021 (2.0%)	0.88 (0.84, 0.92)	⊕⊕⊕◯ **MODERATE**
Vegetable Consumption on Coronary Heart Disease Incidence (follow-up median 10 years)										
18	observational	not serious	not serious[3]	not serious	serious[4]	undetected	dose-response gradient[5]	17,172/696,330 (2.5%)	0.92 (0.87, 0.96)	⊕⊕◯◯ **LOW**
Bananas Consumption on Coronary Heart Disease Incidence (follow-up median 7.6 years)										
1	observational	not serious	not serious[6]	serious[7]	serious[8]	undetected[9]	none	365/122,635 (0.3%)	0.76 (0.56, 1.02)	⊕◯◯◯ **VERY LOW**
Berries Consumption on Coronary Heart Disease Incidence (follow-up median 8 years)										
4	observational	not serious	serious[10]	not serious	serious[11]	undetected[9]	none	2,233/100,296 (2.2%)	0.94 (0.82, 1.09)	⊕◯◯◯ **VERY LOW**
Citrus Fruit Consumption on Coronary Heart Disease Incidence (follow-up median 9 years)										
10	observational	not serious	not serious	not serious	serious[12]	undetected	dose-response gradient[12]	8,333/364,978 (2.3%)	0.91 (0.85, 0.98)	⊕⊕◯◯ **LOW**
Fruit Juice Consumption on Coronary Heart Disease Incidence (follow-up median 15 years)										
4	observational	not serious	not serious	not serious	serious[14]	undetected[9]	none	7,589/109,898 (6.9%)	0.99 (0.92, 1.07)	⊕◯◯◯ **VERY LOW**
Grapes Consumption on Coronary Heart Disease Incidence (follow-up median 12 years)										
1	observational	not serious	not serious[6]	serious[15]	serious[16]	undetected[9]	none	8,333/364,978 (2.3%)	0.91 (0.85, 0.98)	⊕◯◯◯ **VERY LOW**
Pommes Consumption on Coronary Heart Disease Incidence (follow-up median 8 years)										
8	observational	not serious	not serious	not serious	serious[17]	undetected[9]	none	4,886/371,684 (1.3%)	0.90 (0.84, 0.97)	⊕◯◯◯ **VERY LOW**
Watermelon Consumption on Coronary Heart Disease Incidence (follow-up median 7.6 years)										
1	observational	not serious	not serious	serious[16]	serious[19]	undetected[9]	none	365/122,635 (0.3%)	0.87 (0.64, 1.18)	⊕◯◯◯ **VERY LOW**
Allium Vegetables Consumption on Coronary Heart Disease Incidence(follow-up median 10 years)										
5	observational	not serious	not serious	not serious	serious[20]	undetected[9]	none	1,734/210,964 (0.8%)	0.93 (0.80, 1.09)	⊕◯◯◯ **VERY LOW**
Cruciferous Vegetables Consumption on Coronary Heart Disease Incidence(follow-up median 11 years)										
8	observational	not serious	not serious	not serious	not serious	undetected[9]	none	9,383/347,453 (2.7%)	1.01 (0.95, 1.07)	⊕⊕◯◯ **LOW**

Green Leafy Vegetables Consumption on Coronary Heart Disease Incidence(follow-up median 16 years)										
5	observational	not serious	not serious	not serious	not serious	undetected[9]	dose-response gradient[21]	6,696/170,250 (3.9%)	0.82 (0.76, 0.89)	⊕⊕⊕◯ **MODERATE**
Tomatoes Consumption on Coronary Heart Disease Incidence(follow-up median 8 years)										
3	observational	not serious	not serious	serious[22]	serious[23]	undetected[9]	none	1,283/134,494 (1.0%)	0.80 (0.57, 1.13)	⊕◯◯◯ **VERY LOW**

[1] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit and vegetable intake and coronary heart disease incidence (CHD) ($p<0.001$).

[2] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and CHD ($p=0.005$).

[3] No downgrade for inconsistency as the presence of inter-study heterogeneity ($I^2=53\%$, $p=0.002$) was explained by the removal of Dauchet et al. 2010 ($I^2=0\%$, $p=0.5$)

[4] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.87) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.96) crosses the MID.

[5] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between vegetable intake and CHD ($p<0.001$).

[6] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available

[7] Downgrade for serious indirectness as evidence is based on only 1 geographical regions (China) and may not be generalizable to different populations.

[8] Downgrade for serious imprecision, as the upper bound of the 95% CIs (RR, 1.02) crosses the MID (RR<0.95).

[9] No downgrade for publication bias as publication bias could not be assessed due to lack of power for assessing funnel plot asymmetry and small study effects (i.e. <10 observations available).

[10] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity ($I^2=74\%$, $p=0.008$), which could not be explained by sensitivity analyses.

[11] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.82 to 1.09) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[12] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.85) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.98) crosses the MID.

[13] Upgrade for a dose-response gradient, as the MKSPLINE analysis indicated a significant non-linear inverse relationship between citrus intake and incident CHD ($p=0.005$).

[14] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.92 to 1.07) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[15] Downgrade for serious indirectness as evidence is based on 1 female cohort of health professionals and may not be generalizable to different populations.

[16] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.85) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.98) crosses the MID.

[17] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.84) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.97) crosses the MID.

[18] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.64 to 1.18) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[19] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.80 to 1.09) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[20] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and CVD mortality ($p=0.002$). The MKSPLINE procedure indicated a departure from linearity ($p=0.004$) at threshold of 0.5 servings/day as observed by visual inspection.

[21] Downgrade for serious indirectness as the evidence is based only on female populations, predominately (77.9%) of which reside in USA, and may not be generalizable to different populations.

[22] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.57 to 1.13) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05)

Table S7. GRADE Assessment for Fruits and Vegetables and Coronary Heart Disease Mortality

Quality Assessment								Study Event Rates (%)	Relative Risk (95% CI)	Certainty
No. of Cohorts	**Design**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication Bias**	**Other**			
Fruit and Vegetable Consumption on Coronary Heart Disease Mortality (follow-up median 18 years)										
5	observational	not serious	not serious	not serious	not serious	undetected[1]	dose-response gradient[2]	3,240/489,635 (0.7%)	0.81 (0.72, 0.92)	⊕⊕⊕◯ **MODERATE**
Fruit Consumption on Coronary Heart Disease Mortality (follow-up median 13 years)										
21	observational	not serious	serious[3]	not serious	not serious	undetected	dose-response gradient[4]	14,786/1,398,863 (1.1%)	0.86 (0.82, 0.90)	⊕⊕◯◯ **LOW**
Vegetable Consumption on Coronary Heart Disease Mortality (follow-up median 13 years)										
18	observational	not serious	not serious	not serious	not serious	undetected	dose-response gradient[5]	26,007/1,968,325 (1.3%)	0.86 (0.83, 0.89)	⊕⊕⊕◯ **MODERATE**
Bananas Consumption on Coronary Heart Disease Mortality (follow-up median 20 years)										
1	observational	not serious	not serious[6]	serious[7]	serious[8]	undetected[1]	none	2,384/9,964 (4.9%)	1.04 (0.81, 1.34)	⊕◯◯◯ **VERY LOW**
Berries Consumption on Coronary Heart Disease Mortality (follow-up median 17 years)										
5	observational	not serious	not serious	not serious	serious[9]	undetected[1]	none	5,141/105,420 (4.9%)	0.98 (0.91, 1.05)	⊕◯◯◯ **VERY LOW**
Citrus Fruit Consumption on Coronary Heart Disease Mortality (follow-up median 16 years)										
6	observational	not serious	not serious	serious[10]	serious[11]	undetected[1]	none	5,309/180,574 (2.9%)	0.91 (0.85, 0.96)	⊕◯◯◯ **VERY LOW**
Dried Fruit Consumption on Coronary Heart Disease Mortality (follow-up median 17 years)										
1	observational	not serious	not serious[6]	serious[12]	serious[13]	undetected[1]	none	38/30,458 (0.1%)	0.79 (0.47, 1.31)	⊕◯◯◯ **VERY LOW**
Fruit Juice Consumption on Coronary Heart Disease Mortality (follow-up median 17 years)										
3	observational	serious[14]	not serious	not serious[15]	serious[16]	undetected[1]	none	1,249/141,170 (0.9%)	0.87 (0.75, 1.01)	⊕◯◯◯ **VERY LOW**
Grapes Consumption on Coronary Heart Disease Mortality (follow-up median 17 years)										
3	observational	not serious	not serious	serious[17]	serious[18]	undetected[1]	none	2,846/106, 782 (2.7%)	0.97 (0.77, 1.21)	⊕◯◯◯ **VERY LOW**
Pommes Consumption on Coronary Heart Disease Mortality (follow-up median 19 years)										
5	observational	not serious	not serious	serious[19]	not serious	undetected[1]	none	4,650/146,407 (3.2%)	0.84 (0.76, 0.92)	⊕◯◯◯ **VERY LOW**
Allium Vegetables Consumption on Coronary Heart Disease Mortality (follow-up median 15 years)										
4	observational	not serious	serious[20]	serious[21]	not serious	undetected[1]	none	1,280/75,434 (1.7%)	0.67 (0.57, 0.79)	⊕◯◯◯ **VERY LOW**
Carrots Consumption on Coronary Heart Disease Mortality (follow-up median 13years)										

1	observational	not serious	not serious[6]	serious[22]	serious[23]	undetected[1]	none	64/10,802 (0.6%)	0.76 (0.37, 1.58)	⨁◯◯◯ **VERY LOW**
Celery Consumption on Coronary Heart Disease Mortality (follow-up median 16 years)										
1	observational	not serious	not serious[24]	serious[25]	serious[26]	undetected[1]	none	1,329/34,492 (3.9%)	0.92 (0.80, 1.06)	⨁◯◯◯ **VERY LOW**
Cruciferous Vegetables Consumption on Coronary Heart Disease Mortality (follow-up median 16 years)										
6	observational	serious[27]	serious[28]	not serious	serious[29]	undetected[1]	none	7,420/296,772 (2.5%)	0.91 (0.85, 0.98)	⨁◯◯◯ **VERY LOW**
Green Leafy Vegetables Consumption on Coronary Heart Disease Mortality (follow-up median 17 years)										
5	observational	serious[30]	not serious	not serious	not serious	undetected[1]	none	4,591/148,133 (3.1%)	0.86 (0.78. 0.94)	⨁◯◯◯ **VERY LOW**
Tomatoes Consumption on Coronary Heart Disease Mortality (follow-up median 16 years)										
3	observational	serious[31]	not serious	not serious	serious[32]	undetected[1]	none	3,657/175,088 (2.1%)	0.92 (0.82, 1.04)	⨁◯◯◯ **VERY LOW**

[1] No downgrade for publication bias as publication bias could not be assessed due to lack of power for assessing funnel plot asymmetry and small study effects (i.e. <10 observations available).

[2] Upgrade for a dose-response gradient, as the MKSPLINE analysis revealed a significant non-linear inverse relationship between fruit and vegetable intake and CHD mortality (p=0.044)

[3] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=62%, p<0.0001). Although heterogeneity could be partially explained by the removal of Du et al. 2017 (I^2=44%, p=0.01) and Hjartaker et al. 2015 (I^2=46%, p=0.007) during sensitivity analyses, the presence of residual heterogeneity could not be excluded.

[4] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and CHD mortality (p<0.001).

[5] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between vegetable intake and CHD mortality (p=0.005).

[6] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available.

[7] Downgrade for serious indirectness as evidence is based on 1 male cohort and may not be generalizable to different populations.

[8] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.81 to 1.34) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[9] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.91 to 1.05) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[10] Downgrade for serious indirectness as evidence is based on a predominately (≥69.6%) female populations and may not be generalizable to different populations.

[11] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.85) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.96) crosses the MID.

[12] Downgrade for serious indirectness as evidence is based on 1 female cohort and may not be generalizable to different populations.

[13] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.47 to 1.31) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[14] Downgrade for serious risk of bias as 56% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 5/9).

[15] No downgrade for inconsistency as the presence of inter-study heterogeneity (I^2=71%, p=0.02) was explained by the removal of Collin et al. 2019 (I^2=0%, p=0.45).

[16] Downgrade for serious imprecision, as the upper bound of the 95% CIs (RR, 1.01) crosses the MID (RR<0.95).

[17] Downgrade for serious indirectness as evidence is based on a predominately (91%) female population of which the majority are health professionals and may not be generalizable to different populations.

[18] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.77 to 1.21) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[19] Downgrade for serious indirectness as evidence is based on a predominately (82.1%) female populations and may not be generalizable to different populations.

[20] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=88%, p<0.00001). Although heterogeneity could be partially explained by the removal of Blekkenhorst et al. 2017 (I^2=47%, p=0.13) during sensitivity analyses, the presence of residual heterogeneity could not be excluded.

[21] Downgrade for serious indirectness as evidence is based on a predominately (95.4%) female populations and may not be generalizable to different populations.

[22] Downgrade for serious indirectness as evidence is based on 1 female cohort and may not be generalizable to different populations.

[23] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.37 to 1.58) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[24] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available.

[25] Downgrade for serious indirectness as evidence is based on 1 female cohort and may not be generalizable to different populations.

[26] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.80 to 1.06) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[27] Downgrade for serious risk of bias as 39.3% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 1/9).

[28] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=88%, p<0.00001) which could not be explained by sensitivity analyses.

[29] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.85) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 0.98) crosses the MID.

[30] Downgrade for serious risk of bias as 36.8% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 1/9)

[31] Downgrade for serious risk of bias as 48.0% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 1/9)

[32] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.82) includes the minimally important difference (MID) of 5% while the upper bound of the 95% CI (RR, 1.04) crosses the MID.

Table S8. GRADE Assessment for Fruits and Vegetables and Stroke Incidence

Quality Assessment								Study Event Rates (%)	Relative Risk (95% CI)	Certainty
No. of Cohorts	**Design**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication Bias**	**Other**			
Fruit and Vegetable Consumption on Stroke Incidence (follow-up median 9 years)										
14	observational	not serious	not serious	not serious	not serious	undetected	dose-response gradient[1]	11,091/532,667 (2.1%)	0.82 (0.77, 0.88)	⊕⊕⊕◯ **MODERATE**
Fruit Consumption on Stroke Incidence (follow-up median 14 years)										
17	observational	not serious	not serious	not serious	not serious	undetected	dose-response gradient[2]	43,702/987,983 (4.4%)	0.82 (0.79, 0.85)	⊕⊕⊕◯ **MODERATE**
Vegetable Consumption on Stroke Incidence (follow-up median 14 years)										
16	observational	not serious	serious[3]	not serious	not serious	undetected	dose-response gradient[4]	13,607/564,531 (2.4%)	0.82 (0.83, 0.93)	⊕⊕⊕◯ **MODERATE**
Berries Consumption on Stroke Incidence (follow-up median 10 years)										
4	observational	not serious	not serious[5]	not serious	serious[6]	undetected[7]	none	5,967/143,662 (4.2%)	1.03 (0.94, 1.13)	⊕◯◯◯ **VERY LOW**
Citrus Fruit Consumption on Stroke Incidence (follow-up median 11 years)										
8	observational	not serious	serious[8]	not serious	not serious	undetected[7]	dose-response gradient[9]	7,142/225,613 (3.2%)	0.88 (0.82, 0.94)	⊕⊕◯◯ **LOW**
Fruit Juice Consumption on Stroke Incidence (follow-up median 11 years)										
4	observational	not serious	not serious[10]	not serious	serious[11]	undetected[7]	none	1,705/148,839 (1.2%)	0.82 (0.68, 0.99)	⊕◯◯◯ **VERY LOW**
Pommes Consumption on Stroke Incidence (follow-up median 14 years)										
5	observational	not serious	not serious	not serious	not serious	undetected[7]	dose-response gradient[12]	7,364/146,723 (5.0%)	0.89 (0.84, 0.95)	⊕⊕⊕◯ **MODERATE**
Allium Vegetables Consumption on Stroke Incidence (follow-up median 28 years)										
2	Observational	not serious	not serious	serious[13]	serious[14]	undetected[7]	none	4,912/84,169 (5.8%)	0.89 (0.80, 0.99)	⊕◯◯◯ **VERY LOW**
Cruciferous Vegetables Consumption on Stroke Incidence (follow-up median 12 years)										
6	observational	not serious	serious[15]	not serious	serious[16]	undetected[7]	none	7,706/255,726 (3.0%)	0.98 (0.91, 1.05)	⊕◯◯◯ **VERY LOW**
Green Leafy Vegetables Consumption on Stroke Incidence (follow-up median 9 years)										
4	observational	not serious	not serious	not serious	serious[17]	undetected[7]	dose-response gradient[18]	4,798/196,456 (2.4%)	0.88 (0.79, 0.98)	⊕⊕◯◯ **LOW**
Tomatoes Consumption on Stroke Incidence (follow-up median 7 years)										
1	observational	not serious	not serious[19]	serious[20]	not serious	undetected[7]	dose-response gradient[21]	247/38,445 (0.6%)	0.20 (0.05, 0.82)	⊕⊕◯◯ **LOW**

[1] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit and vegetable intake and stroke incidence (p=0.002).
[2] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and stroke incidence (p<0.001).
[3] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=50%, p=0.006) that could not be explained during sensitivity analysis.
[4] Upgrade for a dose-response gradient, as the MKSPLINE analysis revealed a significant non-linear inverse relationship between vegetable intake and stroke incidence with a departure from linearity at 1.5 servings/day (p=0.012)
[5] No downgrade for inconsistency as the presence of inter-study heterogeneity (I^2=50%, p=0.08) was explained by the removal of Hirvonen et al. 2000 – cerebral infraction (I^2=0%, p=0.41)
during sensitivity analysis.

[6] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.94 to 1.13) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05)

[7] No downgrade for publication bias as publication bias could not be assessed due to lack of power for assessing funnel plot asymmetry and small study effects (i.e. <10 observations available).

[8] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=51%, p=0.04). Although the removal of Larsson et al. 2013 (I^2=37%, p=0.14) or Yamada et al. 2011 (I^2=39%, p=0.12) during sensitivity analysis did partially explain the heterogeneity, the presence of residual heterogeneity could not be excluded.

[9] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between citrus fruit intake and stroke incidence (p=0.033) and an MKSPLINE analysis revealed a significant non-linear inverse relationship between citrus fruit intake and stroke incidence (p=0.039).

[10] No downgrade for inconsistency as the presence of inter-study heterogeneity (I^2=73%, p=0.02) was explained by the removal of Scheffers et al. 2019 (I^2=0%, p=0.47)
[11] Downgrade for serious imprecision, as the upper bound of the 95% CIs (RR, 0.99) crosses the MID (RR<0.95).

[12] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between pommes intake and stroke incidence (p=0.003). MKSPLINE analyses could not be conducted due to small sample size.
[13] Downgrade for serious indirectness as evidence is based on cohorts residing in Northern Europe and may not be generalizable to different populations.
[14] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.80) includes the MID of 5% while the upper bound of the 95% CI (RR, 0.99) crosses the MID.
[15] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=62%, p=0.02). Although the removal of Larsson et al. 2013 (during sensitivity analysis did partially explain the heterogeneity (I^2=40%, p=0.16), the presence of residual heterogeneity could not be excluded.

[16] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.91 to 1.05) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).
[16] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.79) includes the MID of 5% while the upper bound of the 95% CI (RR, 0.98) crosses the MID.
[17] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between green leafy vegetable intake and stroke incidence (p=0.008). MKSPLINE analyses could not be conducted due to small sample size.
[18] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available.

[19] Downgrade for serious indirectness as evidence is based on only 1 cohort of females for USA and may not be generalizable to different populations.

[20] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between tomato intake and stroke incidence (p=0.002). MKSPLINE analyses could not be conducted due to small sample size.

Table S9. GRADE Assessment for Fruits and Vegetables and Stroke Mortality

Quality Assessment								Study Event Rates (%)	Relative Risk (95% CI)	Certainty
No. of Cohorts	**Design**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Publication Bias**	**Other**			
Fruit and Vegetable Consumption on Stroke Mortality (follow-up median 19 years)										
6	observational	not serious	not serious	not serious	not serious	undetected[1]	dose-response gradient[2]	3,051/499,732 (0.6%)	0.73 (0.65, 0.81)	⊕⊕⊕◯ **MODERATE**
Fruit Consumption on Stroke Mortality (follow-up median 20 years)										
14	observational	not serious	serious[3]	not serious	not serious	undetected	dose-response gradient[4]	10,899/1,282,756 (0.8%)	0.87 (0.84, 0.91)	⊕⊕◯◯ **LOW**
Vegetable Consumption on Stroke Mortality (follow-up median 15 years)										
12	observational	not serious	serious[5]	not serious	serious[6]	undetected	dose-response gradient[7]	7,551/780,441 (1.0%)	0.94 (0.90, 0.99)	⊕⊕◯◯ **LOW**
Bananas Consumption on Stroke Mortality (follow-up median 20 years)										
1	observational	not serious	not serious[8]	serious[9]	serious[10]	undetected[1]	none	1,.34/9,766 (10.6%)	1.04 (0.70, 1.54)	⊕◯◯◯ **VERY LOW**
Berries Consumption on Stroke Mortality (follow-up median 19 years)										
2	observational	not serious	not serious	serious[11]	serious[12]	undetected[1]	none	1,182/40,224 (2.9%)	0.97 (0.82, 1.15)	⊕◯◯◯ **VERY LOW**
Citrus Fruit Consumption on Stroke Mortality (follow-up median 20 years)										
4	observational	serious[13]	serious[14]	not serious	not serious	undetected[1]	dose-response gradient[15]	3,869/145,204 (2.7%)	0.90 (0.86, 0.95)	⊕⊕◯◯ **LOW**
Dried Fruit Consumption on Stroke Mortality (follow-up median 17 years)										
1	observational	not serious	not serious	serious[16]	serious[17]	undetected[1]	none	152/30,458 (0.5%)	0.95 (0.80, 1.13)	⊕◯◯◯ **VERY LOW**
Fruit Juice Consumption on Stroke Mortality (follow-up median 17 years)										
2	observational	serious[18]	not serious	not serious	not serious	undetected[1]	dose-response gradient[19]	2,232/128,270 (1.7%)	0.67 (0.60, 0.76)	⊕⊕◯◯ **LOW**
Grapes Consumption on Stroke Mortality (follow-up median 19 years)										
2	observational	not serious	not serious	serious[20]	serious[21]	undetected[1]	none	1,182/40224 (2.9%)	0.74 (0.53, 1.02)	⊕◯◯◯ **VERY LOW**
Pommes Consumption on Stroke Mortality (follow-up median 17 years)										
3	observational	not serious	not serious	serious[22]	serious[23]	undetected[1]	none	1,651/74,716 (2.2%)	0.91 (0.77, 1.09)	⊕◯◯◯ **VERY LOW**
Allium Vegetable Consumption on Stroke Mortality (follow-up median 19 years)										
2	observational	not serious	serious[24]	not serious	serious[25]	undetected[1]	none	544/3,671 (14.8%)	0.99 (0.79, 1.24)	⊕◯◯◯ **VERY LOW**
Carrots Consumption on Stroke Mortality (follow-up median 20 years)										
1	observational	not serious	not serious[8]	serious[9]	not serious	undetected[1]	dose-response gradient[26]	1,034/9,766 (10.6%)	0.54 (0.48, 0.61)	⊕⊕◯◯ **LOW**

Cruciferous Vegetables Consumption on Stroke Mortality (follow-up median 20 years)										
5	observational	serious[27]	not serious	not serious	serious[28]	undetected[1]	none	5,065/195,452 (2.6%)	0.92 (0.85, 1.01)	⨁◯◯◯ **VERY LOW**
Green Leafy Vegetables Consumption on Stroke Mortality (follow-up median 21 years)										
4	observational	serious[29]	serious[30]	not serious	serious[31]	undetected[1]	dose-response gradient[32]	4,103/126,971 (3.2%)	0.90 (0.83, 0.97)	⨁⨁◯◯ **LOW**
Tomatoes Consumption on Stroke Mortality (follow-up median 20 years)										
2	observational	serious[33]	not serious	not serious	serious[33]	undetected[1]	none[34]	3,107/108,260 (2.9%)	1.03 (0.94, 1.12)	⨁◯◯◯ **VERY LOW**

[1] No downgrade for publication bias as publication bias could not be assessed due to lack of power for assessing funnel plot asymmetry and small study effects (i.e. <10 observations available).

[2] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit and vegetable intake and stroke mortality (p=0.005).

[3] Downgrade for serious inconsistency as there was evidence of substantial inter-study heterogeneity (I^2=75%, p<0.00001) which could not be explained by sensitivity analyses.

[4] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit intake and stroke mortality (p<0.001) and an MKSPLINE analysis revealed a significant non-linear inverse relationship between fruit intake and stroke mortality (p<0.001)

[5] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=62%, p=0.0010). Although the removal of Wang et al. 2013 (I^2=43%, p=0.05) or Leeanders et al. 2014 (I^2=48%, p=0.02) during sensitivity analysis did partially explain the heterogeneity, the presence of residual heterogeneity could not be excluded.

[6] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.90) includes the MID of 5% while the upper bound of the 95% CI (RR, 0.99) crosses the MID.

[7] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between vegetable intake and stroke mortality (p=0.025).

[8] No downgrade for inconsistency as analyses for inconsistency could not be performed due to <2 observations available.

[9] Downgrade for serious indirectness as evidence is based on 1 male cohort and may not be generalizable to different populations

[10] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.70 to 1.54) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[11] Downgrade for serious indirectness as evidence is based on a predominately (76%) female population and may not be generalizable to different populations.

[12] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.82) includes the MID of 5% while the upper bound of the 95% CI (RR, 1.15) crosses the MID.

[13] Downgrade for serious risk of bias as 75.3% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 5/9).

[14] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=82%, p=0.0001). Although the removal of Wang et al. 2016 (I^2=40%, p=0.17) during sensitivity analysis did partially explain the heterogeneity, the presence of residual heterogeneity could not be excluded.

[15] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between citrus fruit intake and stroke mortality (p<0.001).

[16] Downgrade for serious indirectness as evidence is based on one female population and may not be generalizable to different populations.

[17] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.80 to 1.13) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[18] Downgrade for serious risk of bias as 62% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 5/9).

[19] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between fruit juice intake and CHD mortality (p=0.002). MKSPLINE analyses could not be conducted due to small sample size.

[20] Downgrade for serious indirectness as evidence is based on a predominately (76%) female population and may not be generalizable to different populations.

[21] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.53 to 1.02) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[22] Downgrade for serious indirectness as evidence is based on a predominately (87%) female population and may not be generalizable to different populations.

[23] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.77) includes the MID of 5% while the upper bound of the 95% CI (RR, 1.09) crosses the MID.

[24] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=96%, p<0.00001).

[25] Downgrade for serious imprecision, as the lower and upper bound of the 95% CIs (RR, 0.79 to 1.24) includes both clinically important benefit (RR<0.95) and harm (RR≥1.05).

[26] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between carrots intake and stroke mortality (p<0.001).

[27] Downgrade for serious risk of bias as 79.4% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 5/9).

[28] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.85) includes the MID of 5% while the upper bound of the 95% CI (RR, 1.01) crosses the MID.

[29] Downgrade for serious risk of bias as 50.0% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 5/9).

[30] Downgrade for serious inconsistency given evidence of substantial inter-study heterogeneity (I^2=50%, p=0.09). Although the removal of Appleby et al. 2002 (I^2=36%, p=0.20) or Wang et al. 2016 (I^2=25%, p=0.05) during sensitivity analysis did partially explain the heterogeneity, the presence of residual heterogeneity could not be excluded.

[31] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.83) includes the MID of 5% while the upper bound of the 95% CI (RR, 0.97) crosses the MID.

[32] Upgrade for a dose-response gradient, as the GLST analysis revealed a significant linear inverse relationship between green leafy vegetable intake and CHD mortality (p=0.032). MKSPLINE analyses could not be conducted due to small sample size.

[33] Downgrade for serious risk of bias as 60.4% of effect estimate is based on Iso et al. 2007, which presented with a high risk of bias (Newcastle-Ottawa Score: 5/9).

[34] Downgrade for serious imprecision, as the lower bound of the 95% CI (RR, 0.94) includes the MID of 5% while the upper bound of the 95% CI (RR, 1.12) crosses the MID.

[35] Dose-response gradient could not be assessed due to insufficient dose ranges available to determine the presence of a linear/non-linear dose response.

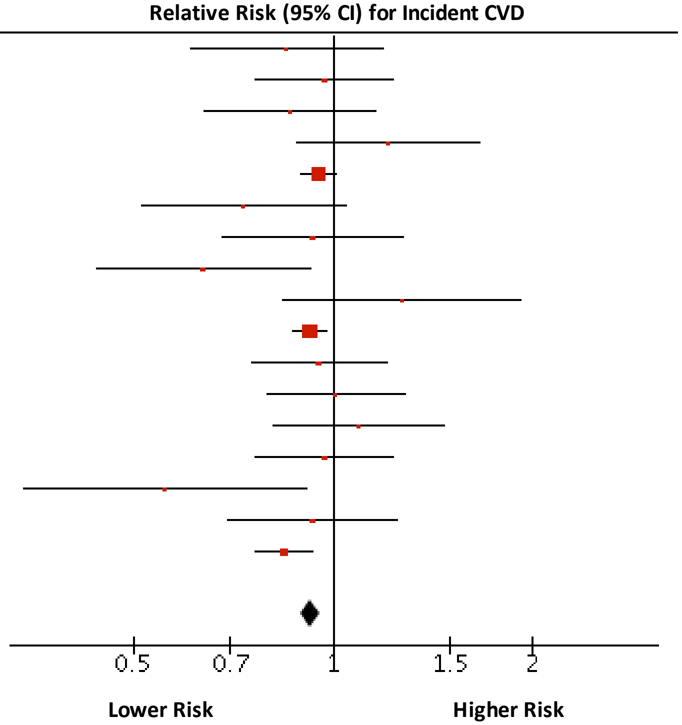
Figure S1. Relation between total fruit and vegetable intake and cardiovascular disease incidence (highest vs. lowest level of intake).

TOTAL FRUIT AND VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Liu 2000	39,127	418	1.1%	0.85 [0.61, 1.19]
Japan Public Health Center - Takachi 2008 - M	35,909	830	2.1%	0.97 [0.77, 1.23]
Japan Public Health Center - Takachi 2008 - F	41,982	556	1.4%	0.86 [0.64, 1.15]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	1.2%	1.21 [0.88, 1.65]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	34.3%	0.95 [0.90, 1.01]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	1.0%	0.73 [0.52, 1.04]
PRIME - Dauchet 2010 - former smokers	3,353	237	1.2%	0.93 [0.68, 1.28]
PRIME - Dauchet 2010 - current smokers	2,297	230	0.9%	0.64 [0.44, 0.93]
PRIME - Dauchet 2010 - never smokers	2,410	145	0.7%	1.27 [0.84, 1.92]
WHI-OS - Belin 2011	93,676	6,006	34.3%	0.92 [0.87, 0.98]
Carphilly Cohort - Elwood 2013	2,235	752	2.1%	0.95 [0.75, 1.20]
British Regional Heart - Atkins 2014	3,328	582	2.1%	1.01 [0.80, 1.28]
SABRE - Eriksen 2015 - European	1,090	225	1.4%	1.09 [0.82, 1.47]
SABRE - Eriksen 2015 - South Asian	1,006	346	2.1%	0.97 [0.77, 1.23]
PREDIMED- Buil-Cosiales 2016	7,216	342	0.5%	0.56 [0.34, 0.91]
PURE - Miller 2017	135,335	4,784	1.4%	0.93 [0.69, 1.25]
EPIC Norfolk - Mytton 2018	22,992	4,965	12.3%	0.84 [0.76, 0.93]
Total (95% CI)	**501,744**	**24,310**	**100.0%**	**0.93 [0.89, 0.96]**

Heterogeneity: Chi² = 21.52, df = 16 (P = 0.16); I² = 26%
Test for overall effect: Z = 4.42 (P < 0.00001)

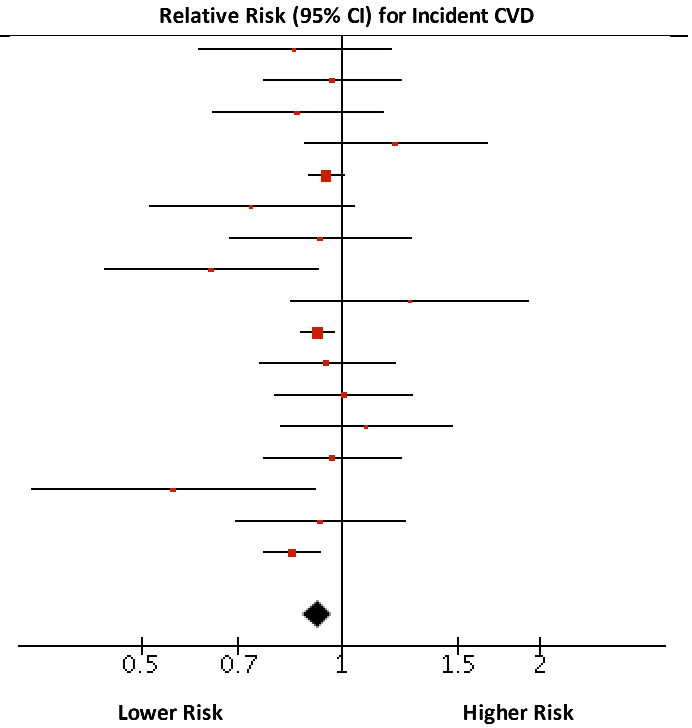


B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Liu 2000	39,127	418	2.3%	0.85 [0.61, 1.19]
Japan Public Health Center - Takachi 2008 - M	35,909	830	4.3%	0.97 [0.77, 1.23]
Japan Public Health Center - Takachi 2008 - F	41,982	556	2.9%	0.86 [0.64, 1.15]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	2.6%	1.21 [0.88, 1.65]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	22.6%	0.95 [0.90, 1.01]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	2.1%	0.73 [0.52, 1.04]
PRIME - Dauchet 2010 - former smokers	3,353	237	2.6%	0.93 [0.68, 1.28]
PRIME - Dauchet 2010 - current smokers	2,297	230	1.9%	0.64 [0.44, 0.93]
PRIME - Dauchet 2010 - never smokers	2,410	145	1.5%	1.27 [0.84, 1.92]
WHI-OS - Belin 2011	93,676	6,006	22.6%	0.92 [0.87, 0.98]
Carphilly Cohort - Elwood 2013	2,235	752	4.3%	0.95 [0.75, 1.20]
British Regional Heart - Atkins 2014	3,328	582	4.3%	1.01 [0.80, 1.28]
SABRE - Eriksen 2015 - European	1,090	225	2.9%	1.09 [0.82, 1.47]
SABRE - Eriksen 2015 - South Asian	1,006	346	4.3%	0.97 [0.77, 1.23]
PREDIMED- Buil-Cosiales 2016	7,216	342	1.1%	0.56 [0.34, 0.91]
PURE - Miller 2017	135,335	4,784	2.9%	0.93 [0.69, 1.25]
EPIC Norfolk - Mytton 2018	22,992	4,965	15.0%	0.84 [0.76, 0.93]
Total (95% CI) [Random Effects]	**501,744**	**24,310**	**100.00%**	**0.92 [0.88, 0.97]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 21.52$, df = 16 (P = 0.16); $I^2 = 26\%$

Test for overall effect: Z = 3.02 (P = 0.002)



All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

FRUIT AND CARDIOVASCULAR DISEASE INCIDENCE

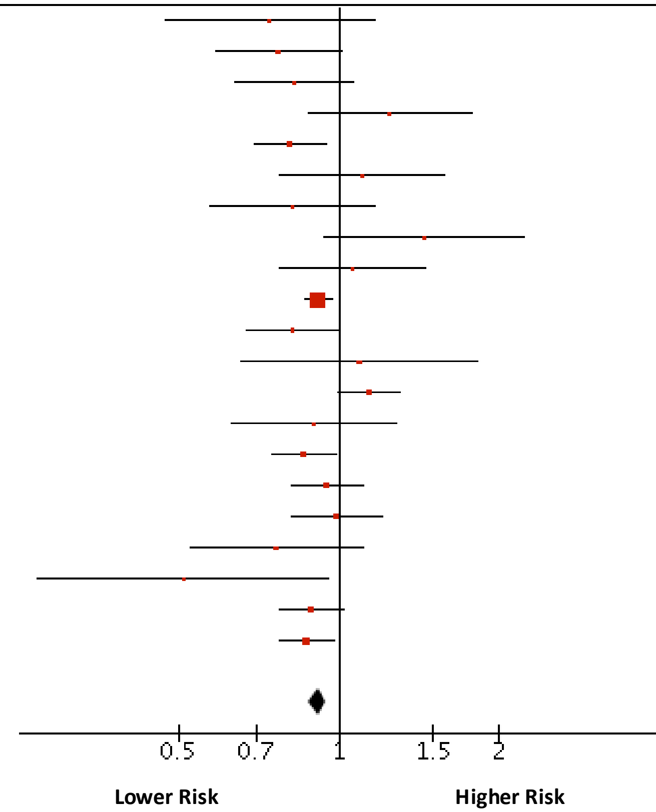
A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	226	0.7%	0.74 [0.47, 1.16]
Japan Public Health Center - Takachi 2008 - F	41,982	556	1.8%	0.77 [0.59, 1.01]
Japan Public Health Center - Takachi 2008 - M	35,909	830	2.1%	0.83 [0.64, 1.07]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	1.1%	1.25 [0.88, 1.77]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	5.4%	0.81 [0.69, 0.95]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	1.1%	1.11 [0.78, 1.57]
PRIME - Dauchet 2010 - current smokers	2,297	230	1.1%	0.82 [0.58, 1.17]
PRIME - Dauchet 2010 - never smokers	2,410	145	0.7%	1.45 [0.94, 2.23]
PRIME - Dauchet 2010 - former smokers	3,353	237	1.4%	1.06 [0.78, 1.45]
WHI-OS - Belin 2011	93,676	6,006	38.6%	0.91 [0.86, 0.97]
WHS - Fitzgerald 2012	34,827	1,094	3.5%	0.82 [0.67, 1.00]
British Women's Heart & Health - Kim 2013	3,080	329	0.5%	1.09 [0.66, 1.82]
EPIC Potsdam - Von Ruesten 2013	23,531	363	7.1%	1.14 [0.99, 1.31]
British Regional Heart - Atkins 2014	3,328	582	1.1%	0.90 [0.63, 1.27]
MONICA Danish - Tognon 2014	1,849	755	7.1%	0.86 [0.75, 0.99]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	1,694	5.4%	0.95 [0.81, 1.11]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	1,227	3.5%	0.99 [0.81, 1.20]
PREDIMED- Buil-Cosiales 2016	7,216	342	1.0%	0.76 [0.53, 1.11]
SUN - Buil-Cosiales - 2017	17,007	112	0.3%	0.51 [0.27, 0.96]
PURE - Miller 2017	135,335	4,784	7.1%	0.89 [0.77, 1.02]
EPIC NL and MORGEN - Scheffers 2019	34,560	3,801	9.7%	0.87 [0.77, 0.98]
Total (95% CI)	**577,323**	**27,205**	**100.0%**	**0.91 [0.88, 0.95]**

Heterogeneity: Chi² = 33.12, df = 20 (P = 0.03); I^2 = 40%

Test for overall effect: Z = 4.88 (P < 0.00001)

Relative Risk (95% CI) for Incident CVD



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	226	1.5%	0.74 [0.47, 1.16]
Japan Public Health Center - Takachi 2008 - F	41,982	556	3.5%	0.77 [0.59, 1.01]
Japan Public Health Center - Takachi 2008 - M	35,909	830	3.9%	0.83 [0.64, 1.07]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	2.3%	1.25 [0.88, 1.77]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	7.3%	0.81 [0.69, 0.95]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	2.3%	1.11 [0.78, 1.57]
PRIME - Dauchet 2010 - current smokers	2,297	230	2.3%	0.82 [0.58, 1.17]
PRIME - Dauchet 2010 - never smokers	2,410	145	1.6%	1.45 [0.94, 2.23]
PRIME - Dauchet 2010 - former smokers	3,353	237	2.8%	1.06 [0.78, 1.45]
WHI-OS - Belin 2011	93,676	6,006	13.4%	0.91 [0.86, 0.97]
WHS - Fitzgerald 2012	34,827	1,094	5.6%	0.82 [0.67, 1.00]
British Women's Heart & Health - Kim 2013	3,080	329	1.2%	1.09 [0.66, 1.82]
EPIC Potsdam - Von Ruesten 2013	23,531	363	8.3%	1.14 [0.99, 1.31]
British Regional Heart - Atkins 2014	3,328	582	2.3%	0.90 [0.63, 1.27]
MONICA Danish - Tognon 2014	1,849	755	8.3%	0.86 [0.75, 0.99]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	1,694	7.3%	0.95 [0.81, 1.11]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	1,227	5.6%	0.99 [0.81, 1.20]
PREDIMED- Buil-Cosiales 2016	7,216	342	2.1%	0.76 [0.53, 1.11]
SUN - Buil-Cosiales - 2017	17,007	112	0.8%	0.51 [0.27, 0.96]
PURE - Miller 2017	135,335	4,784	8.3%	0.89 [0.77, 1.02]
EPIC NL and MORGEN - Scheffers 2019	34,560	3,801	9.5%	0.87 [0.77, 0.98]
Total (95% CI) [Random Effects]	**577,323**	**27,205**	**100.0%**	**0.91 [0.86, 0.97]**

Heterogeneity: Tau² = 0.01; Chi² = 33.12, df = 20 (P = 0.03); I² = 40%

Test for overall effect: Z = 3.07 (P = 0.002)

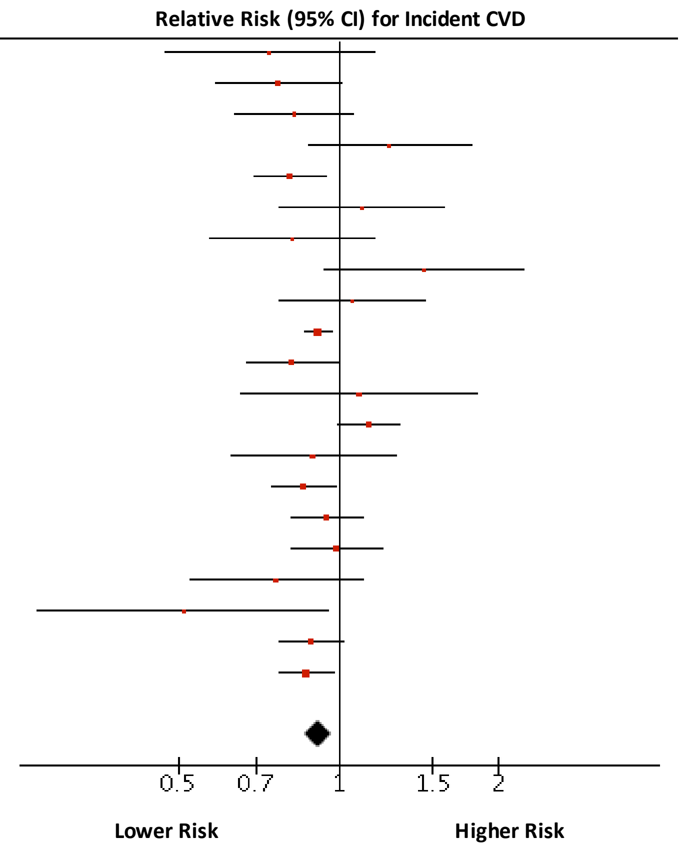


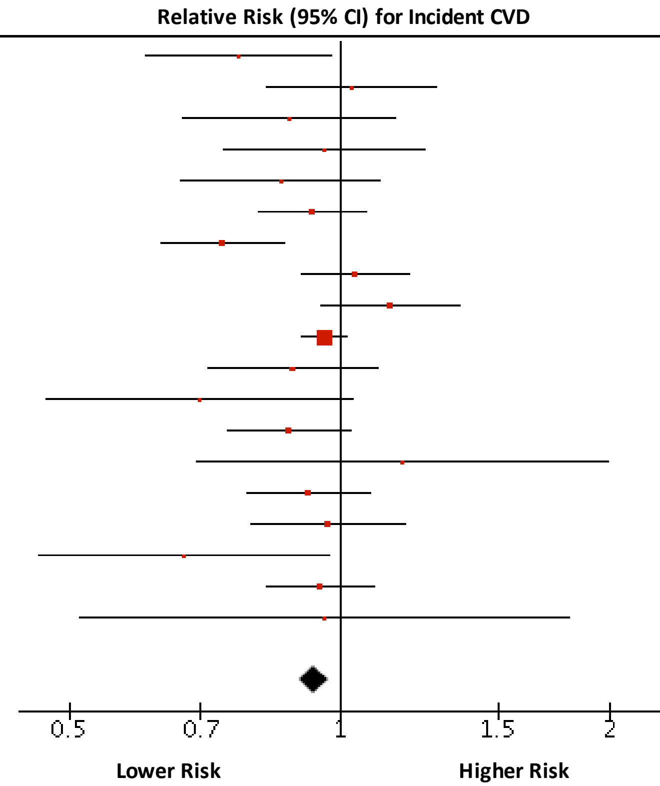
Figure S2. Relation between fruit intake and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	209	2.4%	0.77 [0.61, 0.98]
Japan Public Health Center - Takachi 2008 - M	35,909	582	2.9%	1.03 [0.83, 1.28]
Japan Public Health Center - Takachi 2008 - F	41,982	556	1.8%	0.88 [0.67, 1.16]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	2.0%	0.96 [0.74, 1.24]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	2.0%	0.86 [0.67, 1.11]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	7.0%	0.93 [0.81, 1.07]
PRIME - Dauchet 2010 - current smokers	2,297	230	5.4%	0.74 [0.63, 0.87]
PRIME - Dauchet 2010 - former smokers	3,353	237	7.0%	1.04 [0.91, 1.19]
PRIME - Dauchet 2010 - never smokers	2,410	145	4.3%	1.14 [0.95, 1.36]
WHI-OS - Belin 2011	93,676	6,006	38.4%	0.96 [0.91, 1.02]
WHS - Fitzgerald 2012	34,827	1,094	2.9%	0.89 [0.71, 1.10]
EPIC Potsdam - Von Ruesten 2013	23,531	363	0.9%	0.70 [0.47, 1.03]
MONICA Danish - Tognon 2014	1,849	755	5.4%	0.88 [0.75, 1.03]
British Regional Heart - Atkins 2014	3,328	582	0.5%	1.17 [0.69, 1.99]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	1,694	5.4%	0.92 [0.79, 1.08]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	1,227	3.5%	0.97 [0.80, 1.18]
PREDIMED- Buil-Cosiales 2016	7,216	342	1.0%	0.67 [0.46, 0.97]
PURE - Miller 2017	135,335	4,784	7.0%	0.95 [0.83, 1.09]
SUN - Buil-Cosiales - 2017	17,007	112	0.3%	0.96 [0.51, 1.80]
Total (95% CI)	**539,683**	**22,810**	**100.0%**	**0.94 [0.90, 0.97]**

Heterogeneity: Chi² = 27.44, df = 18 (P = 0.07); I² = 34%
Test for overall effect: Z = 3.51 (P = 0.0004)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	209	4.0%	0.77 [0.61, 0.98]
Japan Public Health Center - Takachi 2008 - M	35,909	582	4.5%	1.03 [0.83, 1.28]
Japan Public Health Center - Takachi 2008 - F	41,982	556	3.1%	0.88 [0.67, 1.16]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	3.5%	0.96 [0.74, 1.24]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	8.2%	0.93 [0.81, 1.07]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	3.5%	0.86 [0.67, 1.11]
PRIME - Dauchet 2010 - former smokers	3,353	237	8.2%	1.04 [0.91, 1.19]
PRIME - Dauchet 2010 - never smokers	2,410	145	6.0%	1.14 [0.95, 1.36]
PRIME - Dauchet 2010 - current smokers	2,297	230	7.0%	0.74 [0.63, 0.87]
WHI-OS - Belin 2011	93,676	6,006	15.0%	0.96 [0.91, 1.02]
WHS - Fitzgerald 2012	34,827	1,094	4.5%	0.89 [0.71, 1.10]
EPIC Potsdam - Von Ruesten 2013	23,531	363	1.7%	0.70 [0.47, 1.03]
British Regional Heart - Atkins 2014	3,328	582	0.9%	1.17 [0.69, 1.99]
MONICA Danish - Tognon 2014	1,849	755	7.0%	0.88 [0.75, 1.03]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	1,227	5.2%	0.97 [0.80, 1.18]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	1,694	7.0%	0.92 [0.79, 1.08]
PREDIMED- Buil-Cosiales 2016	7,216	342	1.8%	0.67 [0.46, 0.97]
SUN - Buil-Cosiales - 2017	17,007	112	0.7%	0.96 [0.51, 1.80]
PURE - Miller 2017	135,335	4,784	8.2%	0.95 [0.83, 1.09]
Total (95% CI) [Random Effects]	**539,683**	**22,810**	**100.0%**	**0.92 [0.88, 0.97]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 27.44$, df = 18 ($P = 0.07$); $I^2 = 34\%$

Test for overall effect: $Z = 2.93$ ($P = 0.003$)

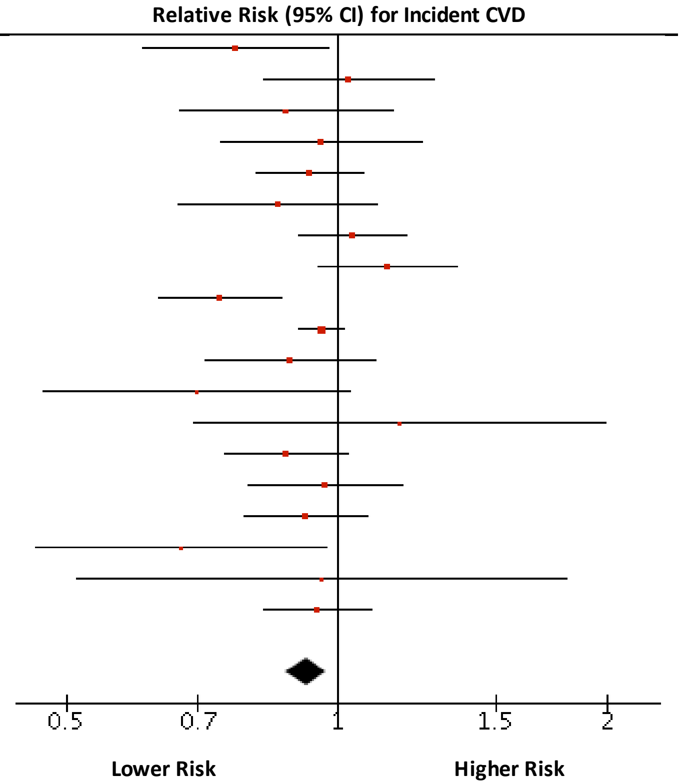


Figure S3. Relation between vegetable intake and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BERRIES AND CARDIOVASCULAR DISEASE INCIDENCE

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2007	38,176	1,004	100.00%	1.27 [0.95, 1.71]
Total (95% CI)	**38,176**	**1,004**	**100.0%**	**1.27 [0.95, 1.71]**

Heterogeneity: Not applicable
Test for overall effect: Z = 1.60 (P = 0.11)

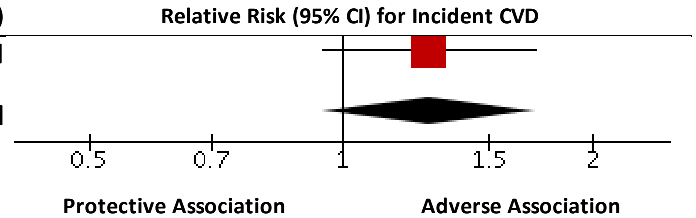


Figure S4. Relation between intake of berries and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

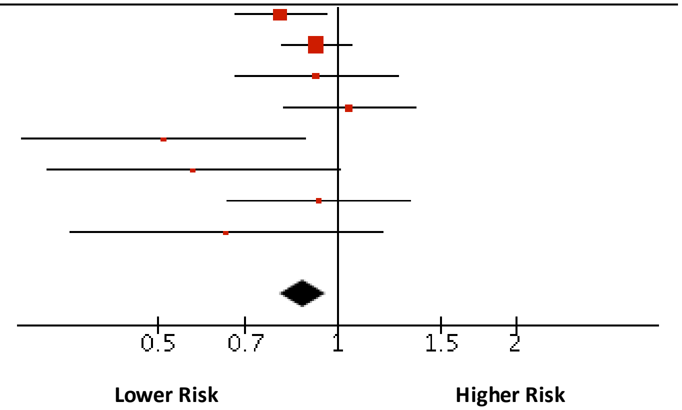
CITRUS FRUIT AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Japan Public Health Center - Takachi 2008	77,891	1,386	25.1%	0.80 [0.67, 0.96]
NHS & HPFS -Joshipura 2009 - Mod. CHO	109,788	3,892	41.5%	0.92 [0.80, 1.06]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	7.9%	0.92 [0.67, 1.26]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	12.0%	1.05 [0.81, 1.36]
Jidni Medical School - Yamada 2011 - F	6,476	218	2.6%	0.51 [0.30, 0.89]
Jidni Medical School - Yamada 2011 - M	4,147	270	2.4%	0.57 [0.32, 1.01]
PREDIMED- Buil-Cosiales 2016	7,216	342	6.3%	0.93 [0.66, 1.33]
SUN - Buil-Cosiales - 2017	17,007	112	2.1%	0.65 [0.35, 1.19]
Total (95% CI) [Fixed Effets]	**222,525**	**6,220**	**100.0%**	**0.88 [0.80, 0.96]**

Heterogeneity: Chi² = 10.49, df = 7 (P = 0.16); I² = 33%
Test for overall effect: Z = 2.95 (P = 0.003)

Relative Risk (95% CI) for Incident CVD



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Japan Public Health Center - Takachi 2008	77,891	1,386	22.9%	0.80 [0.67, 0.96]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	11.5%	0.92 [0.67, 1.26]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	27.9%	0.92 [0.80, 1.06]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	15.3%	1.05 [0.81, 1.36]
Jidni Medical School - Yamada 2011 - M	4,147	270	4.3%	0.57 [0.32, 1.01]
Jidni Medical School - Yamada 2011 - F	6,476	218	4.6%	0.51 [0.30, 0.89]
PREDIMED- Buil-Cosiales 2016	7,216	342	9.6%	0.93 [0.66, 1.33]
SUN - Buil-Cosiales - 2017	17,007	112	3.8%	0.65 [0.35, 1.19]
Total (95% CI) [Random Effects]	**222,525**	**6,220**	**100.0%**	**0.86 [0.76, 0.97]**

Heterogeneity: Tau² = 0.01; Chi² = 10.49, df = 7 (P = 0.16); I² = 33%
Test for overall effect: Z = 2.40 (P = 0.02)

Relative Risk (95% CI) for Incident CVD

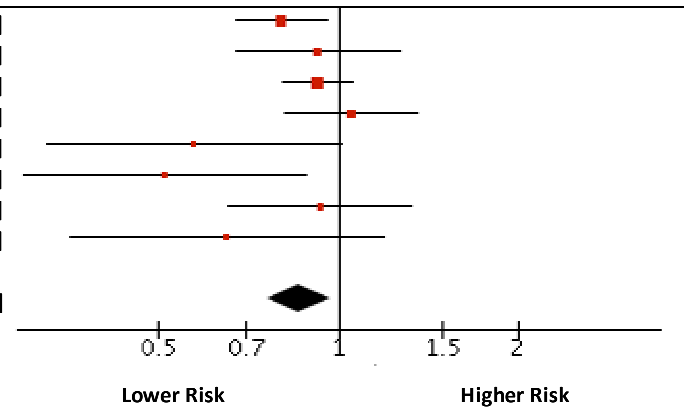


Figure S5. Relation between citrus fruit intake and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

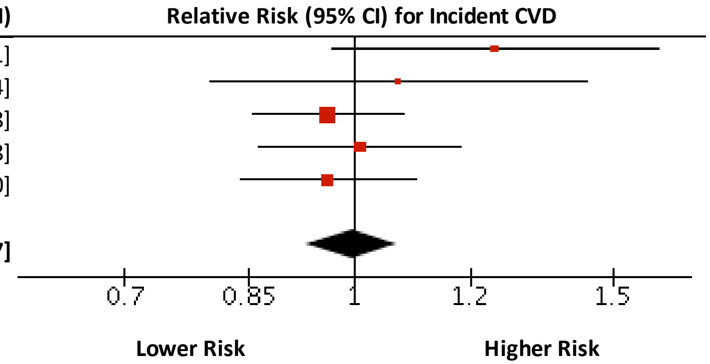
FRUIT JUICE AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	8.0%	1.25 [0.97, 1.61]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	6.0%	1.07 [0.80, 1.44]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	37.5%	0.96 [0.85, 1.08]
EPIC Potsdam - Von Ruesten 2013	23,531	363	21.1%	1.01 [0.86, 1.18]
EPIC NL and MORGEN - Scheffers 2019	34,560	3,801	27.5%	0.96 [0.84, 1.10]
Total (95% CI)	**167,879**	**8,056**	**100.0%**	**1.00 [0.93, 1.07]**

Heterogeneity: Tau² = 0.00; Chi² = 3.86, df = 4 (P = 0.42); I² = 0%

Test for overall effect: Z = 0.06 (P = 0.95)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	8.0%	1.25 [0.97, 1.61]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	6.0%	1.07 [0.80, 1.44]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	37.5%	0.96 [0.85, 1.08]
EPIC Potsdam - Von Ruesten 2013	23,531	363	21.1%	1.01 [0.86, 1.18]
EPIC NL and MORGEN - Scheffers 2019	34,560	3,801	27.5%	0.96 [0.84, 1.10]
Total (95% CI)	**167,879**	**8,056**	**100.0%**	**1.00 [0.93, 1.07]**

Heterogeneity: Tau² = 0.00; Chi² = 3.86, df = 4 (P = 0.42); I² = 0%

Test for overall effect: Z = 0.06 (P = 0.95)

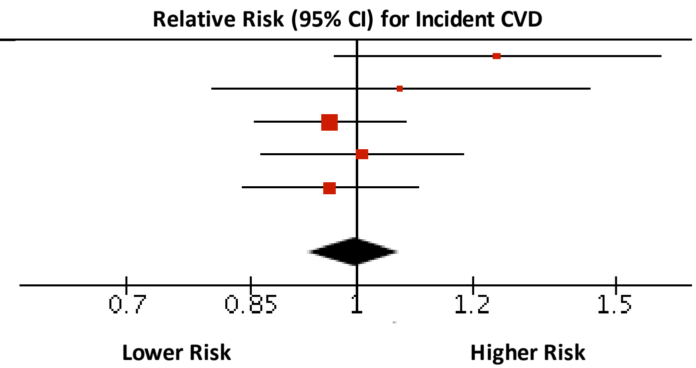


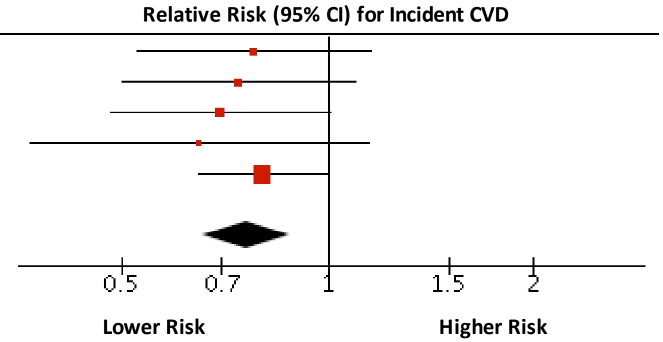
Figure S6. Relation between fruit juice intake and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

POMMES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (a)	38,176	1,004	14.5%	0.78 [0.53, 1.15]
Framingham Offspring Study - Jacques 2015	2,880	518	14.5%	0.74 [0.50, 1.10]
PREDIMED- Buil-Cosiales 2016	7,216	342	16.1%	0.70 [0.48, 1.01]
SUN - Buil-Cosiales - 2017	17,007	112	6.9%	0.65 [0.37, 1.15]
NutriNet-Sante - Adriouch 2018	84,158	602	48.0%	0.80 [0.65, 1.00]
Total (95% CI)	**149,437**	**2,578**	**100.0%**	**0.76 [0.66, 0.88]**

Heterogeneity: $Chi^2 = 0.77$, df = 4 (P = 0.94); $I^2 = 0\%$
Test for overall effect: Z = 3.58 (P = 0.0003)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (a)	38,176	1,004	14.5%	0.78 [0.53, 1.15]
Framingham Offspring Study - Jacques 2015	2,880	518	14.5%	0.74 [0.50, 1.10]
PREDIMED- Buil-Cosiales 2016	7,216	342	16.1%	0.70 [0.48, 1.01]
SUN - Buil-Cosiales - 2017	17,007	112	6.9%	0.65 [0.37, 1.15]
NutriNet-Sante - Adriouch 2018	84,158	602	48.0%	0.80 [0.65, 1.00]
Total (95% CI) [Random Effects]	**149,437**	**2,578**	**100.0%**	**0.76 [0.66, 0.88]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.77$, df = 4 (P = 0.94); $I^2 = 0\%$
Test for overall effect: Z = 3.58 (P = 0.0003)

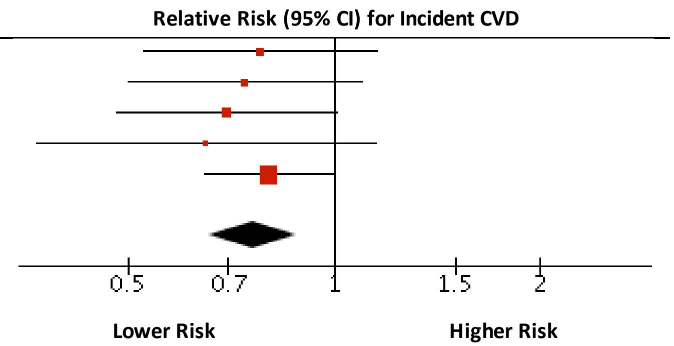


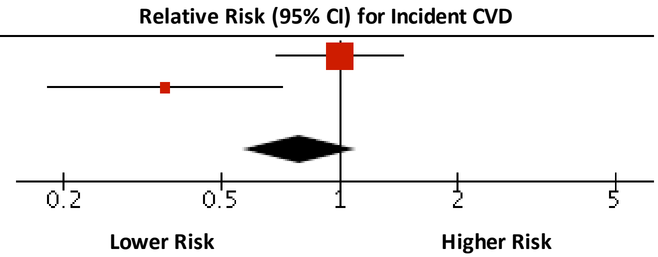
Figure S7. Relation between pommes intake and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

ALLIUM VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (a)	38,445	729	77.2%	1.00 [0.69, 1.45]
Theran Lipid and Glucose - Bahadoran 2017	2,369	79	22.8%	0.36 [0.18, 0.72]
Total (95% CI)	**40,814**	**808**	**100.0%**	**0.79 [0.57, 1.10]**

Heterogeneity: Chi² = 6.56, df = 1 (P = 0.01); I² = 85%
Test for overall effect: Z = 1.39 (P = 0.16)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (a)	38,445	729	54.20%	1.00 [0.69, 1.45]
Theran Lipid and Glucose - Bahadoran 2017	2,369	79	45.80%	0.36 [0.18, 0.72]
Total (95% CI) [Random Effects]	**40,814**	**808**	**100.00%**	**0.63 [0.23, 1.70]**

Heterogeneity: Tau² = 0.44; Chi² = 6.56, df = 1 (P = 0.01); I² = 85%
Test for overall effect: Z = 0.92 (P = 0.36)

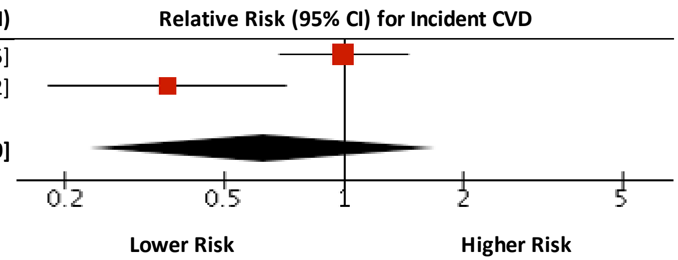


Figure S8. Relation between intake of allium vegetables and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

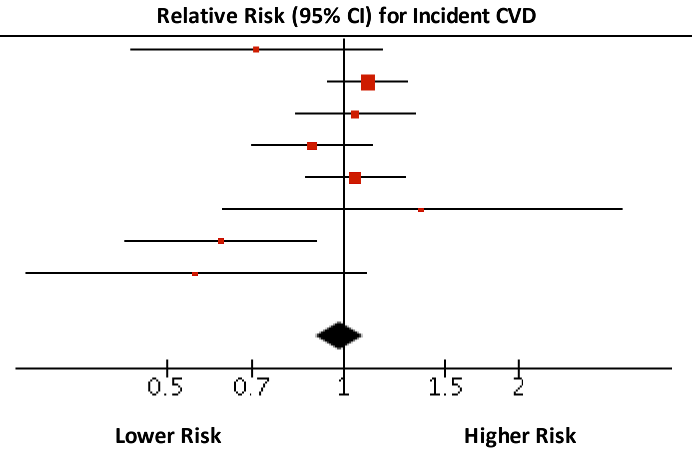
CRUCIFEROUS VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (a)	38,445	729	3.5%	0.71 [0.44, 1.16]
Japan Public Health Center - Takachi 2008	77,891	1,386	34.4%	1.11 [0.94, 1.29]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	15.3%	1.05 [0.83, 1.33]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	15.3%	0.89 [0.70, 1.12]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	22.0%	1.05 [0.86, 1.28]
EPIC Potsdam - Von Ruesten 2013	23,531	363	1.4%	1.36 [0.62, 2.99]
PREDIMED- Buil-Cosiales 2016	7,216	342	6.1%	0.62 [0.43, 0.90]
SUN - Buil-Cosiales - 2017	17,007	112	1.9%	0.56 [0.29, 1.09]
Total (95% CI)	**273,878**	**6,824**	**100.0%**	**0.99 [0.90, 1.08]**

Heterogeneity: Chi² = 14.65, df = 7 (P = 0.04); I² = 52%

Test for overall effect: Z = 0.28 (P = 0.78)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (a)	38,445	729	7.2%	0.71 [0.44, 1.16]
Japan Public Health Center - Takachi 2008	77,891	1,386	21.7%	1.11 [0.94, 1.29]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	16.8%	0.89 [0.70, 1.12]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	19.2%	1.05 [0.86, 1.28]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	16.8%	1.05 [0.83, 1.33]
EPIC Potsdam - Von Ruesten 2013	23,531	363	3.3%	1.36 [0.62, 2.99]
PREDIMED- Buil-Cosiales 2016	7,216	342	10.5%	0.62 [0.43, 0.90]
SUN - Buil-Cosiales - 2017	17,007	112	4.4%	0.56 [0.29, 1.09]
Total (95% CI) [Random Effects]	**273,878**	**6,824**	**100.0%**	**0.93 [0.80, 1.09]**

Heterogeneity: Tau² = 0.02; Chi² = 14.65, df = 7 (P = 0.04); I² = 52%

Test for overall effect: Z = 0.91 (P = 0.36)

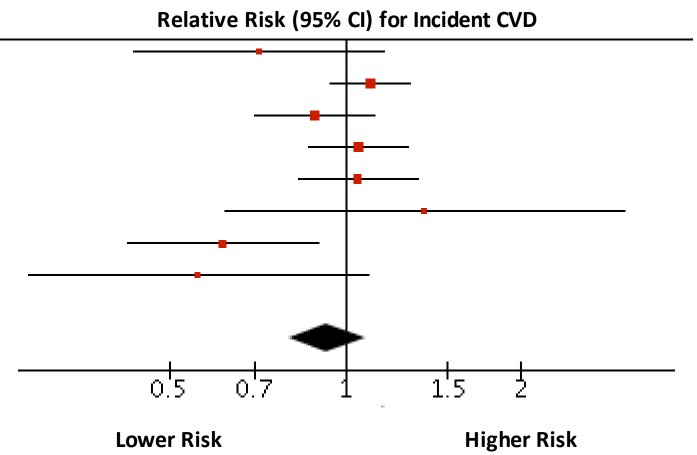


Figure S9. Relation between intake of cruciferous vegetables and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

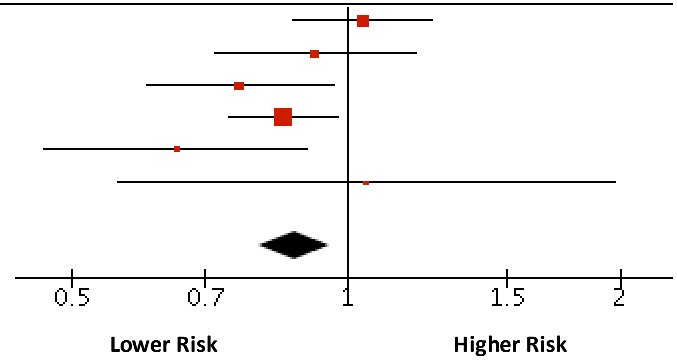
GREEN LEAFY VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Japan Public Health Center - Takachi 2008	77,891	1,386	24.7%	1.04 [0.87, 1.24]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	11.8%	0.92 [0.72, 1.19]
NHS & HPFS -Joshipura 2009 - Low. CHO	-	-	13.9%	0.76 [0.60, 0.97]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	40.8%	0.85 [0.74, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	342	6.9%	0.65 [0.47, 0.91]
SUN - Buil-Cosiales - 2017	17,007	112	2.0%	1.05 [0.56, 1.97]
Total (95% CI)	**211,902**	**5,732**	**100.0%**	**0.87 [0.76, 0.99]**

Heterogeneity: Chi² = 8.69, df = 5 (P = 0.12); I² = 42%
Test for overall effect: Z = 2.93 (P = 0.003)

Relative Risk (95% CI) for Incident CVD



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Japan Public Health Center - Takachi 2008	77,891	1,386	24.7%	1.04 [0.87, 1.24]
NHS & HPFS - Joshipura 2009 - High CHO	109,788	3,892	11.8%	0.92 [0.72, 1.19]
NHS & HPFS -Joshipura 2009 - Low. CHO	-	-	13.9%	0.76 [0.60, 0.97]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	40.8%	0.85 [0.74, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	342	6.9%	0.65 [0.47, 0.91]
SUN - Buil-Cosiales - 2017	17,007	112	2.0%	1.05 [0.56, 1.97]
Total (95% CI)	**211,902**	**5,732**	**100.0%**	**0.87 [0.76, 0.99]**

Heterogeneity: Tau² = 0.01; Chi² = 8.69, df = 5 (P = 0.12); I² = 42%
Test for overall effect: Z = 2.16 (P = 0.03)

Relative Risk (95% CI) for Incident CVD

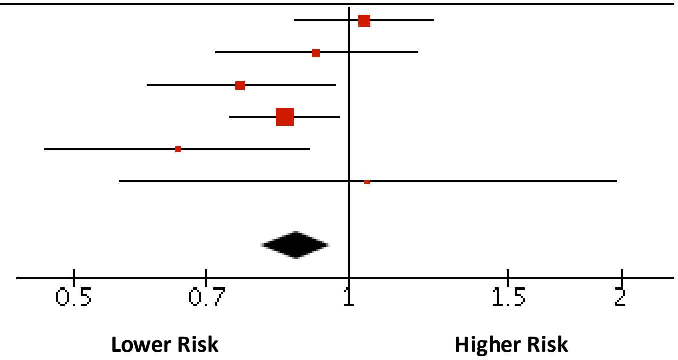


Figure S10. Relation between intake of green leafy vegetables and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

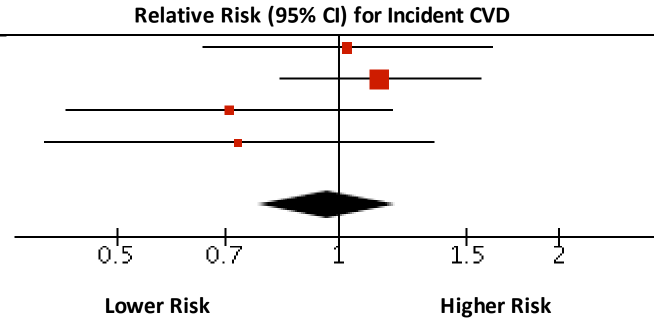
TOMATOES AND CARDIOVASCULAR DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (b) - tomatoes	38,445	729	22.7%	1.03 [0.66, 1.62]
WHS - Sesso 2003 (b) - tomato juice	-	-	47.0%	0.71 [0.43, 1.18]
WHS - Sesso 2003 (b) - tomato based products	-	-	17.8%	1.14 [0.83, 1.56]
SUN - Buil-Cosiales - 2017	17,007	112	12.5%	0.73 [0.40, 1.35]
Total (95% CI)	**55,452**	**841**	**100.0%**	**0.97 [0.78, 1.20]**

Heterogeneity: Chi² = 3.31, df = 3 (P = 0.35); I² = 9%

Test for overall effect: Z = 0.29 (P = 0.77)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (b) - tomatoes	38,445	729	23.5%	1.03 [0.66, 1.62]
WHS - Sesso 2003 (b) - tomato based products	-	-	18.8%	0.71 [0.43, 1.18]
WHS - Sesso 2003 (b) - tomato juice	-	-	44.2%	1.14 [0.83, 1.56]
SUN - Buil-Cosiales - 2017	17,007	112	13.5%	0.73 [0.40, 1.35]
Total (95% CI) [Random Effects]	**55,452**	**841**	**100.0%**	**0.96 [0.76, 1.21]**

Heterogeneity: Tau² = 0.01; Chi² = 3.31, df = 3 (P = 0.35); I² = 9%

Test for overall effect: Z = 0.35 (P = 0.73)

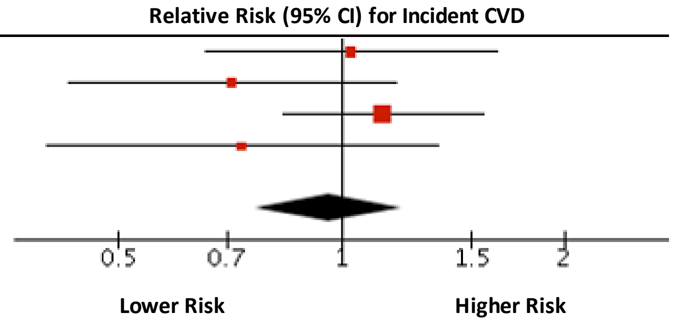
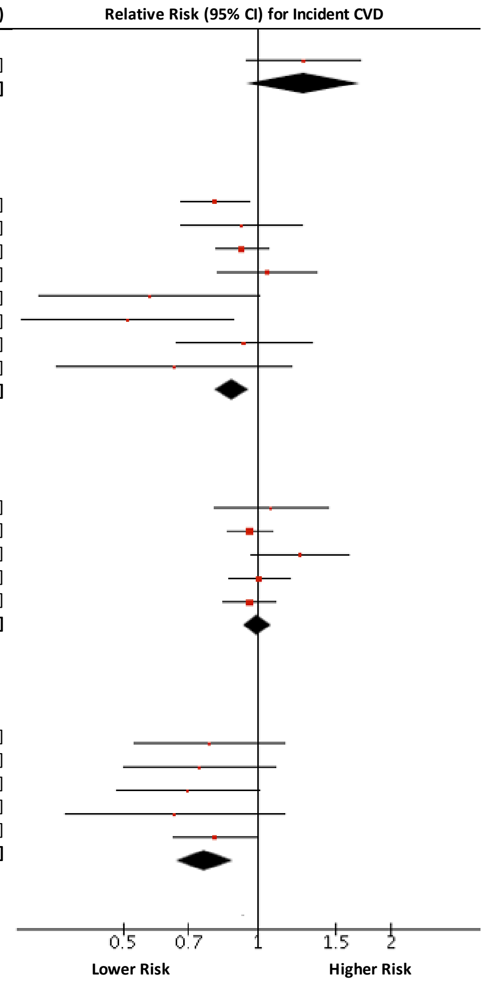


Figure S11. Relation between tomato intake and cardiovascular disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Berries				
WHS - Sesso 2007	38,176	1,004	3.1%	1.27 [0.95, 1.71]
Subtotal (95% CI)	**38,176**	**1,004**	**3.1%**	**1.27 [0.95, 1.71]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.60 (P = 0.11)				
Citrus				
Japan Public Health Center - Takachi 2008	77,891	1,386	8.5%	0.80 [0.67, 0.96]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	2.7%	0.92 [0.67, 1.26]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	14.1%	0.92 [0.80, 1.06]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	4.1%	1.05 [0.81, 1.36]
Jidni Medical School - Yamada 2011 - M	4,147	270	0.8%	0.57 [0.32, 1.01]
Jidni Medical School - Yamada 2011 - F	6,476	218	0.9%	0.51 [0.30, 0.89]
PREDIMED- Buil-Cosiales 2016	7,216	342	2.1%	0.93 [0.66, 1.33]
SUN - Buil-Cosiales - 2017	17,007	112	0.7%	0.65 [0.35, 1.19]
Subtotal (95% CI)	**222,525**	**6,220**	**33.9%**	**0.88 [0.80, 0.96]**
Heterogeneity: Chi² = 10.49, df = 7 (P = 0.16); I² = 33%				
Test for overall effect: Z = 2.95 (P = 0.003)				
Fruit juice				
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	3.1%	1.07 [0.80, 1.44]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	19.2%	0.96 [0.85, 1.08]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	4.1%	1.25 [0.97, 1.61]
EPIC Potsdam - Von Ruesten 2013	23,531	363	10.8%	1.01 [0.86, 1.18]
EPIC NL and MORGEN - Scheffers 2019	34,560	3,801	14.1%	0.96 [0.84, 1.10]
Subtotal (95% CI)	**167,879**	**8,056**	**51.2%**	**1.00 [0.93, 1.07]**
Heterogeneity: Chi² = 3.86, df = 4 (P = 0.42); I² = 0%				
Test for overall effect: Z = 0.06 (P = 0.95)				
Pommes				
WHS - Sesso 2003 (a)	38,176	1,004	1.7%	0.78 [0.53, 1.15]
Framingham Offspring Study - Jacques 2015	2,880	518	1.7%	0.74 [0.50, 1.10]
PREDIMED- Buil-Cosiales 2016	7,216	342	1.9%	0.70 [0.48, 1.01]
SUN - Buil-Cosiales - 2017	17,007	112	0.8%	0.65 [0.37, 1.15]
NutriNet-Sante - Adriouch 2018	84,158	602	5.7%	0.80 [0.65, 1.00]
Subtotal (95% CI)	**149,437**	**2,578**	**11.9%**	**0.76 [0.66, 0.88]**
Heterogeneity: Chi² = 0.77, df = 4 (P = 0.94); I² = 0%				
Test for overall effect: Z = 3.58 (P = 0.0003)				
Test for subgroup differences: Chi² = 16.75, df = 3 (P = 0.0008), I² = 82.1%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Berries				
WHS - Sesso 2007	38,176	1,004	5.8%	1.27 [0.95, 1.71]
Subtotal (95% CI)	**38,176**	**1,004**	**5.8%**	**1.27 [0.95, 1.71]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.60 (P = 0.11)				
Citrus				
Japan Public Health Center - Takachi 2008	77,891	1,386	9.7%	0.80 [0.67, 0.96]
NHS & HPFS -Joshipura 2009 - Mod. CHO	109,788	3,892	11.4%	0.92 [0.80, 1.06]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	6.9%	1.05 [0.81, 1.36]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	5.4%	0.92 [0.67, 1.26]
Jidni Medical School - Yamada 2011 - F	6,476	218	2.3%	0.51 [0.30, 0.89]
Jidni Medical School - Yamada 2011 - M	4,147	270	2.2%	0.57 [0.32, 1.01]
PREDIMED- Buil-Cosiales 2016	7,216	342	4.6%	0.93 [0.66, 1.33]
SUN - Buil-Cosiales - 2017	17,007	112	1.9%	0.65 [0.35, 1.19]
Subtotal (95% CI)	**222,525**	**6,220**	**44.4%**	**0.86 [0.76, 0.97]**
Heterogeneity: Tau² = 0.01; Chi² = 10.49, df = 7 (P = 0.16); I² = 33%				
Test for overall effect: Z = 2.40 (P = 0.02)				
Fruit juice				
NHS & HPFS -Joshipura 2009 - Mod. CHO	109,788	3,892	10.9%	0.96 [0.85, 1.08]
NHS & HPFS - Joshipura 2009 - Low CHO	-	-	4.7%	1.07 [0.80, 1.44]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	5.7%	1.25 [0.97, 1.61]
EPIC Potsdam - Von Ruesten 2013	23,531	363	9.1%	1.01 [0.86, 1.18]
EPIC NL and MORGEN - Scheffers 2019	34,560	3,801	10.0%	0.96 [0.84, 1.10]
Subtotal (95% CI)	**167,879**	**8,056**	**40.5%**	**1.00 [0.93, 1.07]**
Heterogeneity: Tau² = 0.00; Chi² = 3.86, df = 4 (P = 0.42); I² = 0%				
Test for overall effect: Z = 0.06 (P = 0.95)				
Pommes				
NutriNet-Sante - Adriouch 2018	84,158	602	6.9%	0.80 [0.65, 1.00]
WHS - Sesso 2003 (a)	38,176	1,004	3.1%	0.78 [0.53, 1.15]
Framingham Offspring Study - Jacques 2015	2,880	518	3.1%	0.74 [0.50, 1.10]
PREDIMED- Buil-Cosiales 2016	7,216	342	3.3%	0.70 [0.48, 1.01]
SUN - Buil-Cosiales - 2017	17,007	112	1.6%	0.65 [0.37, 1.15]
Subtotal (95% CI)	**149,437**	**2,578**	**18.0%**	**0.76 [0.66, 0.88]**
Heterogeneity: Tau² = 0.00; Chi² = 0.77, df = 4 (P = 0.94); I² = 0%				
Test for overall effect: Z = 3.58 (P = 0.0003)				
Test for subgroup differences: Chi² = 16.40, df = 3 (P = 0.0009), I² = 81.7%				

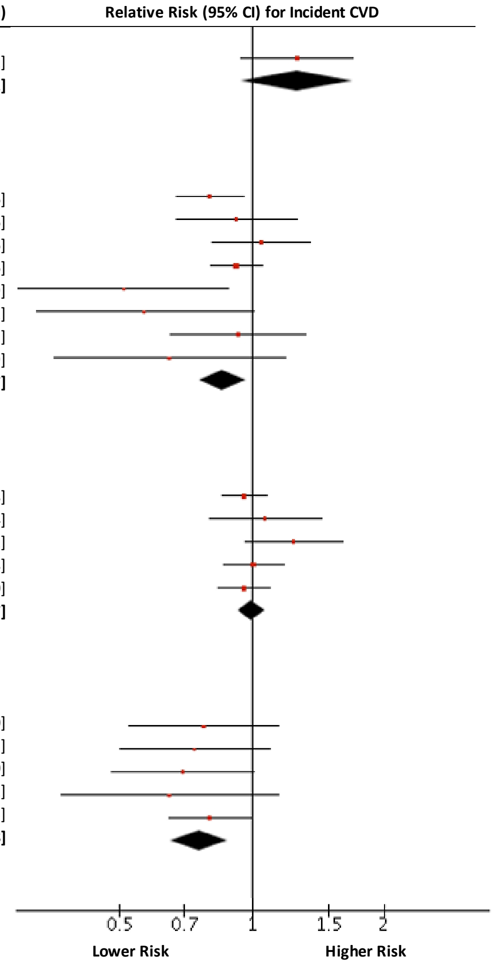
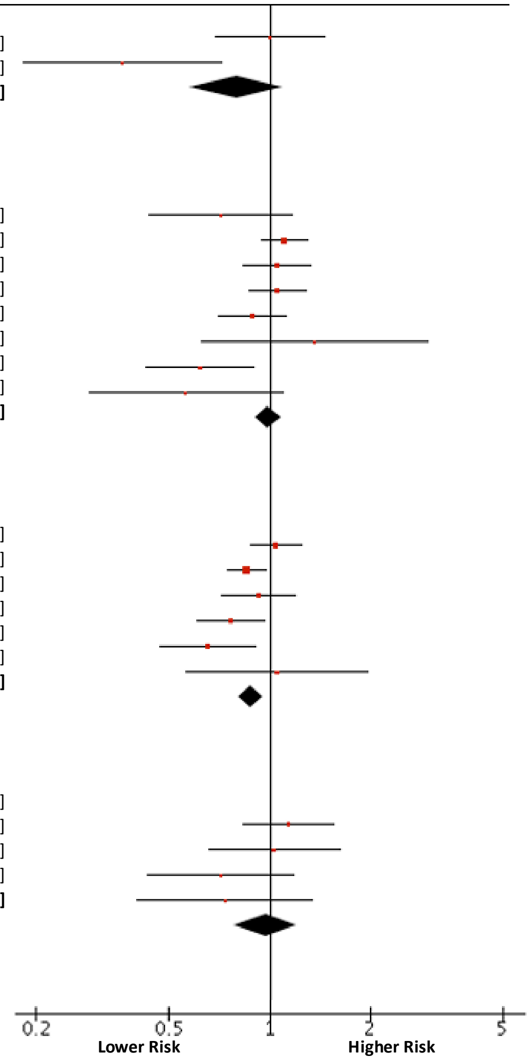


Figure S12. Relation between sources of fruit and CVD incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
WHS - Sesso 2003 (a)	38,445	729	2.6%	1.00 [0.69, 1.45]
Theran Lipid and Glucose - Bahadoran 2017	2,369	79	0.8%	0.36 [0.18, 0.72]
Subtotal (95% CI)	**40,814**	**808**	**3.3%**	**0.79 [0.57, 1.10]**
Heterogeneity: Chi² = 6.56, df = 1 (P = 0.01); I² = 85%				
Test for overall effect: Z = 1.39 (P = 0.16)				
Cruciferous				
WHS - Sesso 2003 (a)	38,445	729	1.5%	0.71 [0.44, 1.16]
Japan Public Health Center - Takachi 2008	77,891	1,386	14.6%	1.11 [0.94, 1.29]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	6.5%	1.05 [0.83, 1.33]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	9.3%	1.05 [0.86, 1.28]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	6.5%	0.89 [0.70, 1.12]
EPIC Potsdam - Von Ruesten 2013	23,531	363	0.6%	1.36 [0.62, 2.99]
PREDIMED- Buil-Cosiales 2016	7,216	342	2.6%	0.62 [0.43, 0.90]
SUN - Buil-Cosiales - 2017	17,007	112	0.8%	0.56 [0.29, 1.09]
Subtotal (95% CI)	**273,878**	**6,824**	**42.3%**	**0.99 [0.90, 1.08]**
Heterogeneity: Chi² = 14.65, df = 7 (P = 0.04); I² = 52%				
Test for overall effect: Z = 0.28 (P = 0.78)				
Green Leafy				
Japan Public Health Center - Takachi 2008	77,891	1,386	11.5%	1.04 [0.87, 1.24]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	19.0%	0.85 [0.74, 0.98]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	5.5%	0.92 [0.72, 1.19]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	6.5%	0.76 [0.60, 0.97]
PREDIMED- Buil-Cosiales 2016	7,216	342	3.2%	0.65 [0.47, 0.91]
SUN - Buil-Cosiales - 2017	17,007	112	0.9%	1.05 [0.56, 1.97]
Subtotal (95% CI)	**211,902**	**5,732**	**46.6%**	**0.88 [0.80, 0.96]**
Heterogeneity: Chi² = 8.69, df = 5 (P = 0.12); I² = 42%				
Test for overall effect: Z = 2.93 (P = 0.003)				
Tomatoes				
WHS - Sesso 2003 (b) - tomato juice	38,445	729	3.6%	1.14 [0.83, 1.56]
WHS - Sesso 2003 (b) - tomatoes	-	-	1.8%	1.03 [0.66, 1.62]
WHS - Sesso 2003 (b) - tomato based products	-	-	1.4%	0.71 [0.43, 1.18]
SUN - Buil-Cosiales - 2017	17,007	112	1.0%	0.73 [0.40, 1.35]
Subtotal (95% CI)	**55,452**	**841**	**7.7%**	**0.97 [0.78, 1.20]**
Heterogeneity: Chi² = 3.31, df = 3 (P = 0.35); I² = 9%				
Test for overall effect: Z = 0.29 (P = 0.77)				
Test for subgroup differences: Chi² = 4.34, df = 3 (P = 0.23), I² = 30.8%				

Relative Risk (95% CI) for Incident CVD



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
WHS - Sesso 2003 (a)	38,445	729	4.3%	1.00 [0.69, 1.45]
Theran Lipid and Glucose - Bahadoran 2017	2,369	79	1.7%	0.36 [0.18, 0.72]
Subtotal (95% CI)	**40,814**	**808**	**6.0%**	**0.63 [0.23, 1.70]**
Heterogeneity: Tau² = 0.44; Chi² = 6.56, df = 1 (P = 0.01); I² = 85%				
Test for overall effect: Z = 0.92 (P = 0.36)				
Cruciferous				
WHS - Sesso 2003 (a)	38,445	729	2.9%	0.71 [0.44, 1.16]
Japan Public Health Center - Takachi 2008	77,891	1,386	9.3%	1.11 [0.94, 1.29]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	7.0%	1.05 [0.83, 1.33]
NHS & HPFS -Joshipura 2009 - Mod. CHO	-	-	8.1%	1.05 [0.86, 1.28]
NHS & HPFS - Joshipura 2009 - High CHO	-	-	7.0%	0.89 [0.70, 1.12]
EPIC Potsdam - Von Ruesten 2013	23,531	363	1.3%	1.36 [0.62, 2.99]
PREDIMED- Buil-Cosiales 2016	7,216	342	4.3%	0.62 [0.43, 0.90]
SUN - Buil-Cosiales - 2017	17,007	112	1.8%	0.56 [0.29, 1.09]
Subtotal (95% CI)	**273,878**	**6,824**	**41.7%**	**0.93 [0.80, 1.09]**
Heterogeneity: Tau² = 0.02; Chi² = 14.65, df = 7 (P = 0.04); I² = 52%				
Test for overall effect: Z = 0.91 (P = 0.36)				
Green Leafy				
Japan Public Health Center - Takachi 2008	77,891	1,386	8.7%	1.04 [0.87, 1.24]
NHS & HPFS - Joshipura 2009 - High CHO	0	0	6.6%	0.92 [0.72, 1.19]
NHS & HPFS - Joshipura 2009 - Low CHO	109,788	3,892	7.0%	0.76 [0.60, 0.97]
NHS & HPFS -Joshipura 2009 - Mod. CHO	0	0	9.8%	0.85 [0.74, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	342	4.9%	0.65 [0.47, 0.91]
SUN - Buil-Cosiales - 2017	17,007	112	1.9%	1.05 [0.56, 1.97]
Subtotal (95% CI)	**211,902**	**5,732**	**39.0%**	**0.87 [0.76, 0.99]**
Heterogeneity: Tau² = 0.01; Chi² = 8.69, df = 5 (P = 0.12); I² = 42%				
Test for overall effect: Z = 2.16 (P = 0.03)				
Tomatoes				
WHS - Sesso 2003 (b) - tomatoes	38,445	729	3.3%	1.03 [0.66, 1.62]
WHS - Sesso 2003 (b) - tomato based products	-	-	2.7%	0.71 [0.43, 1.18]
WHS - Sesso 2003 (b) - tomato juice	-	-	5.3%	1.14 [0.83, 1.56]
SUN - Buil-Cosiales - 2017	17,007	112	2.1%	0.73 [0.40, 1.35]
Subtotal (95% CI)	**55,452**	**841**	**13.4%**	**0.96 [0.76, 1.21]**
Heterogeneity: Tau² = 0.01; Chi² = 3.31, df = 3 (P = 0.35); I² = 9%				
Test for overall effect: Z = 0.35 (P = 0.73)				
Test for subgroup differences: Chi² = 1.31, df = 3 (P = 0.73), I² = 0%				

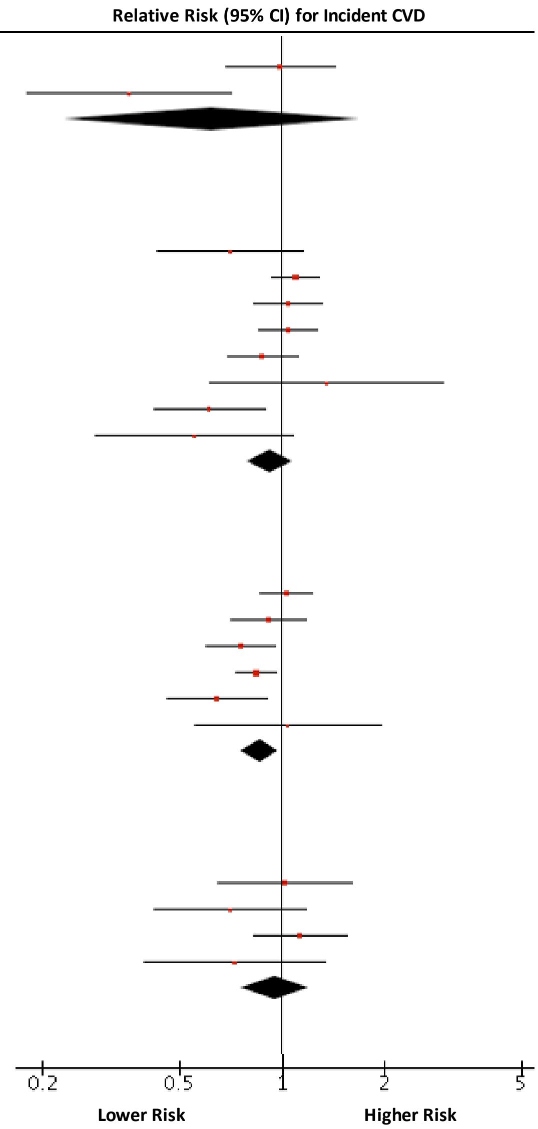


Figure S13. Relation between sources of vegetables and CVD incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity.

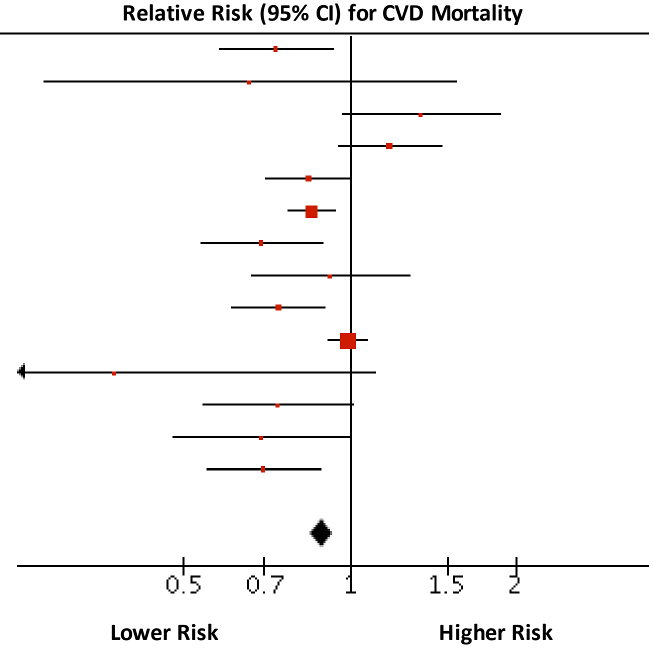
TOTAL FRUIT AND VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
National Health & Nutrition - Bazzano 2002	9,608	1,145	4.1%	0.73 [0.58, 0.93]
Kuopio IHD Risk - Rissanen 2003	1,950	115	0.3%	0.66 [0.28, 1.56]
Odyssey - Genkinger 2004	6,151	378	2.1%	1.35 [0.97, 1.88]
Health and Lifestyle Survey - Kvaavik 2010	4,866	431	4.9%	1.19 [0.96, 1.47]
Shanghai Women Health - Nechuta 2010	71,243	755	7.4%	0.84 [0.71, 1.01]
EPIC - Leenders 2013	451,151	5,125	23.9%	0.85 [0.77, 0.94]
Health Survey of England - Oyebode 2014	65,226	1,554	3.5%	0.69 [0.54, 0.89]
British Regional Heart - Atkins 2014	3,328	327	2.1%	0.92 [0.66, 1.29]
NIPPON DATA80 - Okuda 2015	9,112	823	6.0%	0.74 [0.61, 0.90]
Migrant Study - Hjartaker 2015	9,766	4,595	37.3%	0.99 [0.92, 1.07]
PREDIMED- Buil-Cosiales 2016	7,216	104	0.2%	0.37 [0.12, 1.11]
HAPIEE - Stefler 2016	19,263	438	2.3%	0.74 [0.54, 1.01]
PURE - Miller 2017	135,335	1,649	1.7%	0.69 [0.48, 1.00]
Health and Living Status of Elderly - Lin 2017	4,176	-	4.1%	0.70 [0.55, 0.88]
Total (95% CI)	**798,391**	**17,439**	**100.0%**	**0.89 [0.85, 0.93]**

Heterogeneity: Chi² = 40.92, df = 13 (P < 0.0001); I² = 68%

Test for overall effect: Z = 4.77 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
National Health & Nutrition - Bazzano 2002	9,608	1,145	8.0%	0.73 [0.58, 0.93]
Kuopio IHD Risk - Rissanen 2003	1,950	115	1.3%	0.66 [0.28, 1.56]
Odyssey - Genkinger 2004	6,151	378	5.7%	1.35 [0.97, 1.88]
Shanghai Women Health - Nechuta 2010	71,243	755	9.7%	0.84 [0.71, 1.01]
Health and Lifestyle Survey - Kvaavik 2010	4,866	431	8.6%	1.19 [0.96, 1.47]
EPIC - Leenders 2013	451,151	5,125	12.0%	0.85 [0.77, 0.94]
British Regional Heart - Atkins 2014	3,328	327	5.7%	0.92 [0.66, 1.29]
Health Survey of England - Oyebode 2014	65,226	1,554	7.5%	0.69 [0.54, 0.89]
Migrant Study - Hjartaker 2015	9,766	4,595	12.5%	0.99 [0.92, 1.07]
NIPPON DATA80 - Okuda 2015	9,112	823	9.1%	0.74 [0.61, 0.90]
HAPIEE - Stefler 2016	19,263	438	6.1%	0.74 [0.54, 1.01]
PREDIMED- Buil-Cosiales 2016	7,216	104	0.9%	0.37 [0.12, 1.11]
PURE - Miller 2017	135,335	1,649	5.0%	0.69 [0.48, 1.00]
Health and Living Status of Elderly - Lin 2017	4,176	-	8.0%	0.70 [0.55, 0.88]
Total (95% CI) [Random Effects]	**798,391**	**17,439**	**100.0%**	**0.84 [0.76, 0.94]**

Heterogeneity: $Tau^2 = 0.02$; $Chi^2 = 40.92$, df = 13 (P < 0.0001); $I^2 = 68\%$

Test for overall effect: Z = 3.17 (P = 0.002)

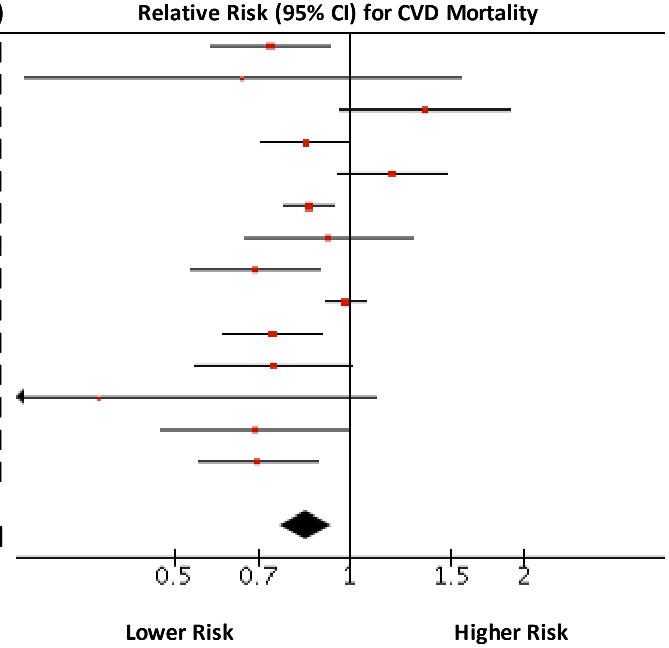


Figure S14. Relation between total fruit and vegetable intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

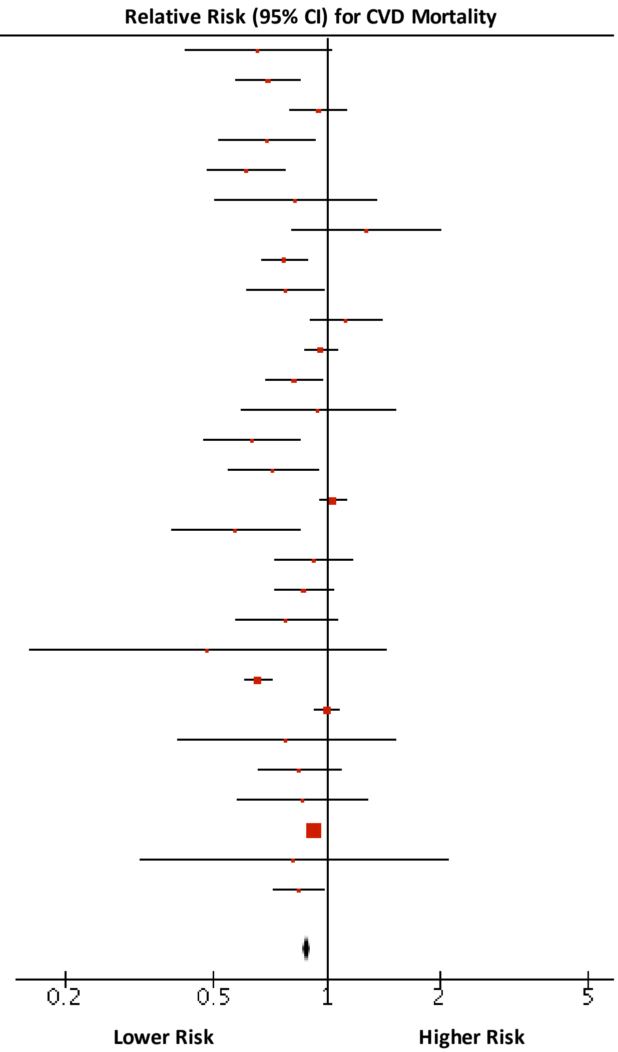
FRUIT AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	226	0.3%	0.66 [0.42, 1.03]
Health Food Shoppers - Appleby 2002 - F	6,416	611	1.6%	0.70 [0.57, 0.85]
Health Food Shoppers - Appleby 2002 - M	4,325	591	2.0%	0.95 [0.80, 1.13]
Melbourne Collaborative Cohort - Harriss 2007	40,653	697	0.7%	0.69 [0.51, 0.93]
EPIC Diabetes - Nothlings 2008	10,262	517	1.1%	0.61 [0.48, 0.78]
Takayama Study - Nakamura 2008 - F	15,724	184	0.3%	0.83 [0.51, 1.35]
Takayama Study - Nakamura 2008 - M	13,355	200	0.3%	1.27 [0.81, 2.00]
JACC - Nagura 2009	59,845	2,243	3.3%	0.77 [0.67, 0.88]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	1.1%	0.78 [0.62, 0.99]
NOMAS - Gardener 2011	2,568	314	1.3%	1.13 [0.91, 1.40]
EPIC - Leenders 2013	451,151	5,125	6.4%	0.96 [0.87, 1.06]
Health Survey of England - Oyebode 2014	65,226	1,554	2.0%	0.82 [0.69, 0.98]
British Regional Heart - Atkins 2014	3,328	327	0.3%	0.95 [0.59, 1.52]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	0.7%	0.63 [0.47, 0.85]
MONICA Danish - Tognon 2014	1,849	223	0.8%	0.72 [0.55, 0.95]
Migrant Study - Hjartaker 2015	9,766	4,595	10.0%	1.04 [0.96, 1.13]
UK Women's Cohort - Lai 2015	30,458	286	0.4%	0.57 [0.39, 0.85]
MONICA Switzerland - Vormund 2015 - F	9,196	634	1.1%	0.92 [0.73, 1.17]
MONICA Switzerland - Vormund 2015 - M	8,665	751	2.0%	0.87 [0.73, 1.04]
HAPIEE - Stefler 2016	19,263	438	0.6%	0.78 [0.57, 1.07]
PREDIMED- Buil-Cosiales 2016	7,216	104	0.1%	0.48 [0.16, 1.44]
China Kadoorie Biobank- Du 2017	462,342	6,166	10.0%	0.66 [0.61, 0.71]
DIET-HD - Saglimbene 2017	9,757	515	10.0%	1.00 [0.92, 1.08]
MONICA France - Berard 2017	1,311	41	0.1%	0.78 [0.40, 1.52]
PURE - Miller 2017	135,335	1,649	0.9%	0.84 [0.65, 1.09]
Cooper Center - Shah 2018 - DASH	11,376	249	0.4%	0.86 [0.58, 1.27]
Singapore Chinese Health - Neelakantan 2018	57,078	4,871	39.9%	0.92 [0.89, 0.96]
Renal Transplant Recipients - Sotomayer 2019	400	49	0.1%	0.82 [0.32, 2.10]
NIPPON DATA80 - Kondo 2019	9,115	1,070	2.5%	0.84 [0.72, 0.99]
Total (95% CI)	**1,581,506**	**39,623**	**100.0%**	**0.88 [0.86, 0.91]**

Heterogeneity: Chi² = 136.43, df = 28 (P < 0.00001); I² = 79%

Test for overall effect: Z = 9.70 (P < 0.00001)



B. Random Effect

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	226	1.8%	0.66 [0.42, 1.03]
Health Food Shoppers - Appleby 2002 - F	6,416	611	4.2%	0.70 [0.57, 0.85]
Health Food Shoppers - Appleby 2002 - M	4,325	591	4.5%	0.95 [0.80, 1.13]
Melbourne Collaborative Cohort - Harriss 2007	40,653	697	3.0%	0.69 [0.51, 0.93]
EPIC Diabetes - Nothlings 2008	10,262	517	3.7%	0.61 [0.48, 0.78]
Takayama Study - Nakamura 2008 - F	15,724	184	1.6%	0.83 [0.51, 1.35]
Takayama Study - Nakamura 2008 - M	13,355	200	1.8%	1.27 [0.81, 2.00]
JACC - Nagura 2009	59,845	2,243	5.0%	0.77 [0.67, 0.88]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	3.7%	0.78 [0.62, 0.99]
NOMAS - Gardener 2011	2,568	314	4.0%	1.13 [0.91, 1.40]
EPIC - Leenders 2013	451,151	5,125	5.5%	0.96 [0.87, 1.06]
Health Survey of England - Oyebode 2014	65,226	1,554	4.5%	0.82 [0.69, 0.98]
British Regional Heart - Atkins 2014	3,328	327	1.7%	0.95 [0.59, 1.52]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	3.0%	0.63 [0.47, 0.85]
MONICA Danish - Tognon 2014	1,849	223	3.2%	0.72 [0.55, 0.95]
Migrant Study - Hjartaker 2015	9,766	4,595	5.8%	1.04 [0.96, 1.13]
UK Women's Cohort - Lai 2015	30,458	286	2.2%	0.57 [0.39, 0.85]
MONICA Switzerland - Vormund 2015 - F	9,196	634	3.7%	0.92 [0.73, 1.17]
MONICA Switzerland - Vormund 2015 - M	8,665	751	4.5%	0.87 [0.73, 1.04]
HAPIEE - Stefler 2016	19,263	438	2.8%	0.78 [0.57, 1.07]
PREDIMED- Buil-Cosiales 2016	7,216	104	0.4%	0.48 [0.16, 1.44]
China Kadoorie Biobank- Du 2017	462,342	6,166	5.8%	0.66 [0.61, 0.71]
DIET-HD - Saglimbene 2017	9,757	515	5.8%	1.00 [0.92, 1.08]
MONICA France - Berard 2017	1,311	41	1.0%	0.78 [0.40, 1.52]
PURE - Miller 2017	135,335	1,649	3.5%	0.84 [0.65, 1.09]
Cooper Center - Shah 2018 - DASH	11,376	249	2.2%	0.86 [0.58, 1.27]
Singapore Chinese Health - Neelakantan 2018	57,078	4,871	6.1%	0.92 [0.89, 0.96]
Renal Transplant Recipients - Sotomayer 2019	400	49	0.5%	0.82 [0.32, 2.10]
NIPPON DATA80 - Kondo 2019	9,115	1,070	4.8%	0.84 [0.72, 0.99]
Total (95% CI) [Random Effects]	**1,581,506**	**39,623**	**100.0%**	**0.83 [0.77, 0.89]**

Heterogeneity: Tau² = 0.02; Chi² = 136.43, df = 28 (P < 0.00001); I² = 79%
Test for overall effect: Z = 5.10 (P < 0.00001)

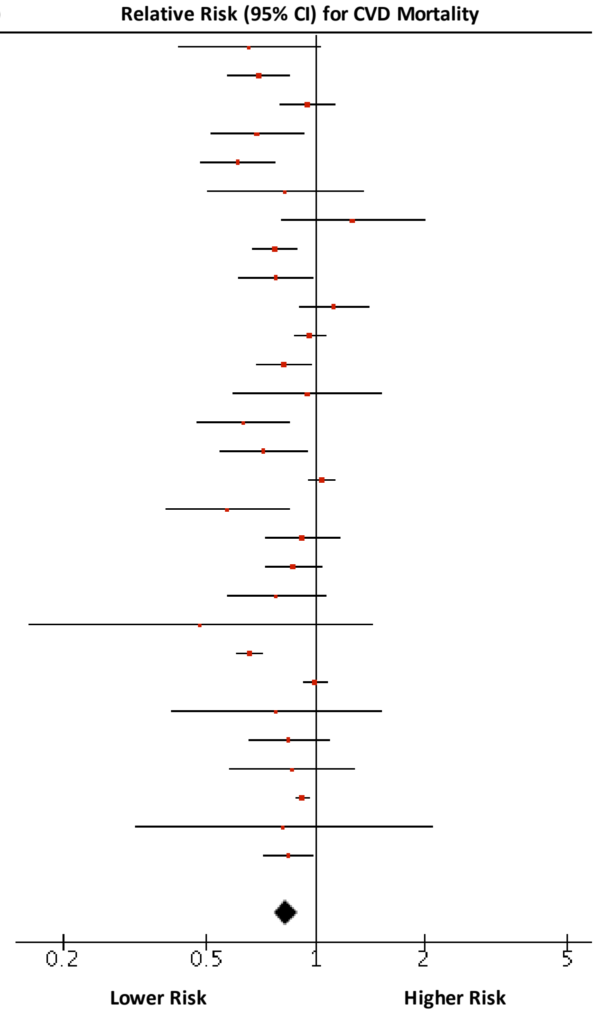


Figure S15. Relation between fruit intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity.

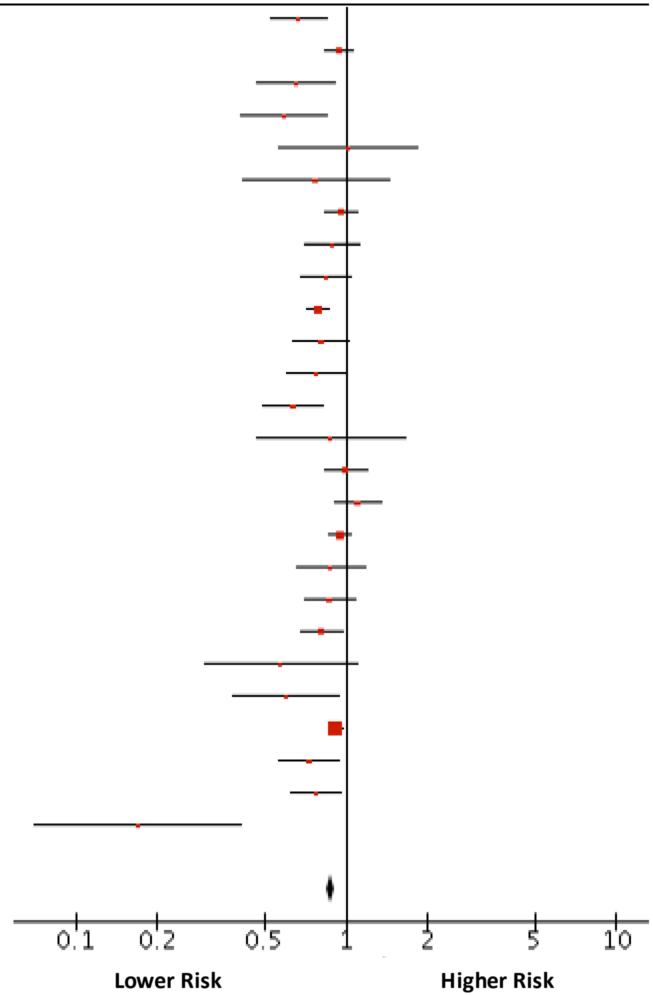
VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	226	2.0%	0.67 [0.53, 0.85]
Health Food Shoppers - Appleby 2002	10,471	1,202	7.8%	0.94 [0.84, 1.06]
Melbourne Collaborative Cohort - Harriss 2007	40,653	697	1.0%	0.66 [0.47, 0.92]
EPIC Diabetes - Nothlings 2008	10,262	517	0.8%	0.59 [0.41, 0.85]
Takayama Study - Nakamura 2008 - M	13,355	200	0.3%	1.02 [0.57, 1.84]
Takayama Study - Nakamura 2008 - F	15,724	184	0.3%	0.77 [0.41, 1.44]
JACC - Nagura 2009	59,485	2,243	5.8%	0.96 [0.84, 1.10]
NOMAS - Gardener 2011	2,568	314	2.0%	0.89 [0.70, 1.12]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	2.3%	0.84 [0.68, 1.05]
EPIC - Leenders 2013	451,151	5,125	11.3%	0.79 [0.71, 0.87]
MONICA Danish - Tognon 2014	1,849	223	2.0%	0.81 [0.64, 1.03]
Health Survey of England - Oyebode 2014	65,226	1,554	1.7%	0.78 [0.60, 1.00]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	1.7%	0.64 [0.49, 0.82]
British Regional Heart - Atkins 2014	3,328	327	0.3%	0.88 [0.47, 1.64]
MONICA Switzerland - Vormund 2015 - M	8,665	751	3.5%	1.00 [0.84, 1.19]
MONICA Switzerland - Vormund 2015 - F	9,196	634	2.8%	1.11 [0.91, 1.34]
Migrant Study - Hjartaker 2015	9,766	4,595	11.3%	0.95 [0.86, 1.05]
HAPIEE - Stefler 2016	19,236	438	1.3%	0.88 [0.65, 1.18]
PURE - Miller 2017	135,335	1,649	2.3%	0.87 [0.70, 1.08]
PLSAW - Blekkenhorst 2017	1,226	238	3.5%	0.81 [0.68, 0.97]
MONICA France - Berard 2017	1,311	41	0.3%	0.57 [0.30, 1.09]
NHANES - Conrad 2018	29,133	726	0.5%	0.60 [0.38, 0.94]
Singapore Chinese Health - Neelakantan 2018	57,078	4,871	31.4%	0.91 [0.86, 0.97]
Cooper Center - Shah 2018 - DASH	11,376	249	1.7%	0.73 [0.57, 0.95]
NIPPON DATA80 - Kondo 2019	9,115	1,070	2.3%	0.78 [0.63, 0.97]
Renal Transplant Recipients - Sotomayer 2019	400	49	0.1%	0.17 [0.07, 0.41]
Total (95% CI)	**1,101,435**	**33,516**	**100.0%**	**0.87 [0.85, 0.90]**

Heterogeneity: $Chi^2 = 61.44$, $df = 25$ ($P < 0.0001$); $I^2 = 59\%$
Test for overall effect: $Z = 7.99$ ($P < 0.00001$)

Relative Risk (95% CI) for CVD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Men Born in 1913 - Strandhagen 2000	730	226	4.0%	0.67 [0.53, 0.85]
Health Food Shoppers - Appleby 2002	10,471	1,202	6.7%	0.94 [0.84, 1.06]
Melbourne Collaborative Cohort - Harriss 2007	40,653	697	2.6%	0.66 [0.47, 0.92]
EPIC Diabetes - Nothlings 2008	10,262	517	2.2%	0.59 [0.41, 0.85]
Takayama Study - Nakamura 2008 - M	13,355	200	1.0%	1.02 [0.57, 1.84]
Takayama Study - Nakamura 2008 - F	15,724	184	0.9%	0.77 [0.41, 1.44]
JACC - Nagura 2009	59,485	2,243	6.2%	0.96 [0.84, 1.10]
NOMAS - Gardener 2011	2,568	314	4.0%	0.89 [0.70, 1.12]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	4.3%	0.84 [0.68, 1.05]
EPIC - Leenders 2013	451,151	5,125	7.2%	0.79 [0.71, 0.87]
MONICA Danish - Tognon 2014	1,849	223	4.0%	0.81 [0.64, 1.03]
Health Survey of England - Oyebode 2014	65,226	1,554	3.6%	0.78 [0.60, 1.00]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	3.6%	0.64 [0.49, 0.82]
British Regional Heart - Atkins 2014	3,328	327	0.9%	0.88 [0.47, 1.64]
MONICA Switzerland - Vormund 2015 - M	8,665	751	5.2%	1.00 [0.84, 1.19]
MONICA Switzerland - Vormund 2015 - F	9,196	634	4.8%	1.11 [0.91, 1.34]
Migrant Study - Hjartaker 2015	9,766	4,595	7.2%	0.95 [0.86, 1.05]
HAPIEE - Stefler 2016	19,236	438	3.0%	0.88 [0.65, 1.18]
PURE - Miller 2017	135,335	1,649	4.3%	0.87 [0.70, 1.08]
PLSAW - Blekkenhorst 2017	1,226	238	5.2%	0.81 [0.68, 0.97]
MONICA France - Berard 2017	1,311	41	0.9%	0.57 [0.30, 1.09]
NHANES - Conrad 2018	29,133	726	1.6%	0.60 [0.38, 0.94]
Singapore Chinese Health - Neelakantan 2018	57,078	4,871	8.1%	0.91 [0.86, 0.97]
Cooper Center - Shah 2018 - DASH	11,376	249	3.6%	0.73 [0.57, 0.95]
NIPPON DATA80 - Kondo 2019	9,115	1,070	4.3%	0.78 [0.63, 0.97]
Renal Transplant Recipients - Sotomayer 2019	400	49	0.50%	0.17 [0.07, 0.41]
Total (95% CI) [Random Effects]	**1,101,435**	**33,516**	**100.0%**	**0.83 [0.78, 0.89]**

Heterogeneity: Tau² = 0.01; Chi² = 61.44, df = 25 (P < 0.0001); I² = 59%
Test for overall effect: Z = 5.63 (P < 0.00001)

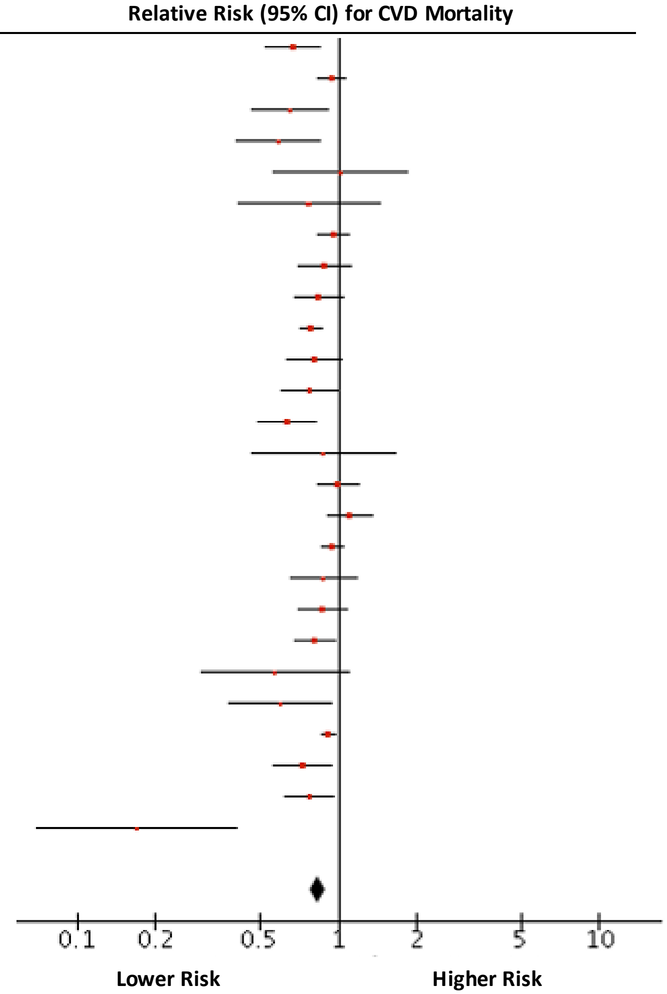
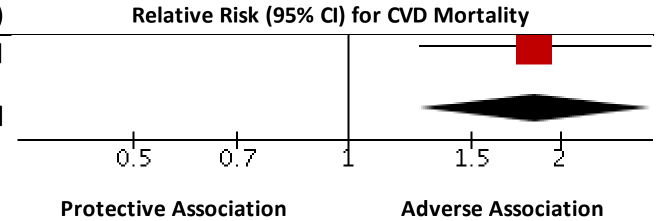


Figure S16. Relation between vegetable intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity.

APRICOTS AND CARDIOVASCULAR DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
DIET-HD - Saglimbene 2017	9,757	515	100.00%	1.84 [1.27, 2.67]
Total (95% CI)	**9,757**	**515**	**100.00%**	**1.84 [1.27, 2.67]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 3.21 (P = 0.001)				



Supplementary Figure 17. Relation between intake of apricots and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BANANAS AND CARDIOVASCULAR DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Migrant Study - Hjartaker 2015 - banana	9,766	4,595	100.0%	1.06 [0.87, 1.29]
Total (95% CI)	**9,766**	**4,595**	**100.0%**	**1.06 [0.87, 1.29]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.60 (P = 0.55)				

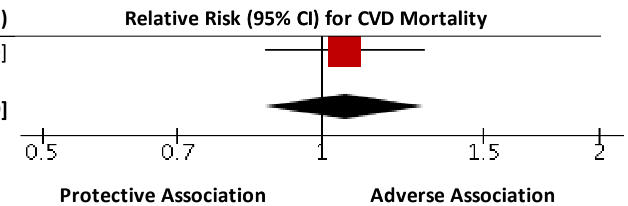


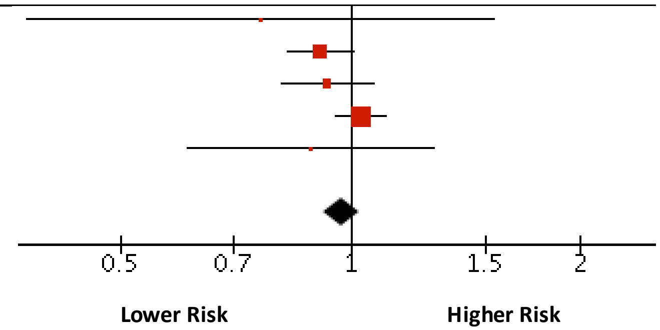
Figure S18. Relation between intake of bananas and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BERRIES AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for CVD Mortality
WHS - Sesso 2007	38,176	204	0.8%	0.76 [0.38, 1.55]	
Iowa WHS - Mink 2007 - strawberries	34,492	2,316	32.6%	0.91 [0.83, 1.01]	
Iowa WHS - Mink 2007 - blueberries	-	-	19.0%	0.93 [0.81, 1.07]	
Migrant Study - Hjartaker 2015	9,766	4,595	44.5%	1.03 [0.95, 1.11]	
UK Women's Cohort - Lai 2015	30,458	286	3.0%	0.89 [0.61, 1.29]	
Total (95% CI)	**112,892**	**7,401**	**100.0%**	**0.97 [0.92, 1.03]**	

Heterogeneity: $Chi^2 = 4.68$, df = 4 (P = 0.32); $I^2 = 15\%$
Test for overall effect: Z = 1.04 (P = 0.30)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for CVD Mortality
Iowa WHS - Mink 2007 - strawberries	34,492	2,316	32.6%	0.91 [0.83, 1.01]	
WHS - Sesso 2007	38,176	204	0.8%	0.76 [0.38, 1.55]	
Iowa WHS - Mink 2007 - blueberries	-	-	19.0%	0.93 [0.81, 1.07]	
Migrant Study - Hjartaker 2015	9,766	4,595	44.5%	1.03 [0.95, 1.11]	
UK Women's Cohort - Lai 2015	30,458	286	3.0%	0.89 [0.61, 1.29]	
Total (95% CI) [Random Effects]	**112,892**	**7,401**	**100.0%**	**0.97 [0.90, 1.03]**	

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 4.68$, df = 4 (P = 0.32); $I^2 = 15\%$
Test for overall effect: Z = 1.06 (P = 0.29)

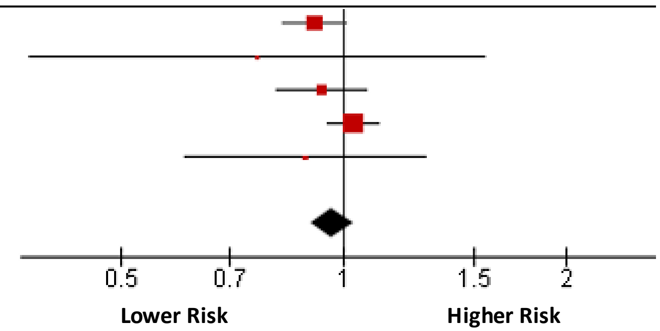


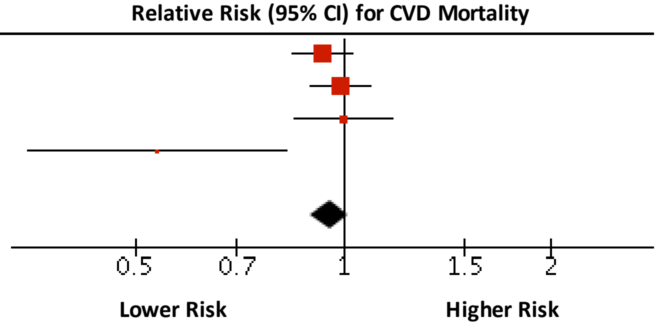
Figure S19. Relation between intake of berries and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CITRUS FRUIT AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007 - grapefruit	34,492	2,316	34.8%	0.93 [0.85, 1.03]
Iowa WHS - Mink 2007 - oranges	-	-	34.8%	0.99 [0.90, 1.09]
Migrant Study - Hjartaker 2015	9,766	4,595	24.0%	1.00 [0.85, 1.18]
UK Women's Cohort - Lai 2015	30,458	286	6.5%	0.54 [0.35, 0.83]
Total (95% CI)	**74,716**	**7,197**	**100.0%**	**0.95 [0.90, 1.02]**

Heterogeneity: Chi² = 7.85, df = 3 (P = 0.05); I² = 62%
Test for overall effect: Z = 1.45 (P = 0.15)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007 - oranges	34,492	2,316	34.8%	0.99 [0.90, 1.09]
Iowa WHS - Mink 2007 - grapefruit	-	-	34.8%	0.93 [0.85, 1.03]
Migrant Study - Hjartaker 2015	9,766	4,595	24.0%	1.00 [0.85, 1.18]
UK Women's Cohort - Lai 2015	30,458	286	6.5%	0.54 [0.35, 0.83]
Total (95% CI) [Random Effects]	**74,716**	**7,197**	**100.0%**	**0.93 [0.83, 1.05]**

Heterogeneity: Tau² = 0.01; Chi² = 7.85, df = 3 (P = 0.05); I² = 62%
Test for overall effect: Z = 1.12 (P = 0.26)

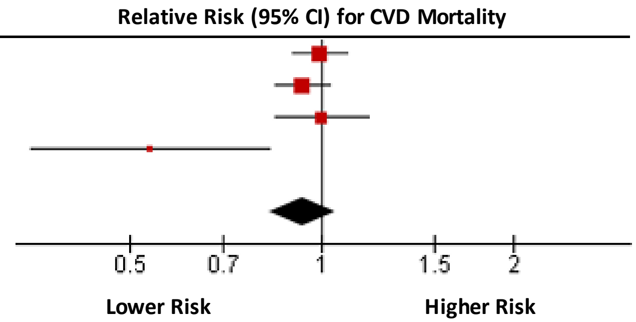


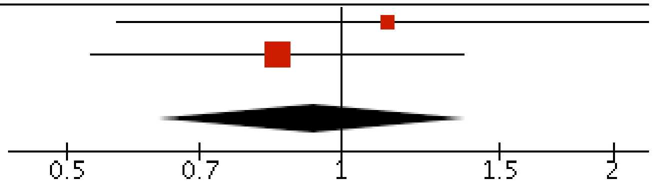
Figure S20. Relation between citrus fruit intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

DRIED FRUIT AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts H C P - Gaziano 1995	1,299	161	32.0%	1.13 [0.57, 2.24]
UK Women's Cohort - Lai 2015	30,458	286	68.0%	0.85 [0.53, 1.36]
Total (95% CI)	**31,757**	**447**	**100.0%**	**0.93 [0.63, 1.37]**

Heterogeneity: Chi² = 0.44, df = 1 (P = 0.51); I² = 0%
Test for overall effect: Z = 0.36 (P = 0.72)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts H C P - Gaziano 1995	1,299	161	32.0%	1.13 [0.57, 2.24]
UK Women's Cohort - Lai 2015	30,458	286	68.0%	0.85 [0.53, 1.36]
Total (95% CI) [Random Effects]	**31,757**	**447**	**100.0%**	**0.93 [0.63, 1.37]**

Heterogeneity: Tau² = 0.00; Chi² = 0.44, df = 1 (P = 0.51); I² = 0%
Test for overall effect: Z = 0.36 (P = 0.72)

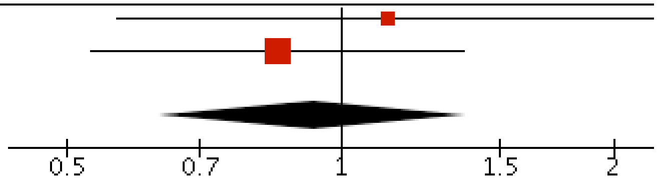


Figure S21. Relation between dried fruit intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity

FRUIT JUICE AND CARDIOVASCULAR DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015	30,458	286	100.0%	0.81 [0.58, 1.13]
Total (95% CI)	**30,458**	**286**	**100.0%**	**0.81 [0.58, 1.13]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.24 (P = 0.22)				

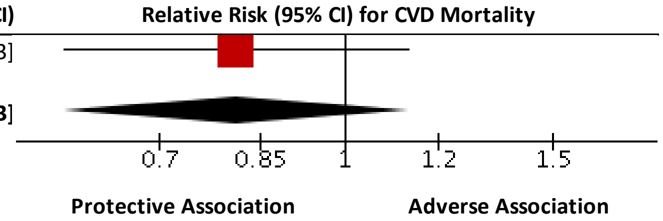


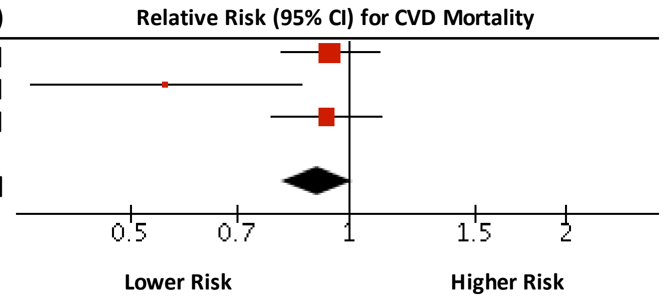
Figure S22. Relation between fruit juice intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

GRAPES AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007 - grapes and raisins	34,492	2,316	52.0%	0.94 [0.81, 1.10]
Migrant Study - Hjartaker 2015 - grapes	9,766	4,595	6.9%	0.93 [0.78, 1.11]
UK Women's Cohort - Lai 2015 - grapes	30,458	286	41.1%	0.56 [0.36, 0.86]
Total (95% CI)	**74,716**	**7,197**	**100.0%**	**0.90 [0.81, 1.01]**

Heterogeneity: Chi² = 5.12, df = 2 (P = 0.08); I² = 61%
Test for overall effect: Z = 1.73 (P = 0.08)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007 - grapes and raisins	34,492	2,316	43.3%	0.94 [0.81, 1.10]
Migrant Study - Hjartaker 2015 - grapes	9,766	4,595	40.5%	0.93 [0.78, 1.11]
UK Women's Cohort - Lai 2015 - grapes	30,458	286	16.2%	0.56 [0.36, 0.86]
Total (95% CI) [Random Effects]	**74,716**	**7,197**	**100.0%**	**0.86 [0.70, 1.06]**

Heterogeneity: Tau² = 0.02; Chi² = 5.12, df = 2 (P = 0.08); I² = 61%
Test for overall effect: Z = 1.42 (P = 0.15)

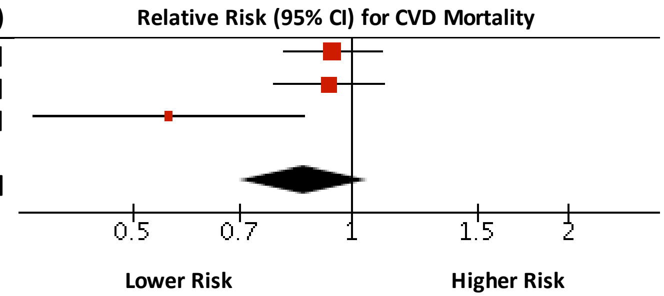


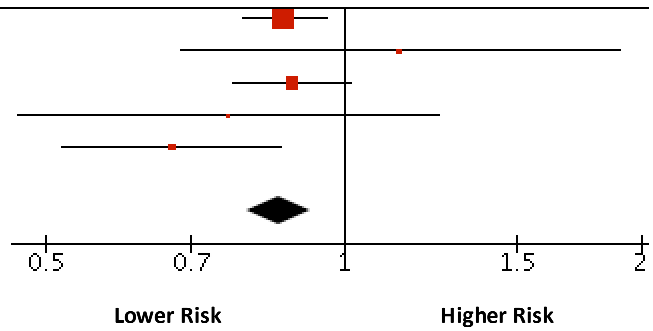
Figure S23. Relation between intake of grapes and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity.

POMMES AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007	34,492	2,316	57.6%	0.87 [0.79, 0.96]
UK Women's Cohort - Lai 2015	30,458	286	2.1%	1.14 [0.68, 1.90]
Migrant Study - Hjartaker 2015	9,766	4,595	29.4%	0.89 [0.77, 1.02]
Hodgson et al. 2016	1,456	235	2.3%	0.76 [0.47, 1.25]
DIET-HD - Saglimbene 2017	9,757	515	8.5%	0.67 [0.52, 0.86]
Total (95% CI)	**85,929**	**7,947**	100.0%	**0.86 [0.80, 0.92]**

Heterogeneity: Chi² = 5.30, df = 4 (P = 0.26); I² = 25%
Test for overall effect: Z = 4.04 (P < 0.0001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007	34,492	2,316	46.3%	0.87 [0.79, 0.96]
UK Women's Cohort - Lai 2015	30,458	286	3.8%	1.14 [0.68, 1.90]
Migrant Study - Hjartaker 2015	9,766	4,595	32.7%	0.89 [0.77, 1.02]
Hodgson et al. 2016	1,456	235	4.1%	0.76 [0.47, 1.25]
DIET-HD - Saglimbene 2017	9,757	515	13.2%	0.67 [0.52, 0.86]
Total (95% CI) [Random Effects]	**85,929**	**7,947**	**100.0%**	**0.85 [0.77, 0.94]**

Heterogeneity: Tau² = 0.00; Chi² = 5.30, df = 4 (P = 0.26); I² = 25%
Test for overall effect: Z = 3.15 (P = 0.002)

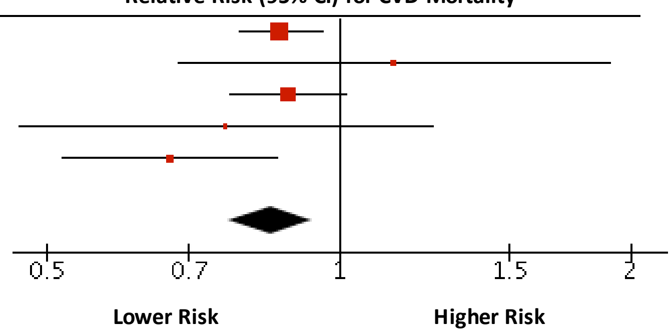


Figure S24. Relation between pommes fruit intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

ALLIUM VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
PLSAW - Blekkenhorst 2017	1,226	238	100.0%	0.33 [0.22, 0.49]
Total (95% CI)	**1,226**	**238**	**100.0%**	**0.33 [0.22, 0.49]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 5.50 (P < 0.00001)				

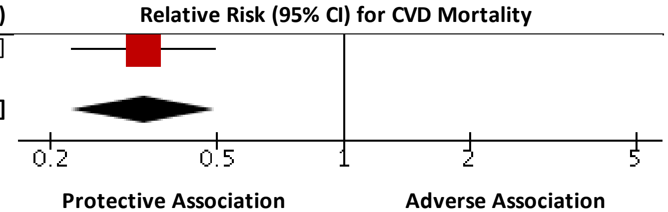


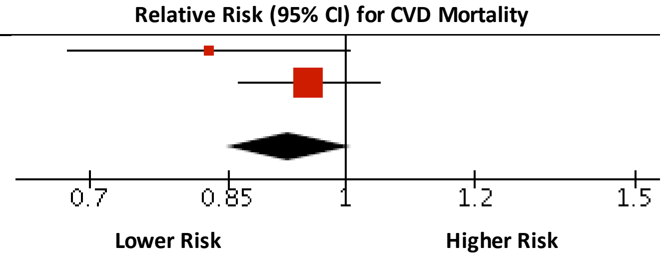
Figure S25. Relation between intake allium vegetables and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CARROTS AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Zutphen Elderly - Buijsse 2008- Carrots	559	197	20.0%	0.83 [0.68, 1.01]
Miigrant Study - Hjartaker 2015 - carrots	9,766	4,595	80.0%	0.95 [0.86, 1.05]
Total (95% CI)	**10,325**	**4,792**	**100.0%**	**0.92 [0.85, 1.01]**

Heterogeneity: $Chi^2 = 1.57$, df = 1 (P = 0.21); $I^2 = 36\%$
Test for overall effect: Z = 1.74 (P = 0.08)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Zutphen Elderly - Buijsse 2008- Carrots	559	197	30.9%	0.83 [0.68, 1.01]
Miigrant Study - Hjartaker 2015 - carrots	9,766	4,595	69.1%	0.95 [0.86, 1.05]
Total (95% CI) [Random Effects]	**10,325**	**4,792**	**100.0%**	**0.91 [0.80, 1.03]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 1.57$, df = 1 (P = 0.21); $I^2 = 36\%$
Test for overall effect: Z = 1.44 (P = 0.15)

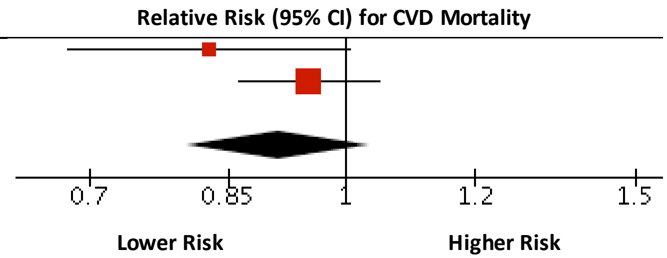


Figure S26. Relation between carrots intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CELERY AND CARDIOVASCULAR DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007 - celery	34,492	2,316	100.0%	0.91 [0.83, 1.01]
Total (95% CI)	**34,492**	**2,316**	**100.0%**	**0.91 [0.83, 1.01]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.80 (P = 0.07)				

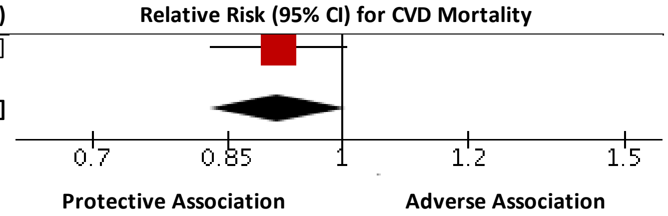


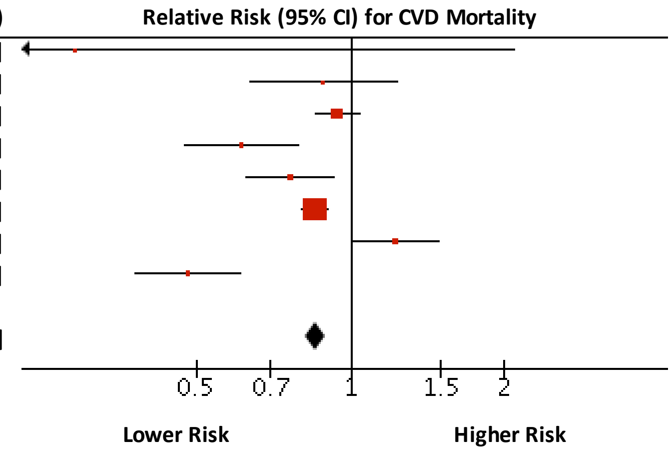
Figure S27. Relation between celery intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CRUCIFEROUS VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	0.1%	0.29 [0.04, 2.10]
Odyssey - Genkinger 2004	6,151	378	1.8%	0.89 [0.64, 1.24]
Iowa WHS - Mink 2007	34,492	2,316	21.3%	0.94 [0.85, 1.04]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	3.2%	0.61 [0.47, 0.79]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	5.3%	0.76 [0.63, 0.93]
Migrant Study - Hjartaker 2015 - cauliflower	9,766	4,595	59.2%	0.85 [0.80, 0.90]
Migrant Study - Hjartaker 2015 - cabbage	-	-	5.3%	1.22 [1.00, 1.49]
PLSAW - Blekkenhorst 2017	1,226	238	3.7%	0.48 [0.38, 0.61]
Total (95% CI)	**187,730**	**13,081**	**100.0%**	**0.85 [0.82, 0.89]**

Heterogeneity: $Chi^2 = 48.35$, df = 7 ($P < 0.00001$); $I^2 = 86\%$
Test for overall effect: Z = 6.79 ($P < 0.00001$)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts Health Care Panel - Gaziano 1995	1299	161	0.6%	0.29 [0.04, 2.10]
Odyssey - Genkinger 2004	6,151	378	10.2%	0.89 [0.64, 1.24]
Iowa WHS - Mink 2007	34,492	2,316	17.1%	0.94 [0.85, 1.04]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	12.5%	0.61 [0.47, 0.79]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	14.3%	0.76 [0.63, 0.93]
Migrant Study - Hjartaker 2015 - cauliflower	9,766	4,595	17.8%	0.85 [0.80, 0.90]
Migrant Study - Hjartaker 2015 - cabbage	-	-	14.3%	1.22 [1.00, 1.49]
PLSAW - Blekkenhorst 2017	1,226	238	13.1%	0.48 [0.38, 0.61]
Total (95% CI) [Random Effects]	**187,730**	**13,081**	**100.0%**	**0.80 [0.68, 0.94]**

Heterogeneity: $Tau^2 = 0.04$; $Chi^2 = 48.35$, df = 7 ($P < 0.00001$); $I^2 = 86\%$
Test for overall effect: Z = 2.75 (P = 0.006)

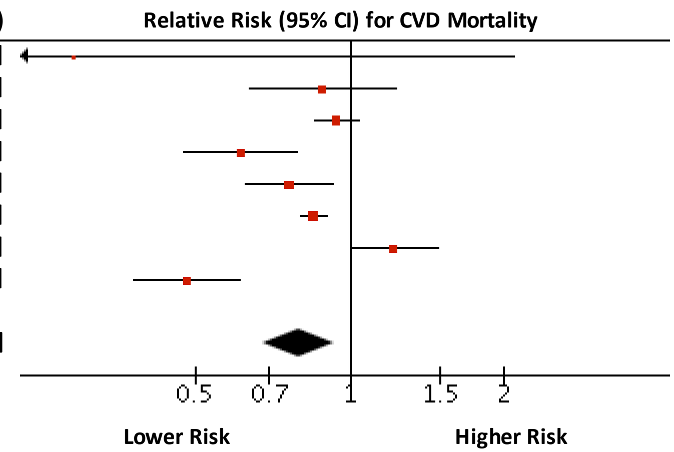


Figure S28. Relation between intake of cruciferous vegetables and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

GREEN LEAFY VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

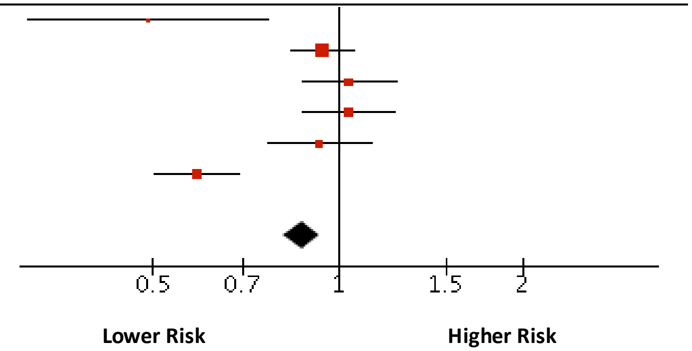
A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	2.3%	0.49 [0.31, 0.77]
Health Food Shoppers - Appleby 2002	10,741	282	34.4%	0.94 [0.84, 1.06]
MONICA Switzerland - Vormund 2015 - M	8,665	751	15.3%	1.04 [0.87, 1.24]
Migrant Study - Hjartaker 2015	9,766	4,595	16.3%	1.04 [0.88, 1.23]
MONICA Switzerland - Vormund 2015 - F	9,196	634	12.4%	0.93 [0.77, 1.13]
PLSAW - Blekkenhorst 2017	1,226	238	19.3%	0.59 [0.50, 0.69]
Total (95% CI)	**40,893**	**6,661**	100.0%	0.87 [0.81, 0.94]

Heterogeneity: Chi² = 40.44, df = 5 (P < 0.00001); I² = 88%

Test for overall effect: Z = 3.86 (P = 0.0001)

Relative Risk (95% CI) for CVD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	10.4%	0.49 [0.31, 0.77]
Health Food Shoppers - Appleby 2002	10,741	282	19.0%	0.94 [0.84, 1.06]
Migrant Study - Hjartaker 2015	9,766	4,595	17.8%	1.04 [0.88, 1.23]
MONICA Switzerland - Vormund 2015 - M	8,665	751	17.6%	1.04 [0.87, 1.24]
MONICA Switzerland - Vormund 2015 - F	9,196	634	17.1%	0.93 [0.77, 1.13]
PLSAW - Blekkenhorst 2017	1,226	238	18.1%	0.59 [0.50, 0.69]
Total (95% CI) [Random Effects]	**40,893**	**6,661**	**100.0%**	**0.84 [0.68, 1.03]**

Heterogeneity: Tau² = 0.06; Chi² = 40.44, df = 5 (P < 0.00001); I² = 88%

Test for overall effect: Z = 1.68 (P = 0.09)

Relative Risk (95% CI) for CVD Mortality

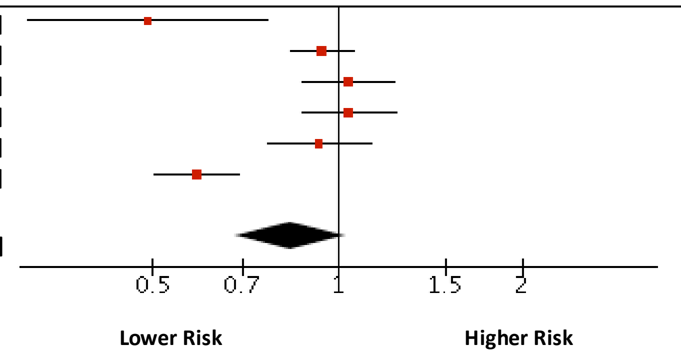


Figure S29. Relation between intake of green leafy vegetables and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

TOMATOES AND CARDIOVASCULAR DISEASE MORTALITY

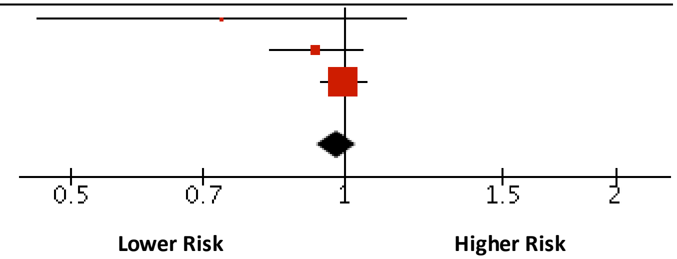
A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	1.2%	0.73 [0.46, 1.17]
Iowa WHS - Mink 2007	34,492	2,316	19.8%	0.93 [0.83, 1.05]
Migrant Study - Hjartaker 2015	9,766	4,595	79.0%	1.00 [0.94, 1.06]
Total (95% CI)	**45,557**	**7,072**	**100.0%**	**0.98 [0.93, 1.04]**

Heterogeneity: $Chi^2 = 2.59$, df = 2 (P = 0.27); $I^2 = 23\%$

Test for overall effect: Z = 0.66 (P = 0.51)

Relative Risk (95% CI) for CVD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	2.5%	0.73 [0.46, 1.17]
Iowa WHS - Mink 2007	34,492	2,316	30.0%	0.93 [0.83, 1.05]
Migrant Study - Hjartaker 2015	9,766	4,595	67.6%	1.00 [0.94, 1.06]
Total (95% CI) [Random Effects]	**45,557**	**7,072**	**100.0%**	**0.97 [0.90, 1.05]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 2.59$, df = 2 (P = 0.27); $I^2 = 23\%$

Test for overall effect: Z = 0.75 (P = 0.45)

Relative Risk (95% CI) for CVD Mortality

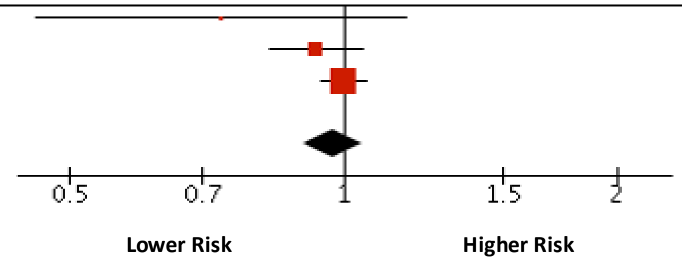
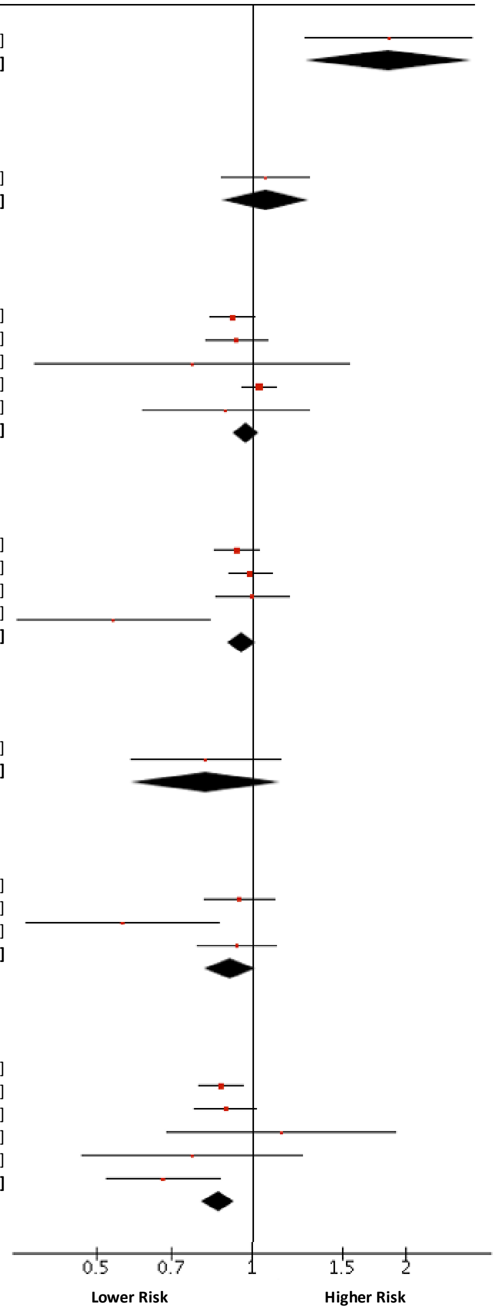


Figure S30. Relation between tomato intake and cardiovascular disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Apricots				
DIET-HD - Saglimbene 2017	9,757	515	0.8%	1.84 [1.27, 2.67]
Subtotal (95% CI)	**9,757**	**515**	**0.8%**	**1.84 [1.27, 2.67]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 3.21 (P = 0.001)				
Bananas				
Migrant Study - Hjartaker 2015 - banana	9,766	4,595	3.0%	1.06 [0.87, 1.29]
Subtotal (95% CI)	**9,766**	**4,595**	**3.0%**	**1.06 [0.87, 1.29]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.60 (P = 0.55)				
Berries				
Iowa WHS - Mink 2007 - strawberries	34,492	2,316	11.8%	0.91 [0.83, 1.01]
Iowa WHS - Mink 2007 - blueberries	-	-	6.0%	0.93 [0.81, 1.07]
WHS - Sesso 2007	38,176	204	0.2%	0.76 [0.38, 1.55]
Migrant Study - Hjartaker 2015	9,766	4,595	18.5%	1.03 [0.95, 1.11]
UK Women's Cohort - Lai 2015	30,458	286	0.8%	0.89 [0.61, 1.29]
Subtotal (95% CI)	**112,892**	**7,401**	**37.4%**	**0.97 [0.92, 1.03]**
Heterogeneity: Chi² = 4.68, df = 4 (P = 0.32); I² = 15%				
Test for overall effect: Z = 1.04 (P = 0.30)				
Citrus				
Iowa WHS - Mink 2007 - grapefruit	34,492	2,316	11.8%	0.93 [0.85, 1.03]
Iowa WHS - Mink 2007 - oranges	-	-	11.8%	0.99 [0.90, 1.09]
Migrant Study - Hjartaker 2015	9,766	4,595	4.1%	1.00 [0.85, 1.18]
UK Women's Cohort - Lai 2015	30,458	286	0.6%	0.54 [0.35, 0.83]
Subtotal (95% CI)	**74,716**	**7,197**	**28.4%**	**0.95 [0.90, 1.02]**
Heterogeneity: Chi² = 7.85, df = 3 (P = 0.05); I² = 62%				
Test for overall effect: Z = 1.45 (P = 0.15)				
Fruit Juice				
UK Women's Cohort - Lai 2015	30,458	286	1.0%	0.81 [0.58, 1.13]
Subtotal (95% CI)	**30,458**	**286**	**1.0%**	**0.81 [0.58, 1.13]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.24 (P = 0.22)				
Grapes				
Iowa WHS - Mink 2007 - grapes and raisins	34,492	2,316	4.6%	0.94 [0.81, 1.10]
UK Women's Cohort - Lai 2015 - grapes	30,458	286	0.6%	0.56 [0.36, 0.86]
Migrant Study - Hjartaker 2015 - grapes	9,766	4,595	3.7%	0.93 [0.78, 1.11]
Subtotal (95% CI)	**74,716**	**7,197**	**8.9%**	**0.90 [0.81, 1.01]**
Heterogeneity: Chi² = 5.12, df = 2 (P = 0.08); I² = 61%				
Test for overall effect: Z = 1.73 (P = 0.08)				
Pommes				
Iowa WHS - Mink 2007	34,492	2,316	11.8%	0.87 [0.79, 0.96]
Migrant Study - Hjartaker 2015	9,766	4,595	6.0%	0.89 [0.77, 1.02]
UK Women's Cohort - Lai 2015	30,458	286	0.4%	1.14 [0.68, 1.90]
Hodgson et al. 2016	1,456	235	0.5%	0.76 [0.47, 1.25]
DIET-HD - Saglimbene 2017	9,757	515	1.8%	0.67 [0.52, 0.86]
Subtotal (95% CI)	**85,929**	**7,947**	**20.5%**	**0.86 [0.80, 0.92]**
Heterogeneity: Chi² = 5.30, df = 4 (P = 0.26); I² = 25%				
Test for overall effect: Z = 4.04 (P < 0.0001)				
Test for subgroup differences: Chi² = 22.57, df = 6 (P = 0.0010), I² = 73.4%				

Relative Risk (95% CI) for CVD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Apricots				
DIET-HD - Saglimbene 2017	9,757	515	2.2%	1.84 [1.27, 2.67
Subtotal (95% CI)	**9,757**	**515**	**2.2%**	**1.84 [1.27, 2.67**
Heterogeneity: Not applicable				
Test for overall effect: Z = 3.21 (P = 0.001)				
Bananas				
Migrant Study - Hjartaker 2015 - banana	9,766	4,595	5.2%	1.06 [0.87, 1.29
Subtotal (95% CI)	**9,766**	**4,595**	**5.2%**	**1.06 [0.87, 1.29**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.60 (P = 0.55)				
Berries				
WHS - Sesso 2007	38,176	204	0.7%	0.76 [0.38, 1.55
Iowa WHS - Mink 2007 - strawberries	34,492	2,316	8.7%	0.91 [0.83, 1.01
Iowa WHS - Mink 2007 - blueberries	-	-	7.2%	0.93 [0.81, 1.07
Migrant Study - Hjartaker 2015	9,766	4,595	9.5%	1.03 [0.95, 1.11
UK Women's Cohort - Lai 2015	30,458	286	2.2%	0.89 [0.61, 1.29
Subtotal (95% CI)	**112,892**	**7,401**	**28.3%**	**0.97 [0.90, 1.03**
Heterogeneity: Tau² = 0.00; Chi² = 4.68, df = 4 (P = 0.32); I² = 15%				
Test for overall effect: Z = 1.06 (P = 0.29)				
Citrus				
Iowa WHS - Mink 2007 - grapefruit	34,492	2,316	8.7%	0.93 [0.85, 1.03
Iowa WHS - Mink 2007 - oranges	-	-	8.7%	0.99 [0.90, 1.09
Migrant Study - Hjartaker 2015	9,766	4,595	6.1%	1.00 [0.85, 1.18
UK Women's Cohort - Lai 2015	30,458	286	1.7%	0.54 [0.35, 0.83
Subtotal (95% CI)	**74,716**	**7,197**	**25.3%**	**0.93 [0.83, 1.05**
Heterogeneity: Tau² = 0.01; Chi² = 7.85, df = 3 (P = 0.05); I² = 62%				
Test for overall effect: Z = 1.12 (P = 0.26)				
Fruit Juice				
UK Women's Cohort - Lai 2015	30,458	286	2.6%	0.81 [0.58, 1.13
Subtotal (95% CI)	**30,458**	**286**	**2.6%**	**0.81 [0.58, 1.13**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.24 (P = 0.22)				
Grapes				
Iowa WHS - Mink 2007 - grapes and raisins	34,492	2,316	6.5%	0.94 [0.81, 1.10
UK Women's Cohort - Lai 2015 - grapes	30,458	286	1.7%	0.56 [0.36, 0.86
Migrant Study - Hjartaker 2015 - grapes	9,766	4,595	5.8%	0.93 [0.78, 1.11
Subtotal (95% CI)	**74,716**	**7,197**	**14.0%**	**0.86 [0.70, 1.06**
Heterogeneity: Tau² = 0.02; Chi² = 5.12, df = 2 (P = 0.08); I² = 61%				
Test for overall effect: Z = 1.42 (P = 0.15)				
Pommes				
Iowa WHS - Mink 2007	34,492	2,316	8.7%	0.87 [0.79, 0.96
UK Women's Cohort - Lai 2015	30,458	286	1.3%	1.14 [0.68, 1.90
Migrant Study - Hjartaker 2015	9,766	4,595	7.2%	0.89 [0.77, 1.02
Hodgson et al. 2016	1,456	235	1.4%	0.76 [0.47, 1.25
DIET-HD - Saglimbene 2017	9,757	515	3.8%	0.67 [0.52, 0.86
Subtotal (95% CI)	**85,929**	**7,947**	**22.4%**	**0.85 [0.77, 0.94**
Heterogeneity: Tau² = 0.00; Chi² = 5.30, df = 4 (P = 0.26); I² = 25%				
Test for overall effect: Z = 3.15 (P = 0.002)				
Test for subgroup differences: Chi² = 19.92, df = 6 (P = 0.003), I² = 69.9%				

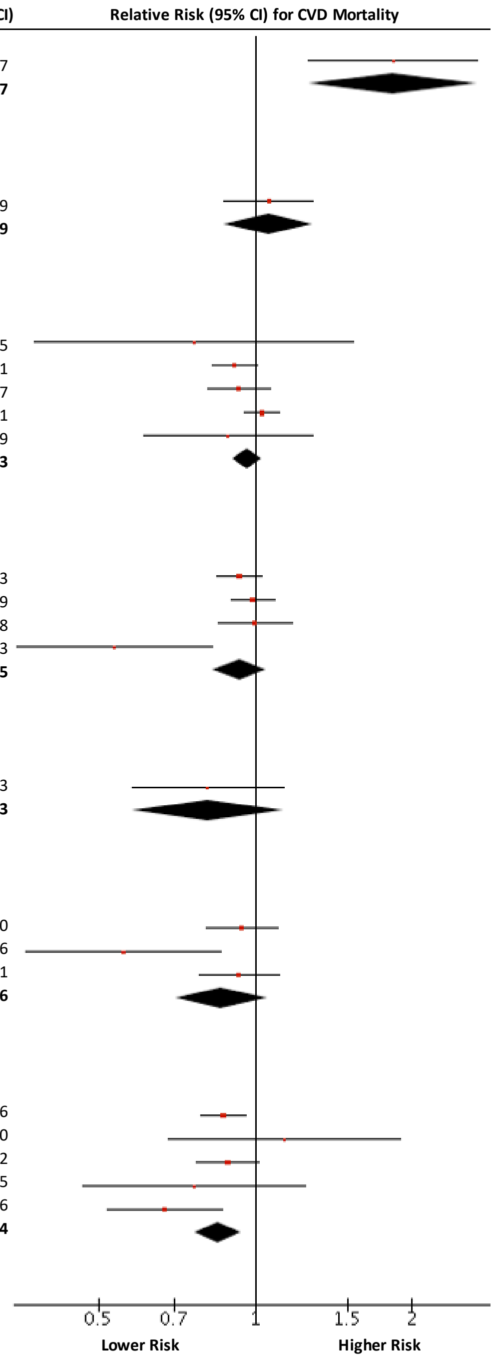
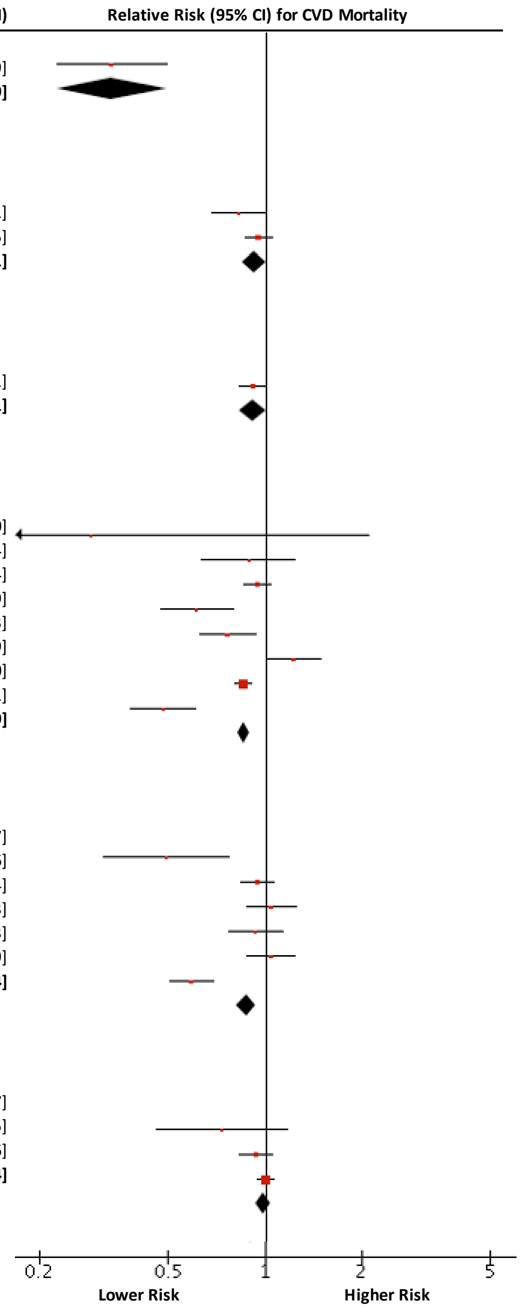


Figure S31. Relation between sources of fruit and CVD mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
1.11.1 Allium				
PLSAW - Blekkenhorst 2017	1,226	238	0.5%	0.33 [0.22, 0.49]
Subtotal (95% CI)	**1,226**	**238**	**0.5%**	**0.33 [0.22, 0.49]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 5.50 (P < 0.00001)				
1.11.2 Carrots				
Zutphen Elderly - Buijsse 2008- Carrots	559	197	2.0%	0.83 [0.68, 1.01]
Miigrant Study - Hjartaker 2015 - carrots	9,766	4,595	8.0%	0.95 [0.86, 1.05]
Subtotal (95% CI)	**10,325**	**4,792**	**10.0%**	**0.92 [0.85, 1.01]**
Heterogeneity: Tau² = 0.00; Chi² = 1.57, df = 1 (P = 0.21); I² = 36%				
Test for overall effect: Z = 1.44 (P = 0.15)				
1.11.3 Celery				
Iowa WHS - Mink 2007 - celery	34,492	2,316	8.0%	0.91 [0.83, 1.01]
Subtotal (95% CI)	**34,492**	**2,316**	**8.0%**	**0.91 [0.83, 1.01]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.80 (P = 0.07)				
1.11.4 Cruciferous				
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	0.0%	0.29 [0.04, 2.10]
Odyssey - Genkinger 2004	6,151	378	0.7%	0.89 [0.64, 1.24]
Iowa WHS - Mink 2007	34,492	2,316	8.0%	0.94 [0.85, 1.04]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	1.2%	0.61 [0.47, 0.79]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	2.0%	0.76 [0.63, 0.93]
Migrant Study - Hjartaker 2015 - cabbage	-	-	2.0%	1.22 [1.00, 1.49]
Migrant Study - Hjartaker 2015 - cauliflower	9,766	4,595	22.2%	0.85 [0.80, 0.90]
PLSAW - Blekkenhorst 2017	1,226	238	1.4%	0.48 [0.38, 0.61]
Subtotal (95% CI)	**187,730**	**13,081**	**37.4%**	**0.85 [0.82, 0.89]**
Heterogeneity: Tau² = 0.04; Chi² = 48.35, df = 7 (P < 0.00001); I² = 86%				
Test for overall effect: Z = 2.75 (P = 0.006)				
1.11.5 Green leafy				
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	0.4%	0.49 [0.31, 0.77]
Health Food Shoppers - Appleby 2002	10,741	282	5.5%	0.94 [0.84, 1.06]
MONICA Switzerland - Vormund 2015 - M	8,665	751	2.5%	1.04 [0.87, 1.24]
MONICA Switzerland - Vormund 2015 - F	9,196	634	2.0%	0.93 [0.77, 1.13]
Migrant Study - Hjartaker 2015	9,766	4,595	2.6%	1.04 [0.88, 1.23]
PLSAW - Blekkenhorst 2017	1,226	238	3.1%	0.59 [0.50, 0.69]
Subtotal (95% CI)	**40,893**	**6,661**	**16.1%**	**0.87 [0.81, 0.94]**
Heterogeneity: Tau² = 0.06; Chi² = 40.44, df = 5 (P < 0.00001); I² = 88%				
Test for overall effect: Z = 1.68 (P = 0.09)				
1.11.6 Tomatoes				
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	0.3%	0.73 [0.46, 1.17]
Iowa WHS - Mink 2007	34,492	2,316	5.5%	0.93 [0.83, 1.05]
Migrant Study - Hjartaker 2015	9,766	4,595	22.2%	1.00 [0.94, 1.06]
Subtotal (95% CI)	**45,557**	**7,072**	**28.0%**	**0.98 [0.93, 1.04]**
Heterogeneity: Tau² = 0.00; Chi² = 2.59, df = 2 (P = 0.27); I² = 23%				
Test for overall effect: Z = 0.75 (P = 0.45)				
Test for subgroup differences: Chi² = 41.70, df = 5 (P < 0.00001), I² = 88.0%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
PLSAW - Blekkenhorst 2017	1,226	238	2.7%	0.33 [0.22, 0.49]
Subtotal (95% CI)	**1,226**	**238**	**2.7%**	**0.33 [0.22, 0.49]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 5.50 (P < 0.00001)				
Carrots				
Zutphen Elderly - Buijsse 2008- Carrots	559	197	5.0%	0.83 [0.68, 1.01]
Miigrant Study - Hjartaker 2015 - carrots	9,766	4,595	6.3%	0.95 [0.86, 1.05]
Subtotal (95% CI)	**10,325**	**4,792**	**11.3%**	**0.91 [0.80, 1.03]**
Heterogeneity: Tau² = 0.00; Chi² = 1.57, df = 1 (P = 0.21); I² = 36%				
Test for overall effect: Z = 1.44 (P = 0.15)				
Celery				
Iowa WHS - Mink 2007 - celery	34,492	2,316	6.3%	0.91 [0.83, 1.01]
Subtotal (95% CI)	**34,492**	**2,316**	**6.3%**	**0.91 [0.83, 1.01]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.80 (P = 0.07)				
Cruciferous				
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	0.2%	0.29 [0.04, 2.10]
Odyssey - Genkinger 2004	6,151	378	3.3%	0.89 [0.64, 1.24]
Iowa WHS - Mink 2007	34,492	2,316	6.3%	0.94 [0.85, 1.04]
Shanghai Women Health - Zhang 2011 (a)	73,360	3,442	4.2%	0.61 [0.47, 0.79]
Shanghai Men Health - Zhang 2011 (a)	61,436	1,951	5.0%	0.76 [0.63, 0.93]
Migrant Study - Hjartaker 2015 - cabbage	9,766	4,595	5.0%	1.22 [1.00, 1.49]
Migrant Study - Hjartaker 2015 - cauliflower	-	-	6.7%	0.85 [0.80, 0.90]
PLSAW - Blekkenhorst 2017	1,226	238	4.5%	0.48 [0.38, 0.61]
Subtotal (95% CI)	**187,730**	**13,081**	**35.1%**	**0.80 [0.68, 0.94]**
Heterogeneity: Tau² = 0.04; Chi² = 48.35, df = 7 (P < 0.00001); I² = 86%				
Test for overall effect: Z = 2.75 (P = 0.006)				
Green leafy				
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	2.3%	0.49 [0.31, 0.77]
Health Food Shoppers - Appleby 2002	10,741	282	6.1%	0.94 [0.84, 1.06]
MONICA Switzerland - Vormund 2015 - F	9,196	634	5.0%	0.93 [0.77, 1.13]
MONICA Switzerland - Vormund 2015 - M	8,665	751	5.3%	1.04 [0.87, 1.24]
Migrant Study - Hjartaker 2015	9,766	4,595	5.4%	1.04 [0.88, 1.23]
PLSAW - Blekkenhorst 2017	1,226	238	5.6%	0.59 [0.50, 0.69]
Subtotal (95% CI)	**40,893**	**6,661**	**29.6%**	**0.84 [0.68, 1.03]**
Heterogeneity: Tau² = 0.06; Chi² = 40.44, df = 5 (P < 0.00001); I² = 88%				
Test for overall effect: Z = 1.68 (P = 0.09)				
Tomatoes				
Massachusetts Health Care Panel - Gaziano 1995	1,299	161	2.2%	0.73 [0.46, 1.17]
Iowa WHS - Mink 2007	34,492	2,316	6.1%	0.93 [0.83, 1.05]
Migrant Study - Hjartaker 2015	9,766	4,595	6.7%	1.00 [0.94, 1.06]
Subtotal (95% CI)	**45,557**	**7,072**	**14.9%**	**0.97 [0.90, 1.05]**
Heterogeneity: Tau² = 0.00; Chi² = 2.59, df = 2 (P = 0.27); I² = 23%				
Test for overall effect: Z = 0.75 (P = 0.45)				
Test for subgroup differences: Chi² = 31.45, df = 5 (P < 0.00001), I² = 84.1%				

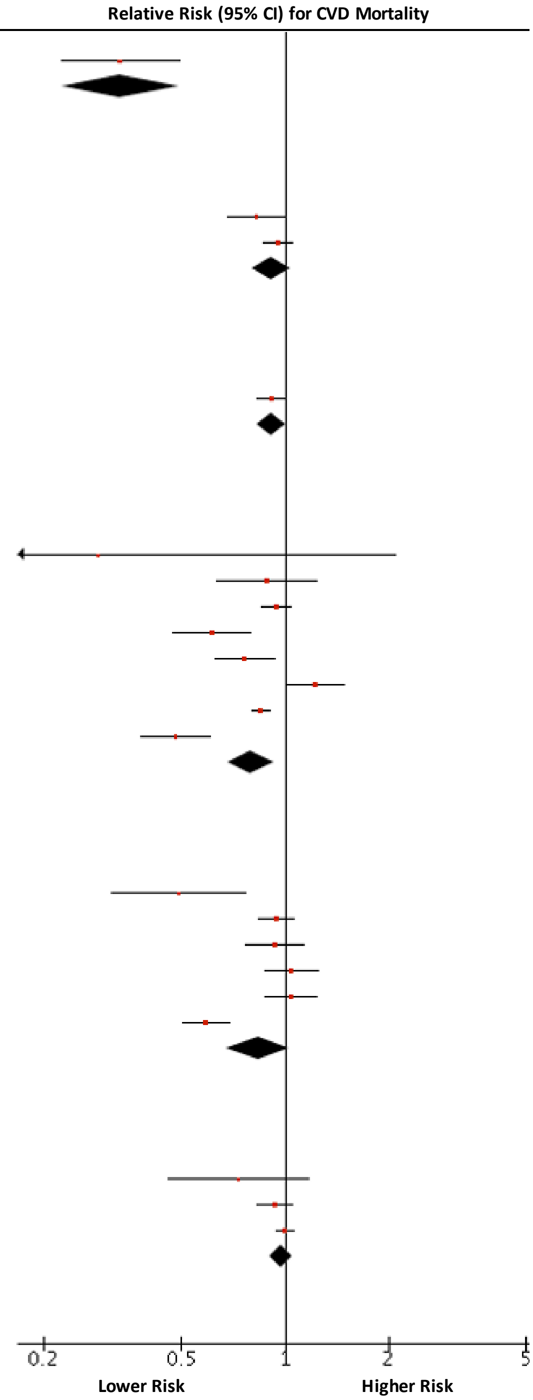


Figure S32. Relation between sources of vegetables and CVD mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

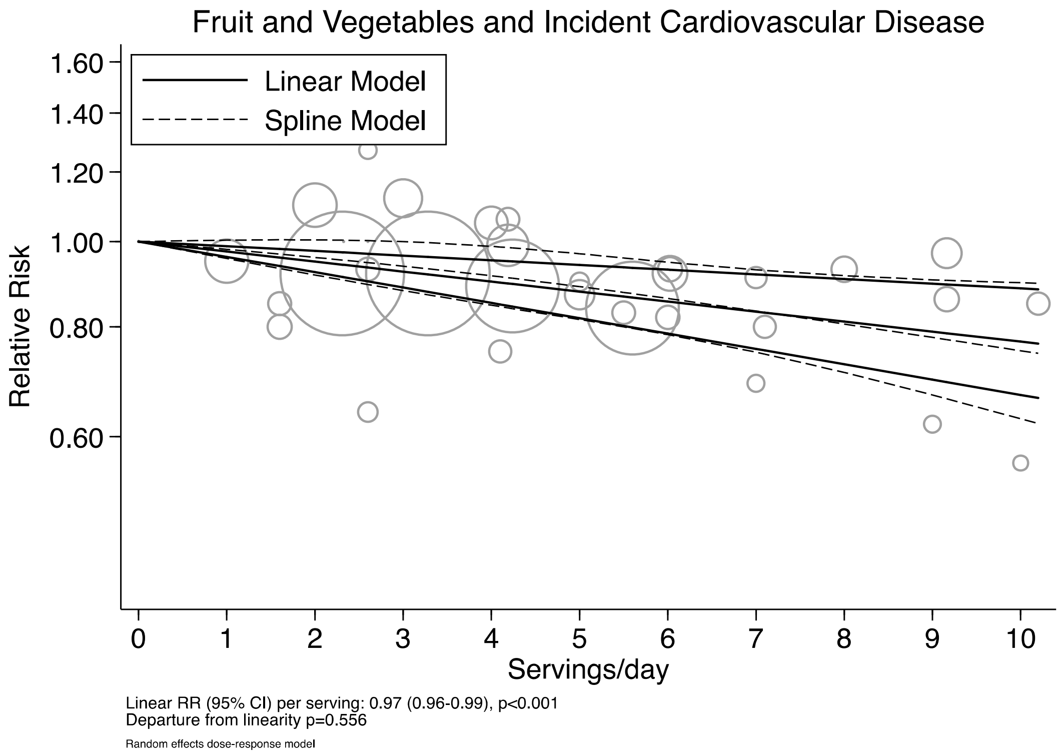


Figure S33. Linear and cubic-spline dose-response relation between increasing fruit and vegetable intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

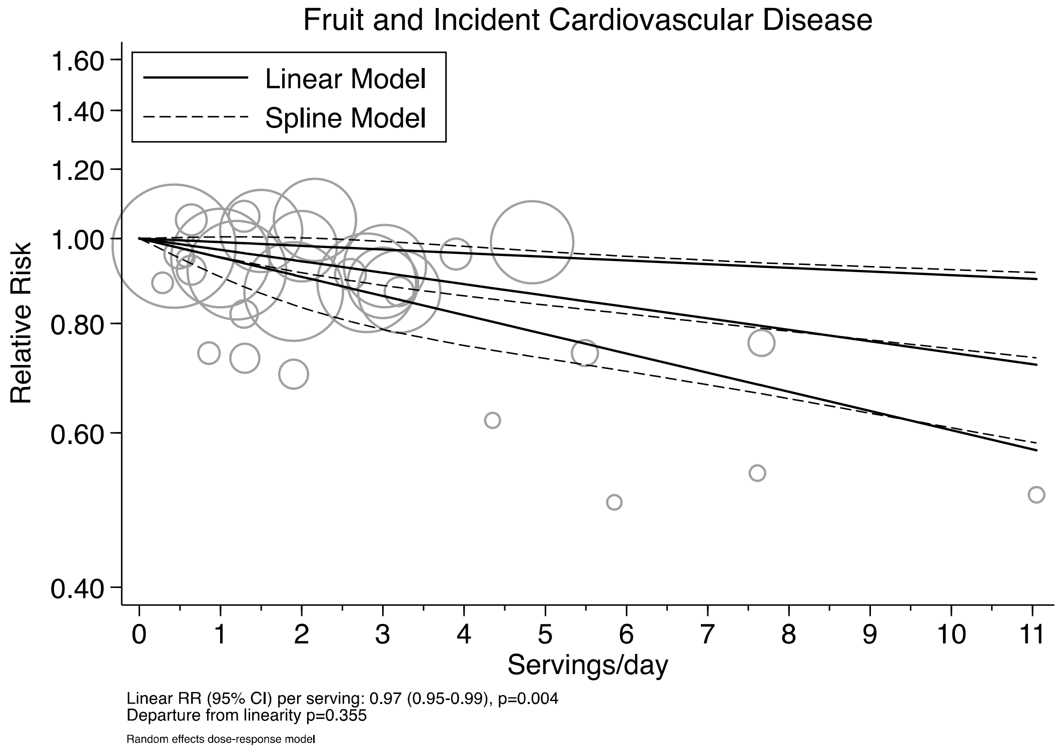


Figure S34. Linear and cubic-spline dose-response relation between increasing fruit intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

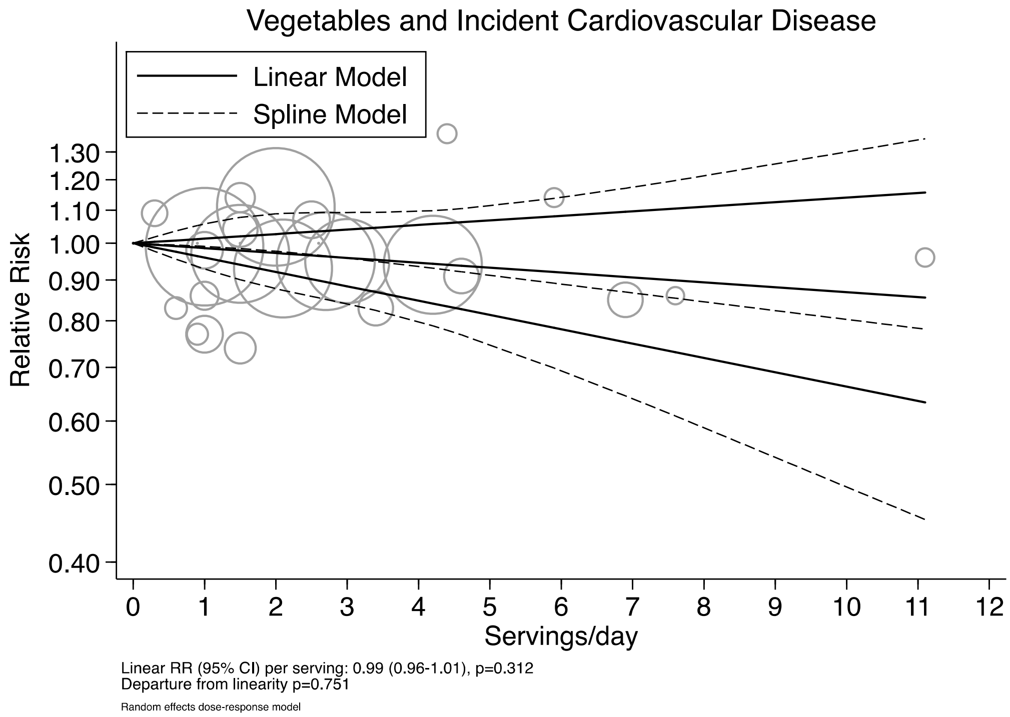


Figure S35. Linear and cubic-spline dose-response relation between increasing intake of vegetables and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

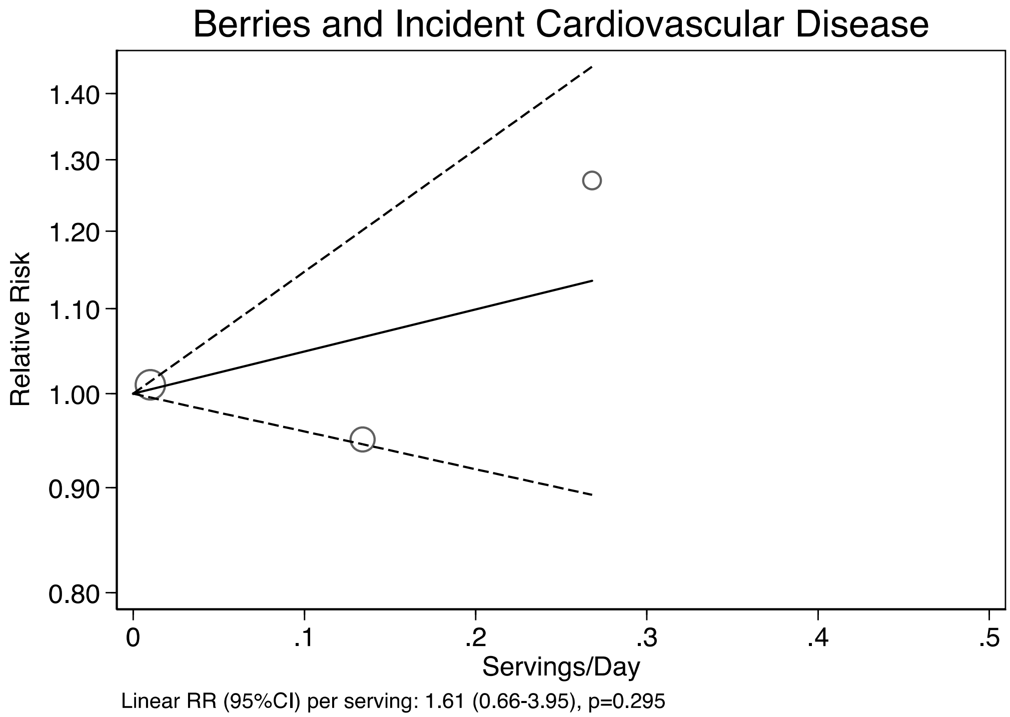


Figure S36. Linear dose-response relation between increasing berries intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

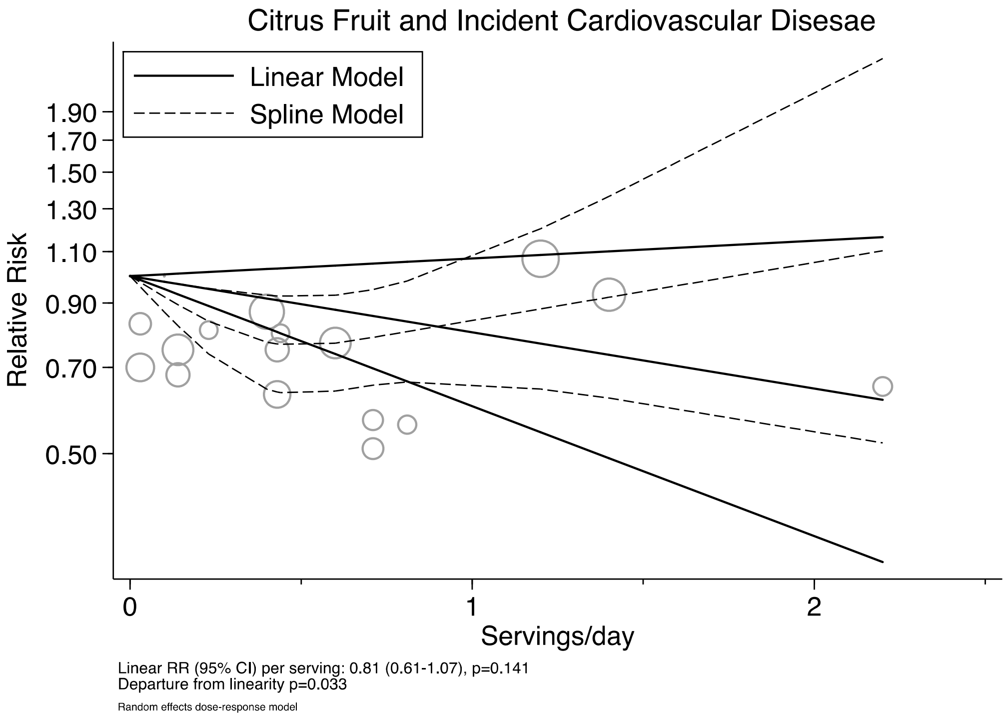


Figure S37. Linear and cubic-spline dose-response relation between increasing citrus fruit intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

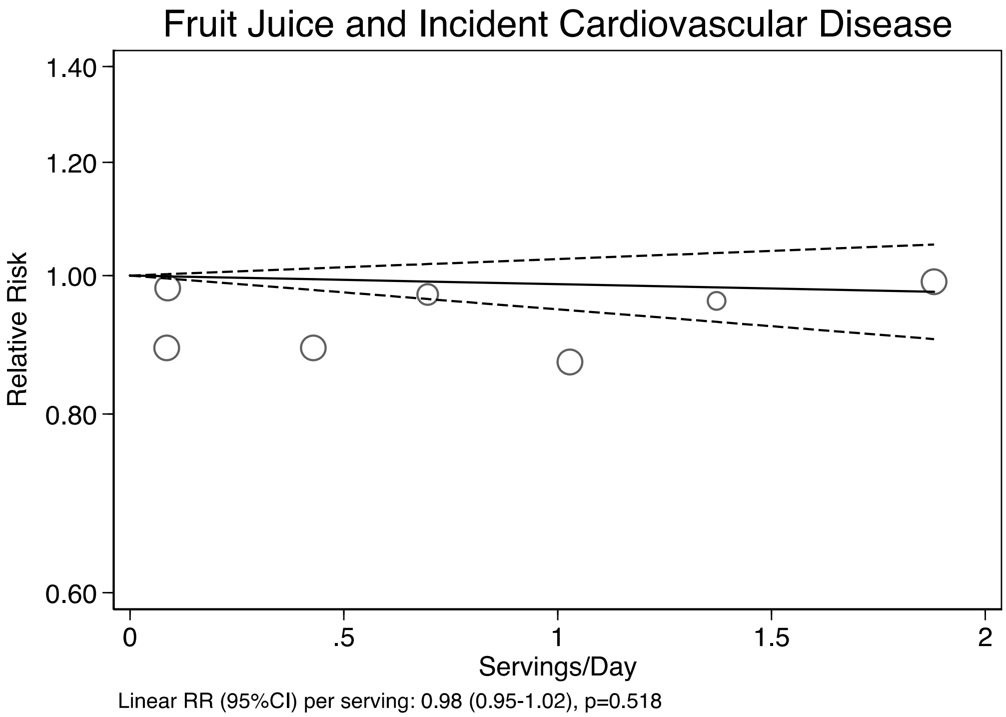


Figure S38. Linear and cubic-spline dose-response relation between increasing fruit juice intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

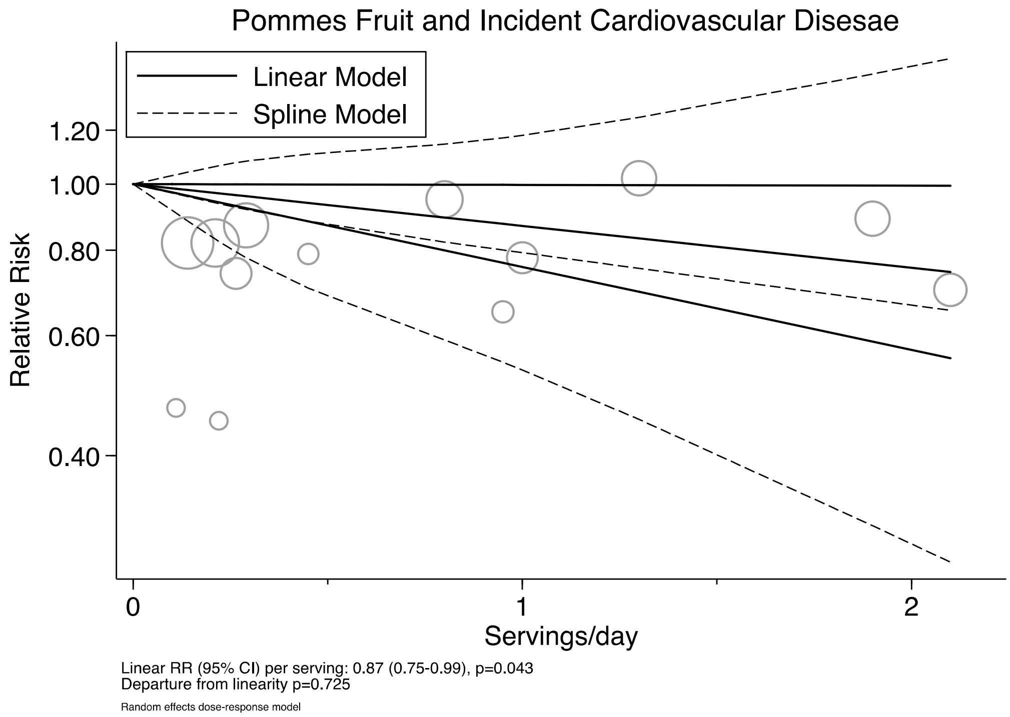


Figure S39. Linear dose-response relation between increasing pommes intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

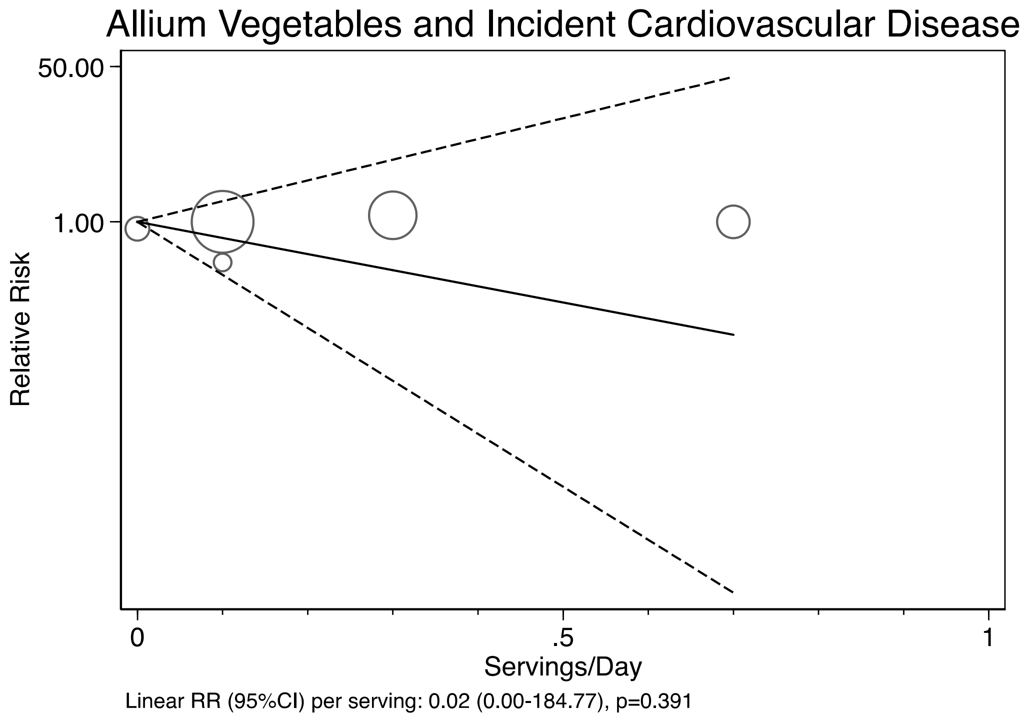


Figure S40. Linear dose-response relation between increasing intake of allium vegetables and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

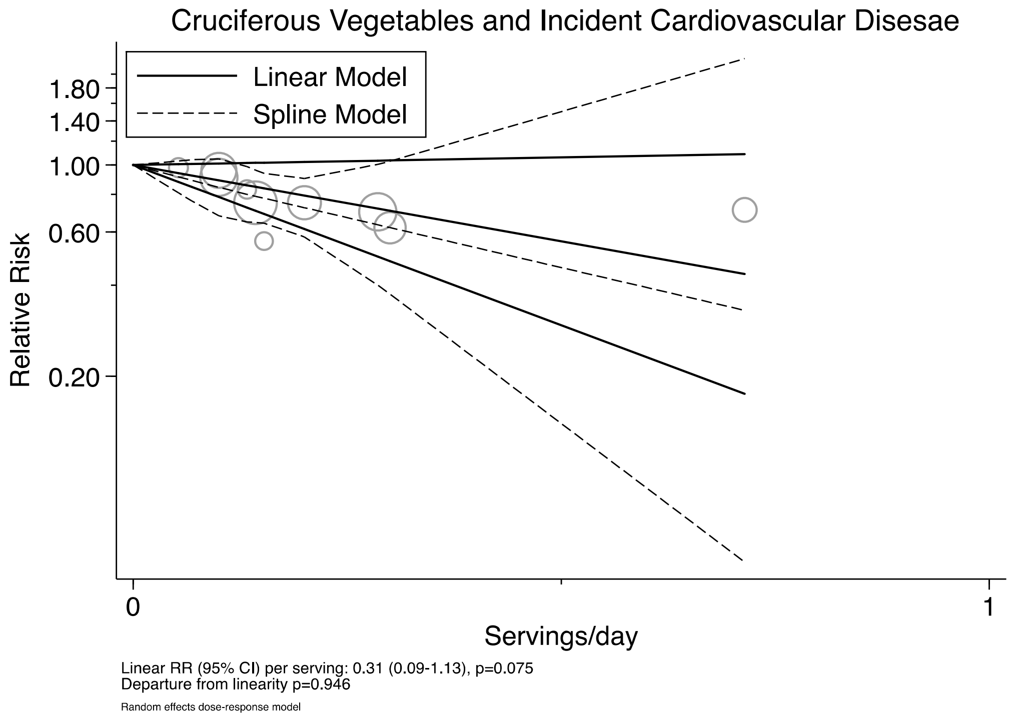


Figure S41. Linear dose-response relation between increasing intake of cruciferous vegetables and incidence of cardiovascular disease y. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

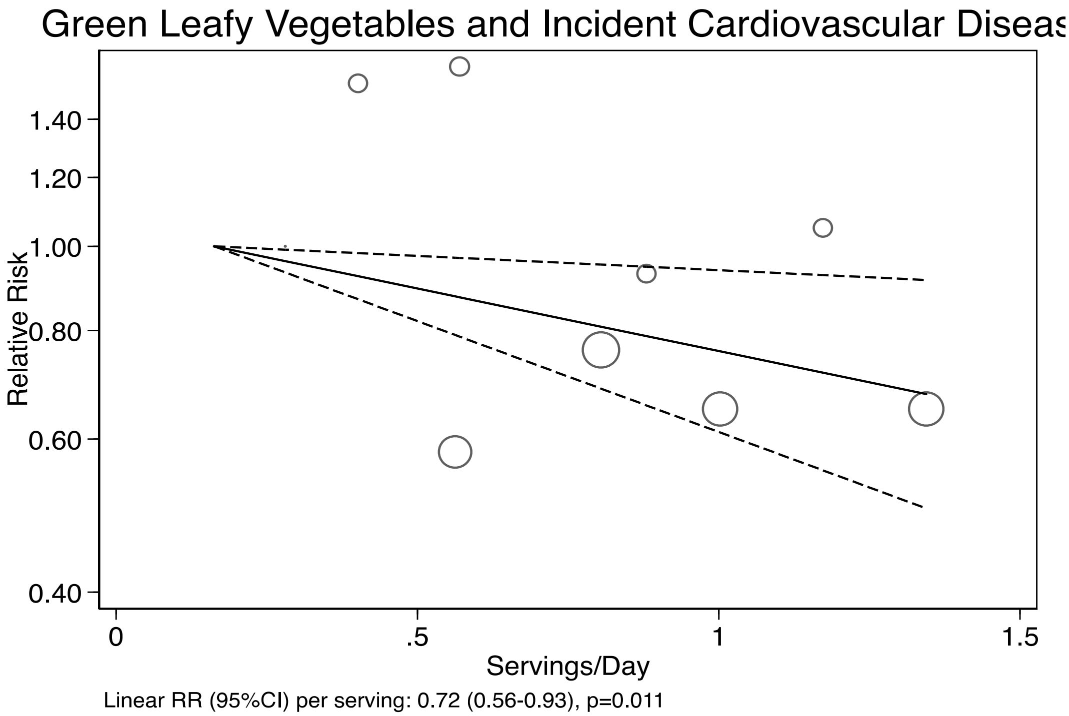


Figure S42. Linear dose-response relation between increasing intake of green leafy vegetables and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

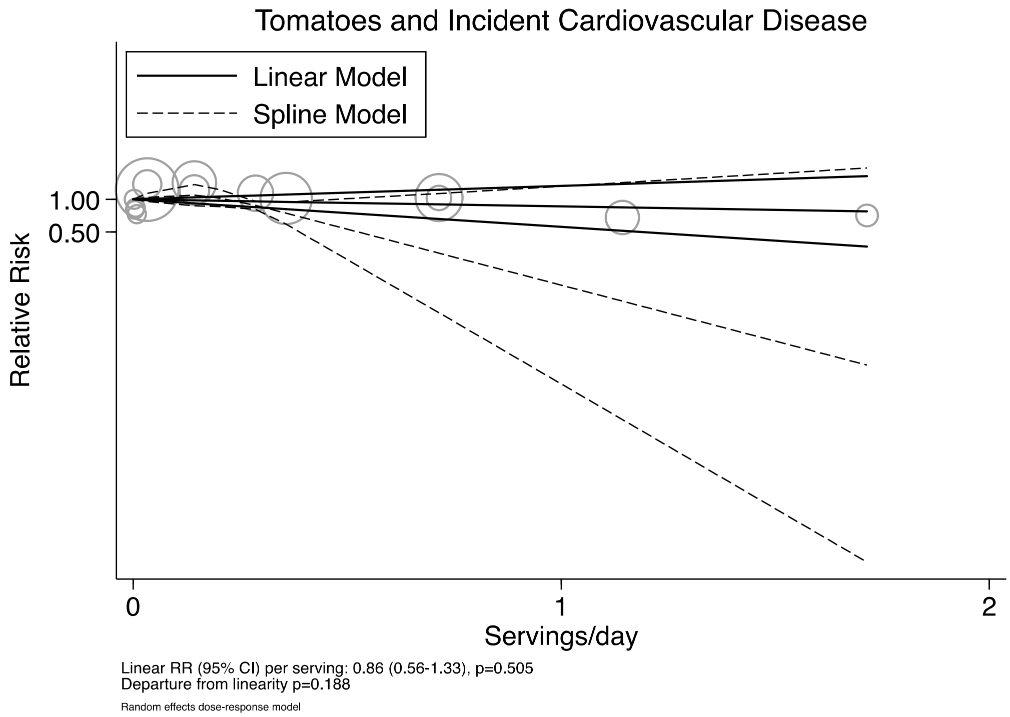


Figure S43. Linear and cubic-spline dose-response relation between increasing tomato intake and incidence of cardiovascular disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

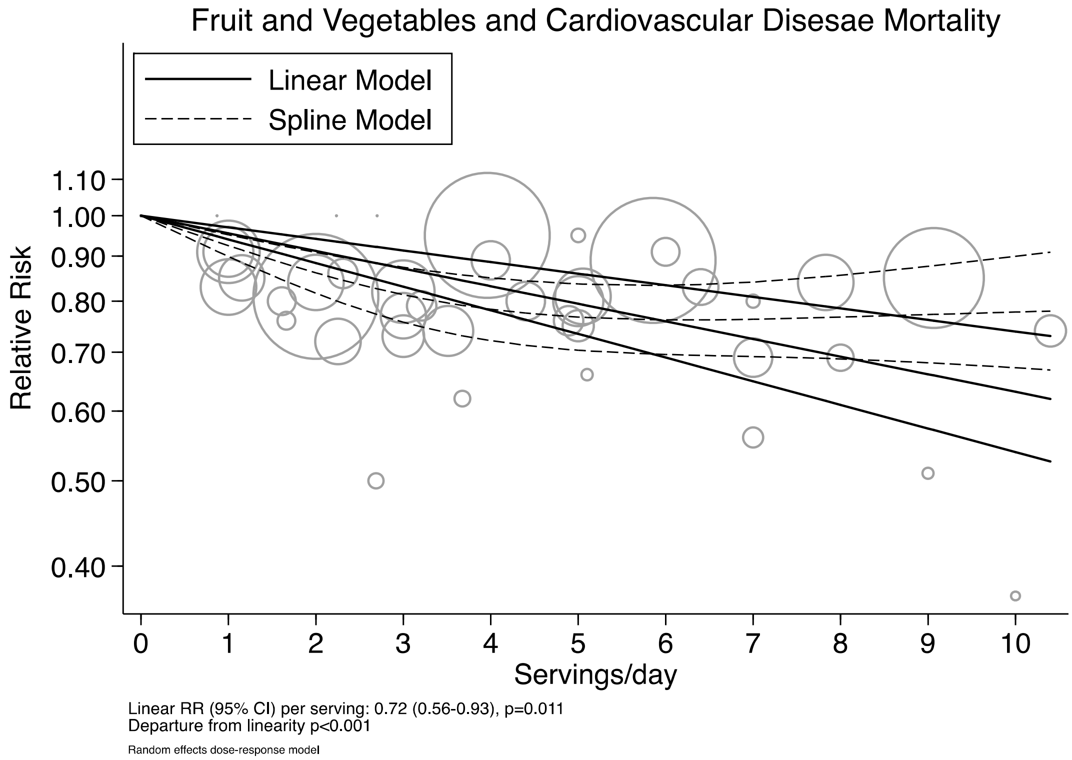


Figure S44. Linear and cubic-spline dose-response relation between increasing fruit and vegetable intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

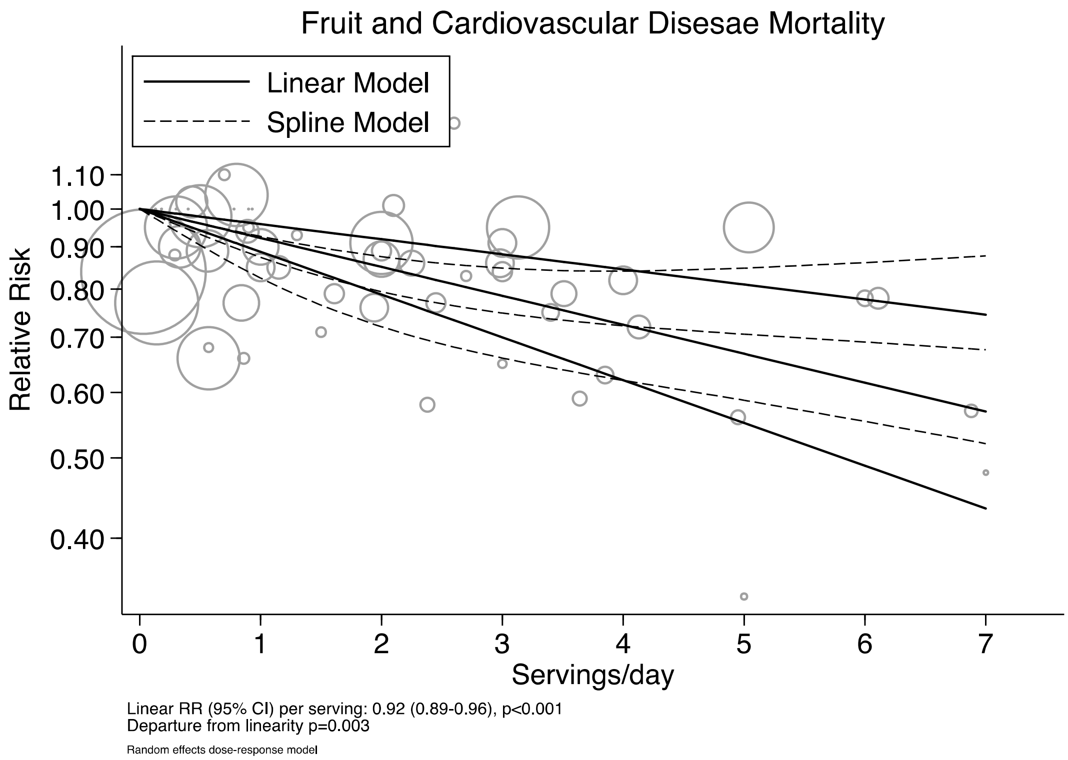


Figure S45. Linear and cubic-spline dose-response relation between increasing fruit intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

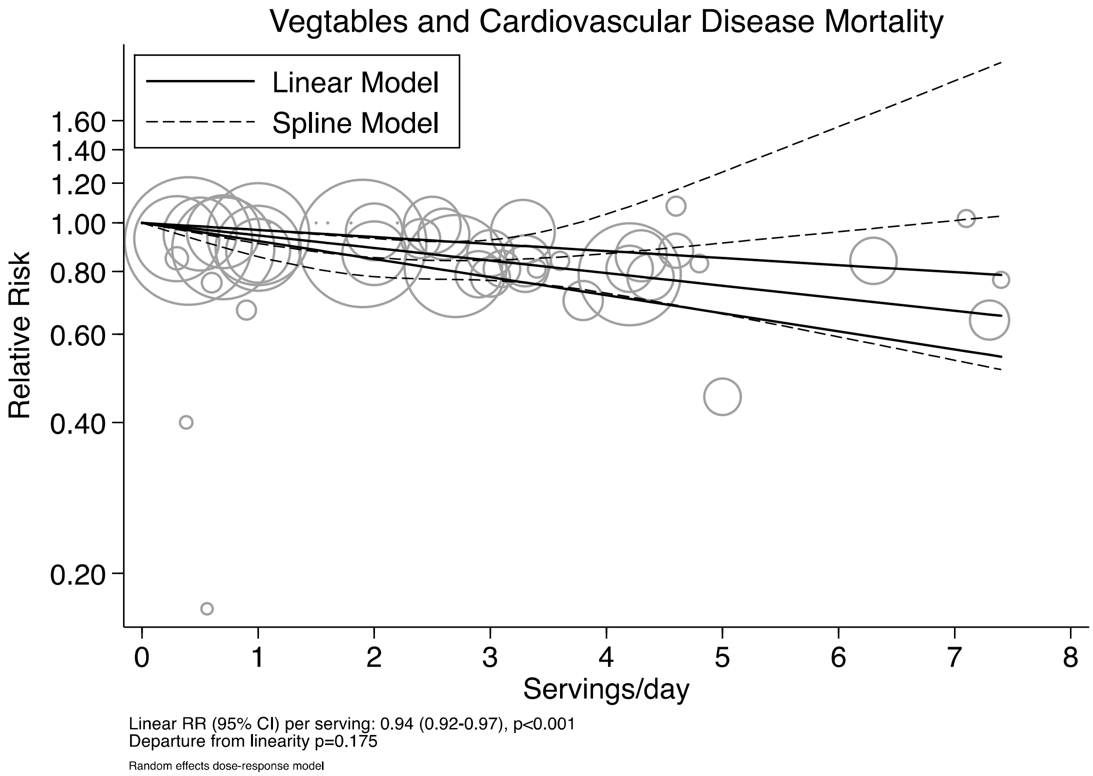


Figure S46. Linear and cubic-spline dose-response relation between increasing intake of vegetables and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

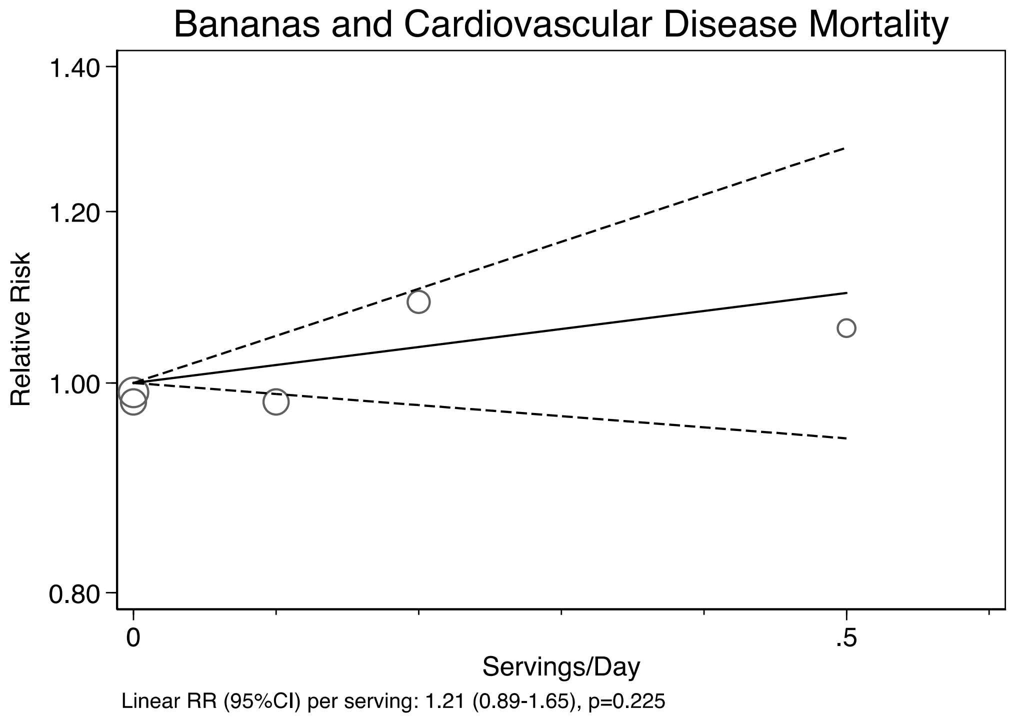


Figure S47. Linear dose-response relation between increasing banana intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

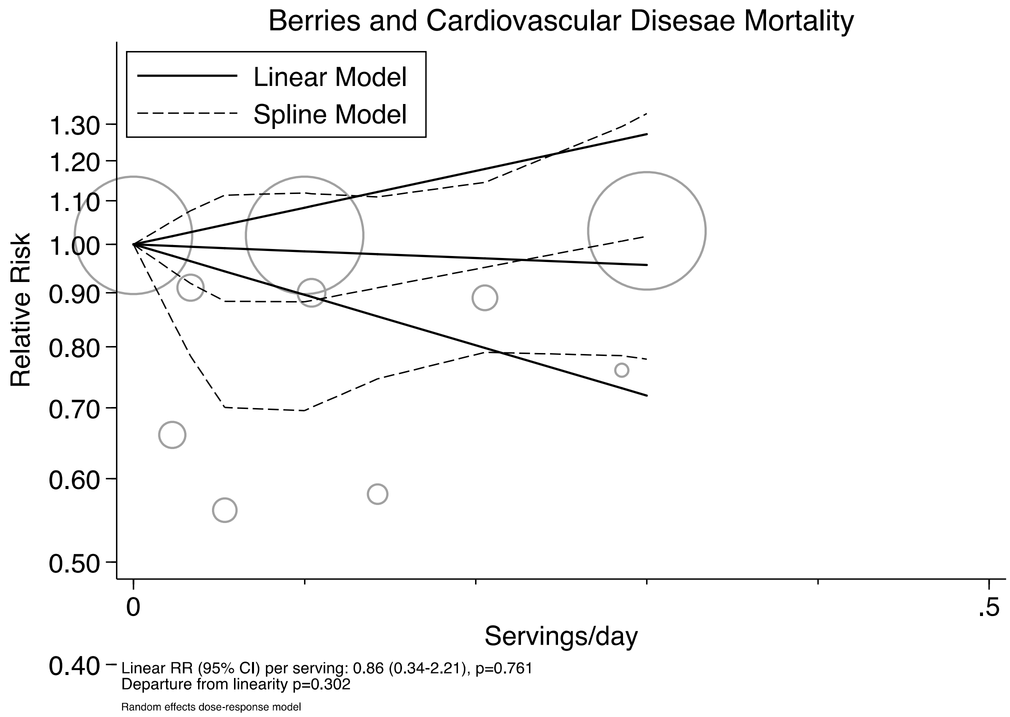


Figure S48. Linear and cubic-spline dose-response relation between increasing berry fruit intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

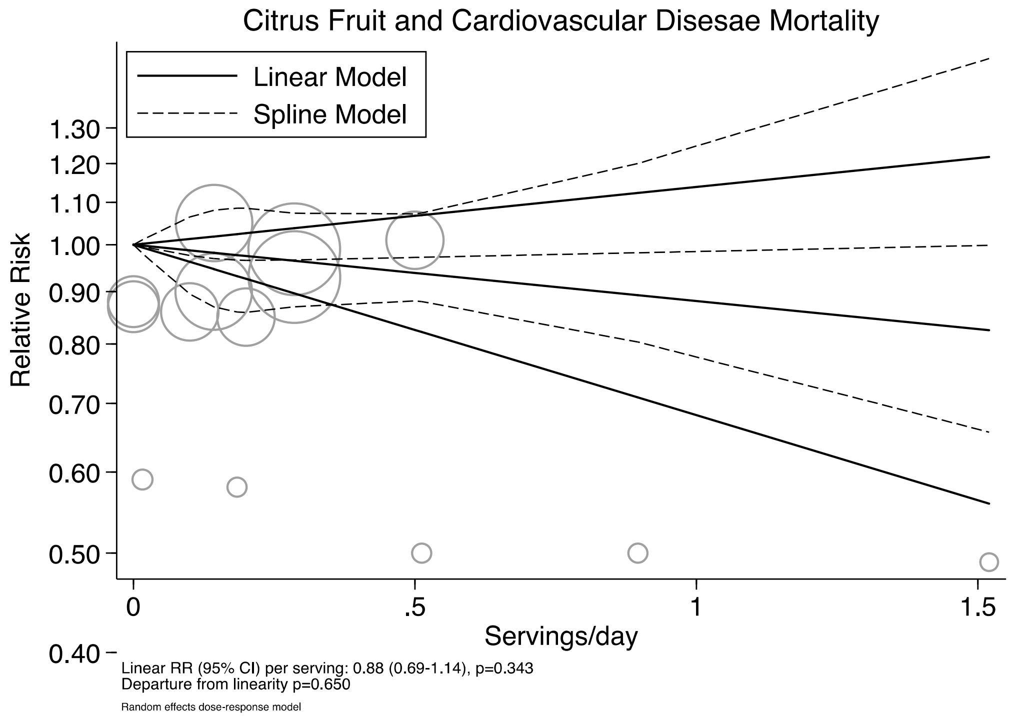


Figure S49. Linear and cubic-spline dose-response relation between increasing citrus fruit intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

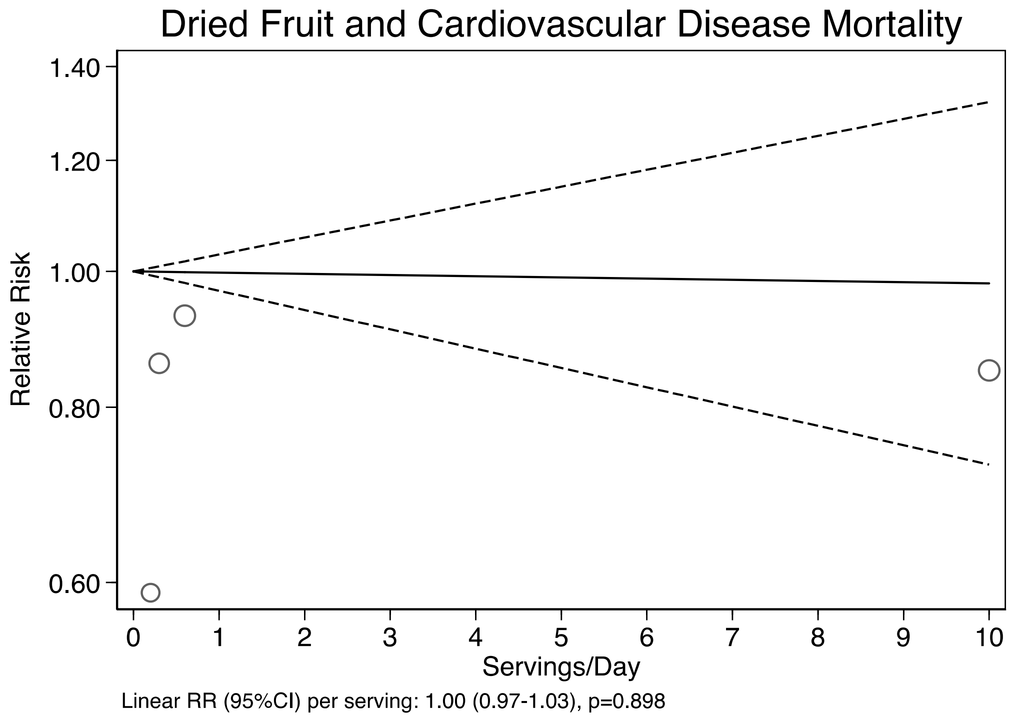


Figure S50. Linear and cubic-spline dose-response relation between increasing dried fruit intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

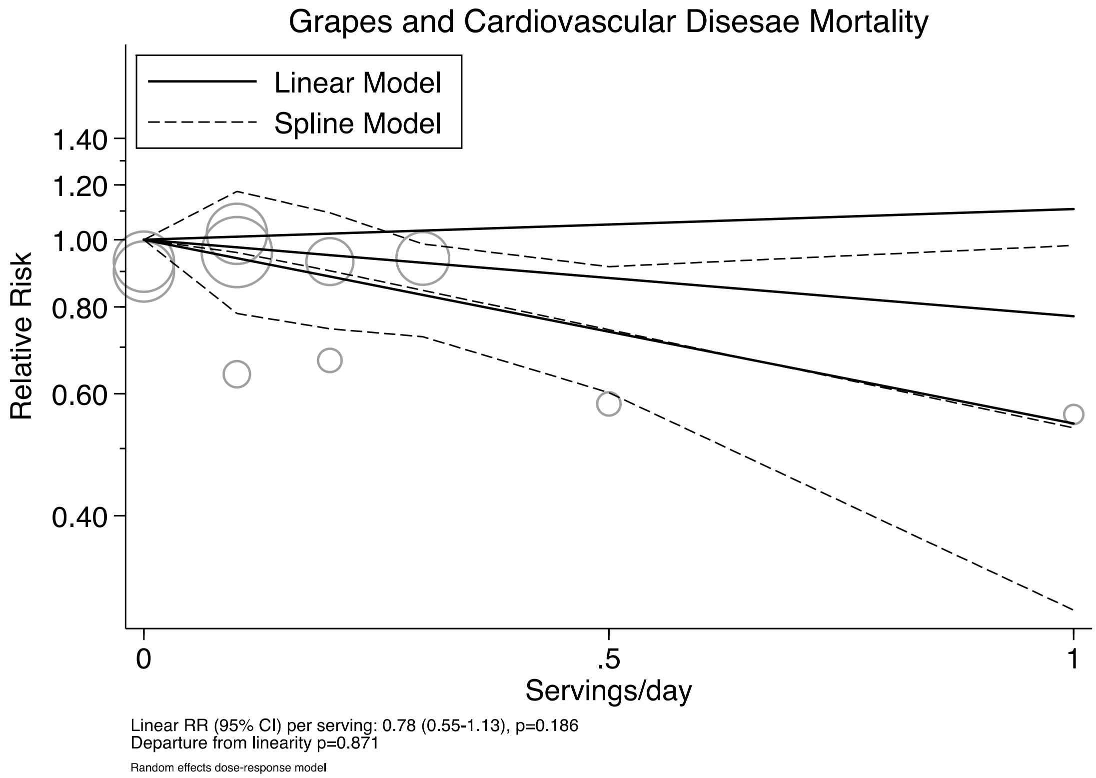


Figure S51. Linear and cubic-spline dose-response relation between increasing grapes intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

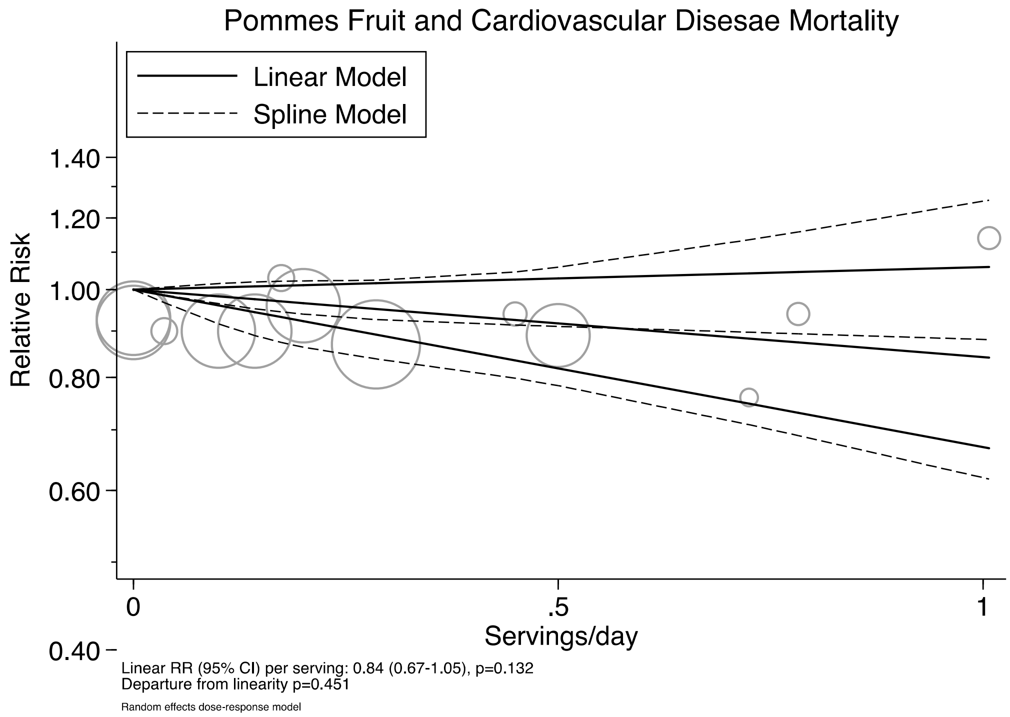


Figure S52. Linear and cubic-spline dose-response relation between increasing pommes intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

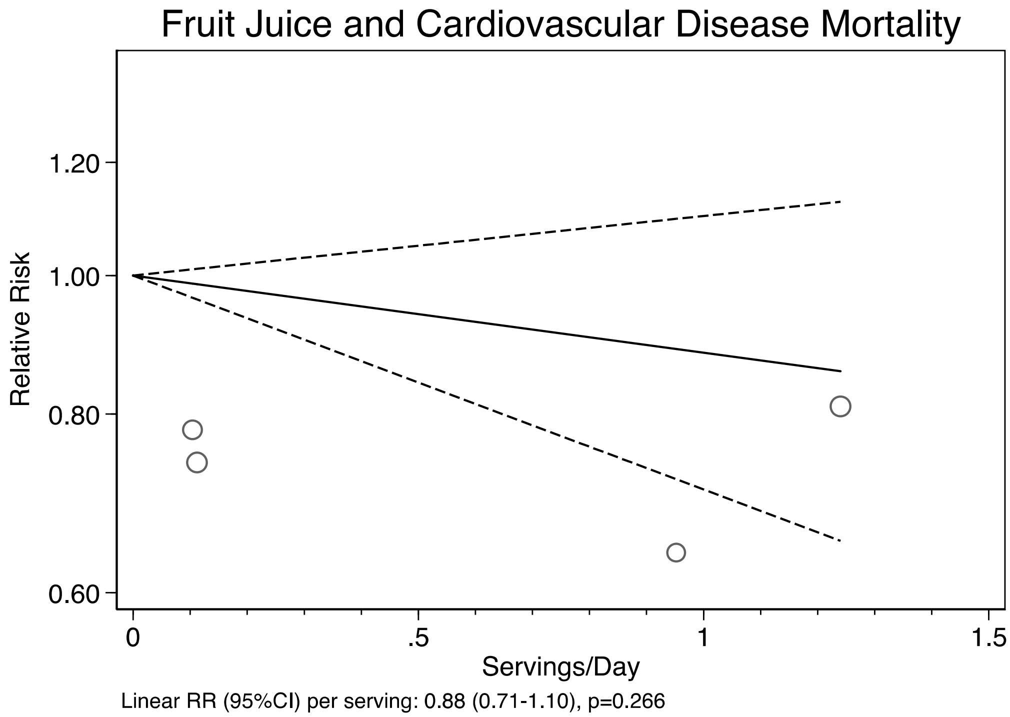


Figure S53. Linear dose-response relation between increasing fruit juice intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

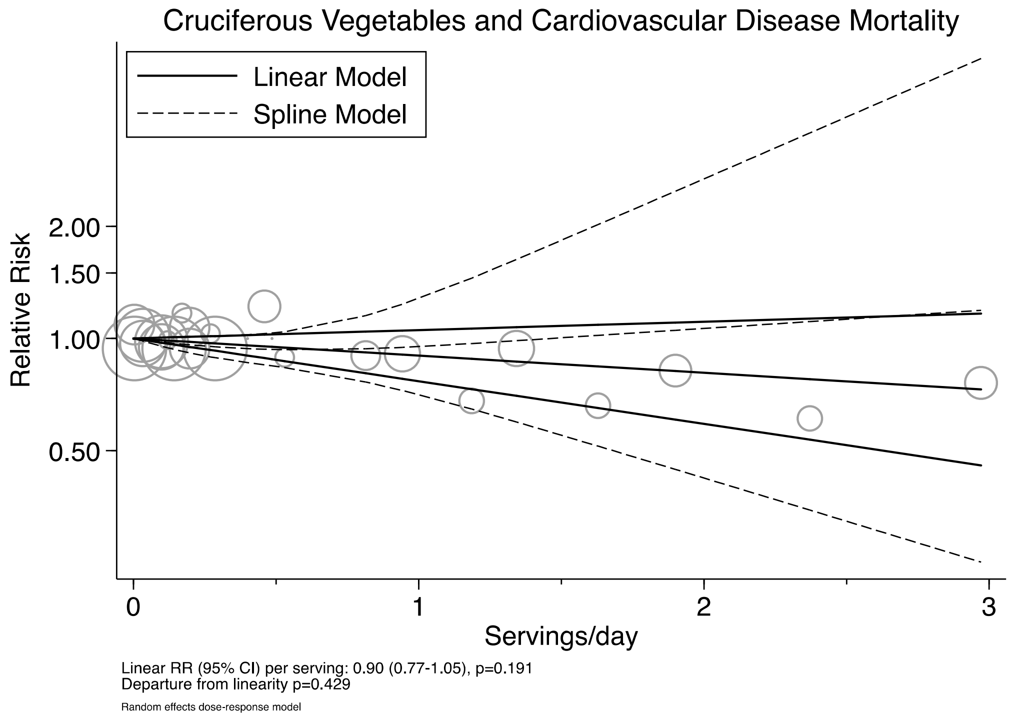


Figure S54. Linear and cubic-spline dose-response relation between increasing intake of cruciferous vegetables and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

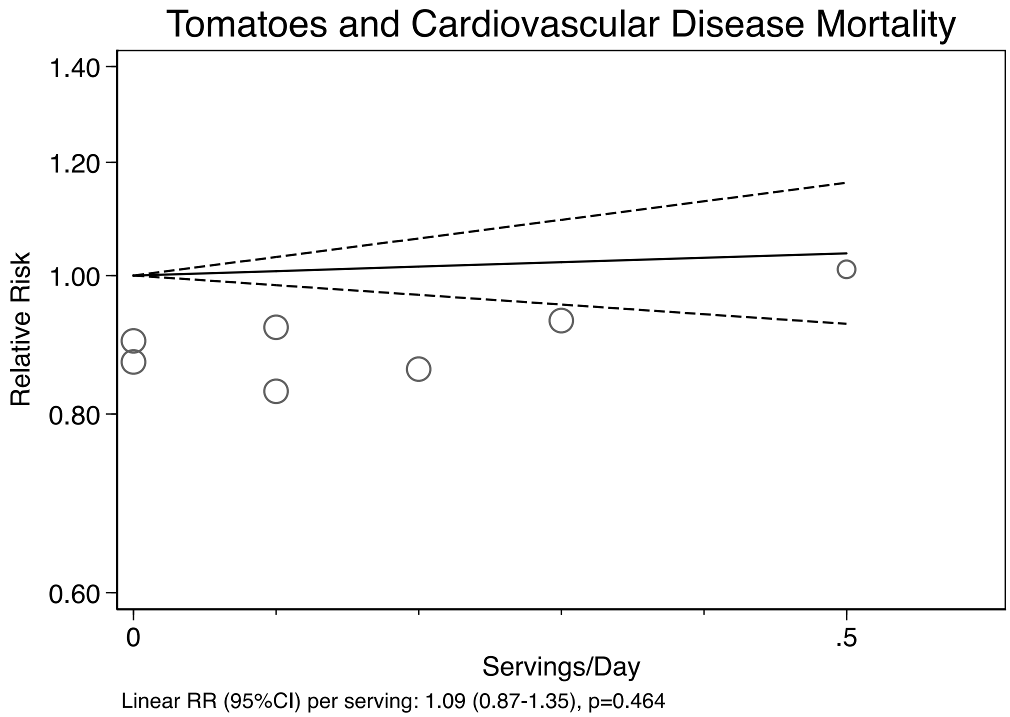


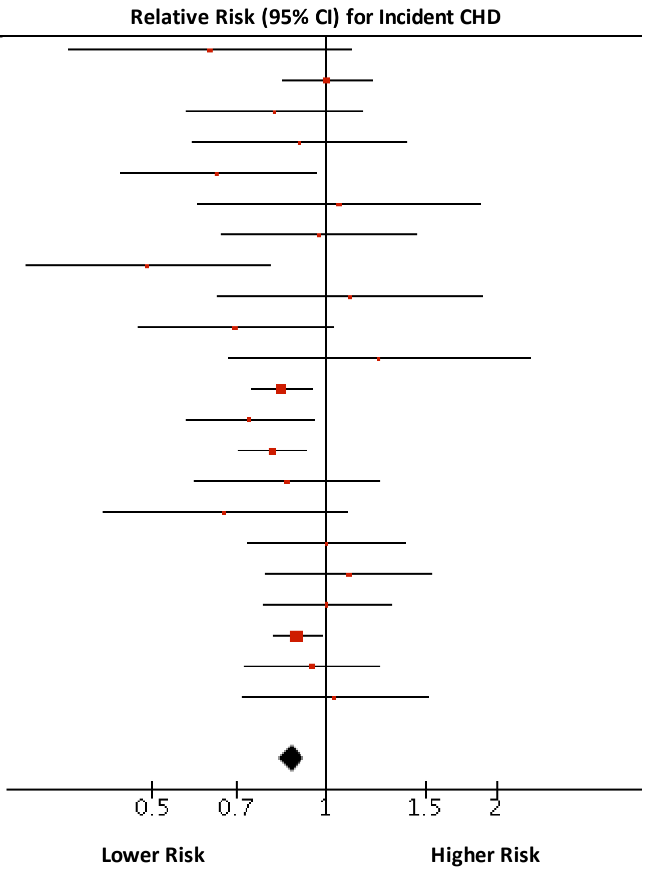
Figure S55. Linear dose-response relation between increasing tomato intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

TOTAL FRUIT AND VEGETABLES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Liu 2000	39,127	126	0.8%	0.63 [0.36, 1.11]
National Health & Nutrition - Bazzano 2002	9,608	1,786	8.2%	1.01 [0.85, 1.20]
ARIC - Steffen 2003	11,940	535	2.0%	0.82 [0.58, 1.17]
EPIC Norway - Bingham 2008	11,134	678	1.4%	0.90 [0.59, 1.39]
Swedish National Farm Register - Holmberg 2009	1,738	138	1.7%	0.65 [0.44, 0.96]
PRIME - Dauchet 2010 - never smokers	2,410	145	0.8%	1.06 [0.60, 1.87]
PRIME - Dauchet 2010 - former smokers	3,353	140	1.7%	0.98 [0.66, 1.45]
PRIME - Dauchet 2010 - current smokers	2,297	230	1.1%	0.49 [0.30, 0.80]
EPIC Italy - Bendinelli 2011	29,689	144	0.9%	1.11 [0.65, 1.88]
MORGEN - Oude Griep 2011 (b)	20,069	245	1.7%	0.70 [0.47, 1.03]
Japan Diabetes Complications Study - Tanaka 201	1,414	96	0.7%	1.25 [0.68, 2.29]
HPFS - Bhupathiraju 2013	42,135	3,607	18.4%	0.84 [0.75, 0.95]
Health and Wellbeing Surveillance - Gunnell 2013	14,890	538	3.9%	0.74 [0.57, 0.96]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	13.5%	0.81 [0.71, 0.93]
Shanghai Men Health - Yu 2014	67,211	148	1.8%	0.86 [0.59, 1.25]
Shanghai Women Health - Yu 2014	55,242	217	1.1%	0.67 [0.41, 1.09]
British Regional Heart - Atkins 2014	3,328	307	2.6%	1.01 [0.74, 1.38]
SABRE - Eriksen 2015 - European	1,090	207	2.3%	1.11 [0.79, 1.54]
SABRE - Eriksen 2015 - South Asian	1,006	313	3.9%	1.01 [0.78, 1.30]
CCHS - Kobylecki 2015	78,527	2,823	26.5%	0.90 [0.81, 0.99]
PURE - Miller 2017	135,335	2,143	3.4%	0.95 [0.72, 1.25]
Japan Public Health Centre - Yoshizaki 2019	16,498	839	1.8%	1.04 [0.72, 1.51]
Total (95% CI)	**619,182**	**17,987**	**100.0%**	**0.88 [0.83, 0.92]**

Heterogeneity: Chi² = 25.25, df = 21 (P = 0.24); I² = 17%
Test for overall effect: Z = 5.12 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Liu 2000	39,127	126	1.2%	0.63 [0.36, 1.11]
National Health & Nutrition - Bazzano 2002	9,608	1,786	9.0%	1.01 [0.85, 1.20]
ARIC - Steffen 2003	11,940	535	2.9%	0.82 [0.58, 1.17]
EPIC Norway - Bingham 2008	11,134	678	2.0%	0.90 [0.59, 1.39]
Swedish National Farm Register - Holmberg 200	1,738	138	2.4%	0.65 [0.44, 0.96]
PRIME - Dauchet 2010 - never smokers	2,410	145	1.2%	1.06 [0.60, 1.87]
PRIME - Dauchet 2010 - former smokers	3,353	140	2.4%	0.98 [0.66, 1.45]
PRIME - Dauchet 2010 - current smokers	2,297	230	1.5%	0.49 [0.30, 0.80]
EPIC Italy - Bendinelli 2011	29,689	144	1.3%	1.11 [0.65, 1.88]
MORGEN - Oude Griep 2011 (b)	20,069	245	2.4%	0.70 [0.47, 1.03]
Japan Diabetes Complications Study - Tanaka 201	1,414	96	1.0%	1.25 [0.68, 2.29]
HPFS - Bhupathiraju 2013	42,135	3,607	14.8%	0.84 [0.75, 0.95]
Health and Wellbeing Surveillance - Gunnell 2013	14,890	538	5.0%	0.74 [0.57, 0.96]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	12.5%	0.81 [0.71, 0.93]
Shanghai Men Health - Yu 2014	67,211	148	2.6%	0.86 [0.59, 1.25]
Shanghai Women Health - Yu 2014	55,242	217	1.5%	0.67 [0.41, 1.09]
British Regional Heart - Atkins 2014	3,328	307	3.5%	1.01 [0.74, 1.38]
SABRE - Eriksen 2015 - European	1,090	207	3.2%	1.11 [0.79, 1.54]
SABRE - Eriksen 2015 - South Asian	1,006	313	5.0%	1.01 [0.78, 1.30]
CCHS - Kobylecki 2015	78,527	2,823	17.7%	0.90 [0.81, 0.99]
PURE - Miller 2017	135,335	2,143	4.5%	0.95 [0.72, 1.25]
Japan Public Health Centre - Yoshizaki 2019	16,498	839	2.6%	1.04 [0.72, 1.51]
Total (95% CI) [Random Effects]	**619,182**	**17,987**	**100.0%**	**0.88 [0.82, 0.93]**

Heterogeneity: Tau² = 0.00; Chi² = 25.25, df = 21 (P = 0.24); I² = 17%

Test for overall effect: Z = 4.11 (P < 0.0001)

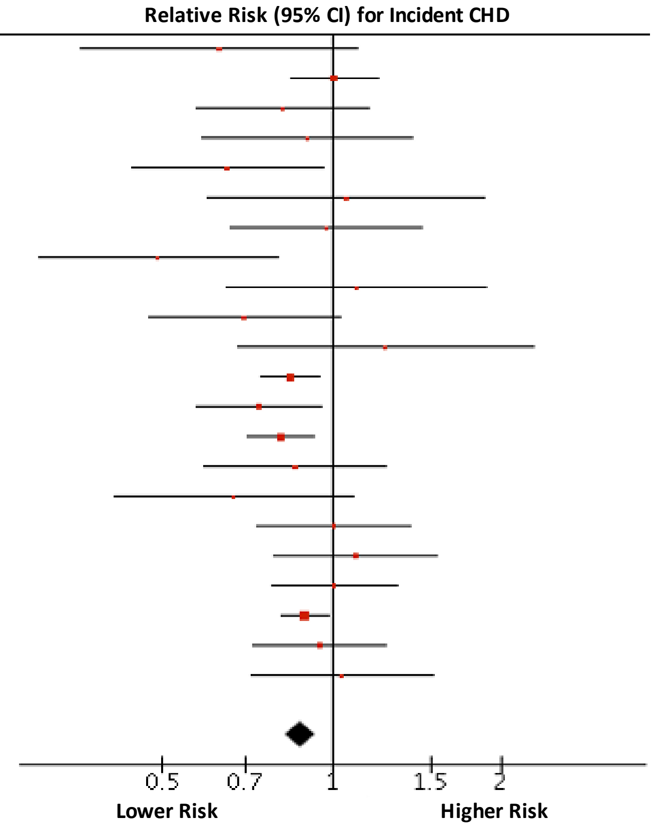


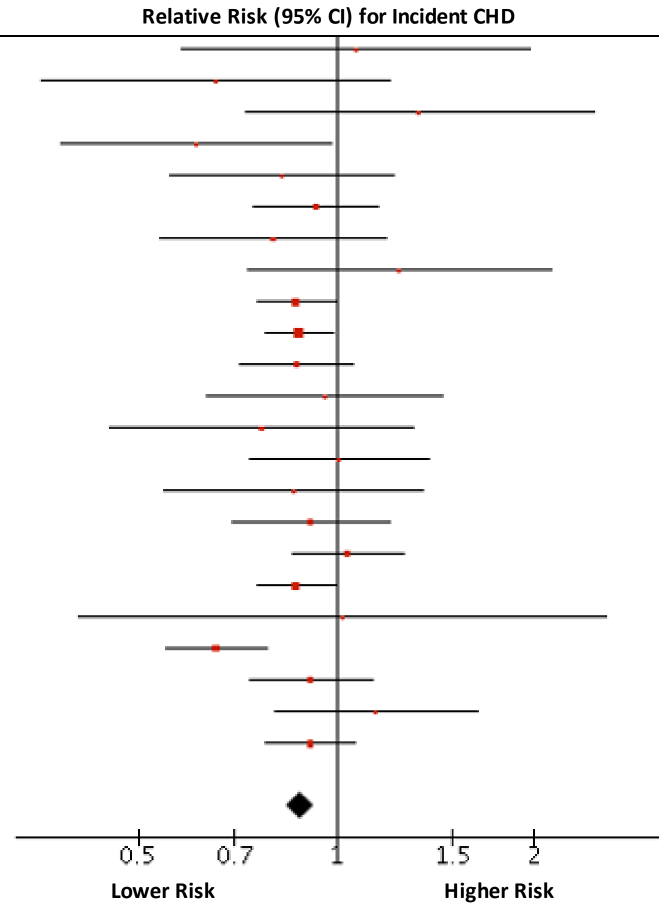
Figure S56. Relation between total fruit and vegetables intake and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

FRUIT AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Adventis Health Study - Fraser -1992	26,473	134	0.6%	1.07 [0.58, 1.97]
WHS - Liu 2000	39,127	126	0.6%	0.66 [0.36, 1.21]
PRIME - Dauchet 2010 - never smokers	2,410	79	0.6%	1.34 [0.73, 2.45]
PRIME - Dauchet 2010 - current smokers	2,297	148	1.1%	0.61 [0.38, 0.98]
PRIME - Dauchet 2010 - former smokers	3,353	140	1.5%	0.83 [0.56, 1.22]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	5.1%	0.93 [0.75, 1.16]
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	1.5%	0.80 [0.54, 1.19]
EPIC Italy - Bendinelli 2011	29,689	144	0.8%	1.25 [0.73, 2.12]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	12.6%	0.87 [0.76, 1.00]
HPFS - Bhupathiraju 2013	42,135	3,607	17.1%	0.88 [0.78, 0.99]
ATBC - Simila 2013	21,955	4,379	6.2%	0.87 [0.71, 1.06]
Shanghai Men Health - Yu 2014	55,424	217	1.4%	0.96 [0.64, 1.45]
Shanghai Women Health - Yu 2014	67,211	148	0.8%	0.77 [0.45, 1.31]
MONICA Danish - Tognon 2014	1,849	161	2.4%	1.01 [0.74, 1.38]
British Regional Heart - Atkins 2014	3,328	307	1.2%	0.86 [0.55, 1.35]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	3.1%	0.91 [0.69, 1.20]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	6.2%	1.04 [0.86, 1.27]
CCHS - Kobylecki 2015	78,527	2,823	12.6%	0.87 [0.76, 1.00]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.3%	1.02 [0.41, 2.56]
China Kadoorie Biobank- Du 2016	451,665	2,551	7.6%	0.66 [0.55, 0.78]
PURE - Miller 2017	135,335	2,143	5.1%	0.91 [0.74, 1.13]
Japan Public Health Centre - Yoshizaki 2019	16,498	839	1.9%	1.15 [0.81, 1.64]
EPIC NL and MORGEN - Scheffers 2019	34,560	2,135	9.6%	0.91 [0.78, 1.07]
Total (95% CI)	**1,170,021**	**23,856**	**100.0%**	**0.88 [0.84, 0.92]**

Heterogeneity: Chi² = 24.96, df = 22 (P = 0.30); I² = 12%
Test for overall effect: Z = 5.11 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Adventis Health Study - Fraser -1992	26,473	134	0.8%	1.07 [0.58, 1.97]
WHS - Liu 2000	39,127	126	0.8%	0.66 [0.36, 1.21]
PRIME - Dauchet 2010 - current smokers	2,297	148	1.3%	0.61 [0.38, 0.98]
PRIME - Dauchet 2010 - former smokers	3,353	140	1.9%	0.83 [0.56, 1.22]
PRIME - Dauchet 2010 - never smokers	2,410	79	0.8%	1.34 [0.73, 2.45]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	5.6%	0.93 [0.75, 1.16]
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	1.9%	0.80 [0.54, 1.19]
EPIC Italy - Bendinelli 2011	29,689	144	1.0%	1.25 [0.73, 2.12]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	11.4%	0.87 [0.76, 1.00]
HPFS - Bhupathiraju 2013	42,135	3,607	14.0%	0.88 [0.78, 0.99]
ATBC - Simila 2013	21,955	4,379	6.5%	0.87 [0.71, 1.06]
Shanghai Men Health - Yu 2014	55,424	217	1.7%	0.96 [0.64, 1.45]
Shanghai Women Health - Yu 2014	67,211	148	1.0%	0.77 [0.45, 1.31]
MONICA Danish - Tognon 2014	1,849	161	2.8%	1.01 [0.74, 1.38]
British Regional Heart - Atkins 2014	3,328	307	1.4%	0.86 [0.55, 1.35]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	3.6%	0.91 [0.69, 1.20]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	6.5%	1.04 [0.86, 1.27]
CCHS - Kobylecki 2015	78,527	2,823	11.4%	0.87 [0.76, 1.00]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.4%	1.02 [0.41, 2.56]
China Kadoorie Biobank- Du 2016	451,665	2,551	7.8%	0.66 [0.55, 0.78]
PURE - Miller 2017	135,335	2,143	5.6%	0.91 [0.74, 1.13]
Japan Public Health Centre - Yoshizaki 2019	16,498	839	2.3%	1.15 [0.81, 1.64]
EPIC NL and MORGEN - Scheffers 2019	34,560	2,135	9.4%	0.91 [0.78, 1.07]
Total (95% CI) [Random Effects]	**1,170,021**	**23,856**	**100.0%**	**0.88 [0.84, 0.93]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 24.96$, df = 22 (P = 0.30); $I^2 = 12\%$

Test for overall effect: Z = 4.43 (P < 0.00001)

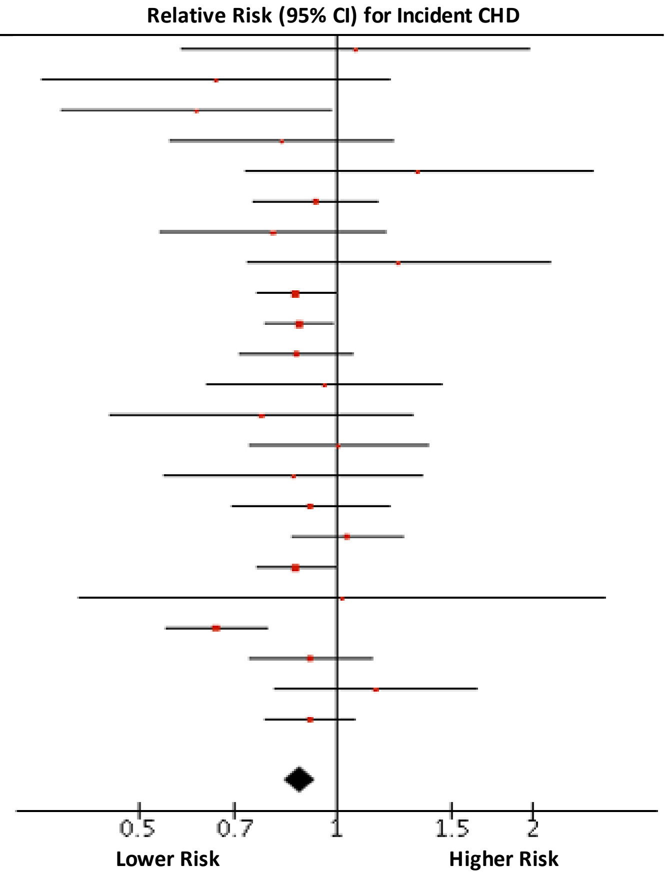


Figure S57. Relation between fruit intake and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

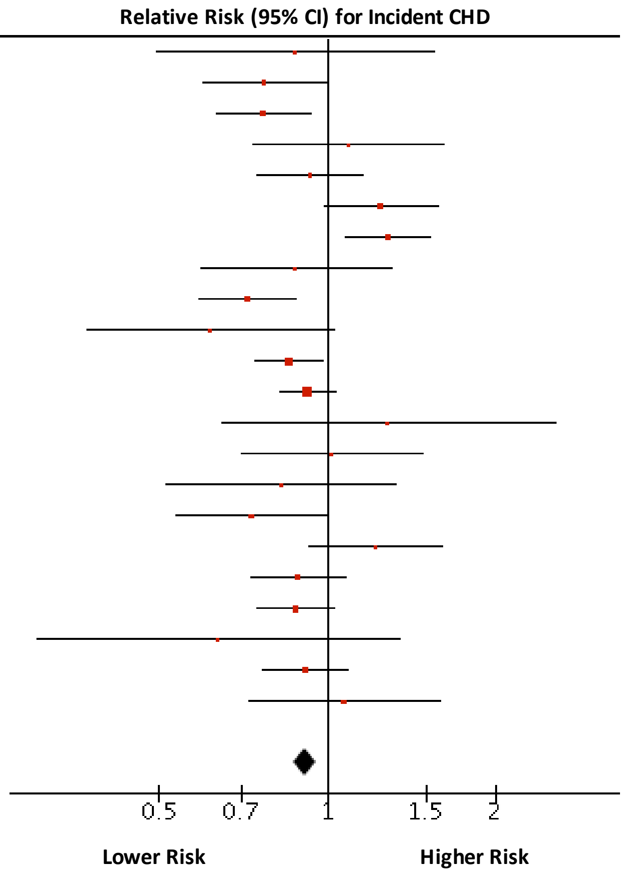
VEGETABLES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Liu 2000	39,127	126	0.7%	0.88 [0.50, 1.55]
Physicians Health Study - Liu 2001	15,520	1,148	3.6%	0.77 [0.60, 0.99]
ATBC - Hirvonen 2001	25,373	1,122	6.1%	0.77 [0.63, 0.94]
Danish Diet Cancer Health - Hansen 2010 - F	25,065	255	1.5%	1.09 [0.74, 1.62]
Danish Diet Cancer Health - Hansen 2010 - M	28,318	820	5.0%	0.93 [0.75, 1.16]
PRIME - Dauchet 2010 - never smokers	2,410	79	4.2%	1.25 [0.98, 1.58]
PRIME - Dauchet 2010 - former smokers	3,353	140	7.5%	1.28 [1.08, 1.53]
MORGEN - Oude Griep 2010	20,069	245	1.5%	0.88 [0.59, 1.30]
PRIME - Dauchet 2010 - current smokers	2,297	148	6.1%	0.72 [0.59, 0.87]
EPIC Italy - Bendinelli 2011	29,689	144	0.9%	0.62 [0.37, 1.03]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	12.4%	0.85 [0.74, 0.98]
HPFS - Bhupathiraju 2013	42,135	3,607	16.9%	0.92 [0.82, 1.04]
British Regional Heart - Atkins 2014	3,328	307	0.5%	1.28 [0.65, 2.55]
Shanghai Men Health - Yu 2014	55,424	217	1.7%	1.02 [0.70, 1.48]
Shanghai Women Health - Yu 2014	67,211	148	1.1%	0.83 [0.52, 1.32]
MONICA Danish - Tognon 2014	1,849	161	2.4%	0.73 [0.54, 1.00]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	3.1%	1.22 [0.93, 1.61]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	6.1%	0.89 [0.73, 1.08]
CCHS - Kobylecki 2015	78,527	2,823	9.5%	0.88 [0.75, 1.03]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.4%	0.64 [0.30, 1.34]
PURE - Miller 2017	135,335	2,143	7.5%	0.91 [0.77, 1.09]
Japan Public Health Centre - Yoshizaki 2019	16,498	839	1.5%	1.07 [0.72, 1.59]
Total (95% CI)	**696,330**	**17,172**	**100.0%**	**0.92 [0.87, 0.96]**

Heterogeneity: $Chi^2 = 44.99$, df = 21 (P = 0.002); $I^2 = 53\%$

Test for overall effect: Z = 3.59 (P = 0.0003)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Liu 2000	39,127	126	1.6%	0.88 [0.50, 1.55]
Physicians Health Study - Liu 2001	15,520	1,148	4.9%	0.77 [0.60, 0.99]
ATBC - Hirvonen 2001	25,373	1,122	6.3%	0.77 [0.63, 0.94]
Danish Diet Cancer Health - Hansen 2010 - F	25,065	255	2.9%	1.09 [0.74, 1.62]
Danish Diet Cancer Health - Hansen 2010 - M	28,318	820	5.8%	0.93 [0.75, 1.16]
PRIME - Dauchet 2010 - never smokers	2,410	79	5.4%	1.25 [0.98, 1.58]
PRIME - Dauchet 2010 - former smokers	3,353	140	6.8%	1.28 [1.08, 1.53]
MORGEN - Oude Griep 2010	20,069	245	2.9%	0.88 [0.59, 1.30]
PRIME - Dauchet 2010 - current smokers	2,297	148	6.3%	0.72 [0.59, 0.87]
EPIC Italy - Bendinelli 2011	29,689	144	1.9%	0.62 [0.37, 1.03]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	7.8%	0.85 [0.74, 0.98]
HPFS - Bhupathiraju 2013	42,135	3,607	8.3%	0.92 [0.82, 1.04]
British Regional Heart - Atkins 2014	3,328	307	1.2%	1.28 [0.65, 2.55]
Shanghai Men Health - Yu 2014	55,424	217	3.1%	1.02 [0.70, 1.48]
Shanghai Women Health - Yu 2014	67,211	148	2.2%	0.83 [0.52, 1.32]
MONICA Danish - Tognon 2014	1,849	161	3.9%	0.73 [0.54, 1.00]
CCHS - Kobylecki 2015	78,527	2,823	7.3%	0.88 [0.75, 1.03]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	4.6%	1.22 [0.93, 1.61]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	6.3%	0.89 [0.73, 1.08]
PREDIMED- Buil-Cosiales 2016	7,216	118	1.0%	0.64 [0.30, 1.34]
PURE - Miller 2017	135,335	2,143	6.8%	0.91 [0.77, 1.09]
Japan Public Health Centre - Yoshizaki 2019	16,498	839	2.9%	1.07 [0.72, 1.59]
Total (95% CI) [Random Effects]	**696,330**	**17,172**	**100.0%**	**0.92 [0.85, 0.99]**

Heterogeneity: Tau² = 0.02; Chi² = 44.99, df = 21 (P = 0.002); I² = 53%

Test for overall effect: Z = 2.14 (P = 0.03)

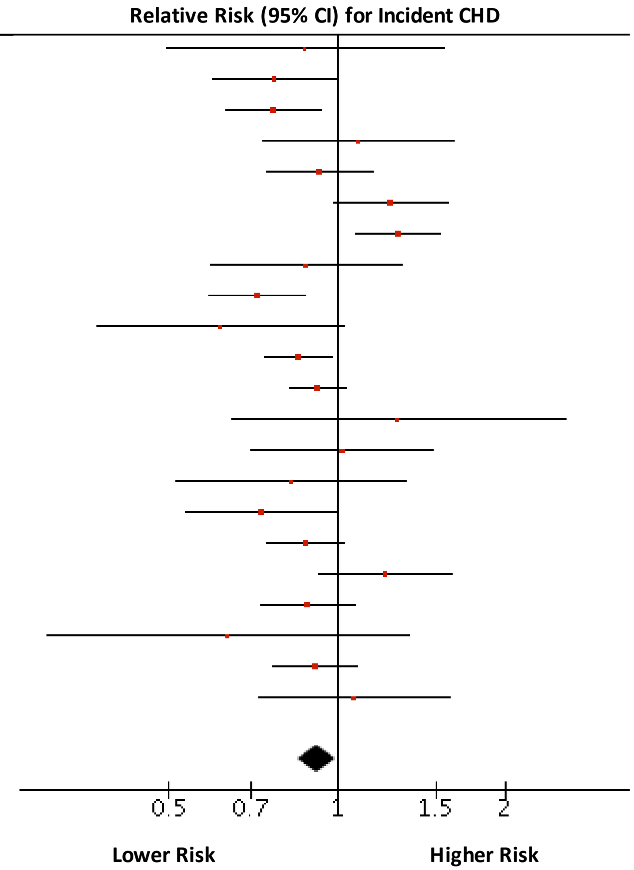


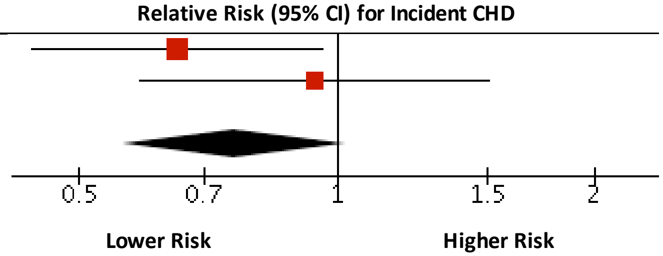
Figure S58. Relation between intake of vegetables and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity.

BANANAS AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Shanghai Women Health - Yu 2014 - bananas	67,211	148	59.0%	0.94 [0.59, 1.51]
Shanghai Men Health - Yu 2014 - bananas	55,424	217	41.0%	0.65 [0.44, 0.96]
Total (95% CI)	**122,635**	**365**	**100.0%**	**0.76 [0.56, 1.02]**

Heterogeneity: Chi² = 1.40, df = 1 (P = 0.24); I² = 29%
Test for overall effect: Z = 1.81 (P = 0.07)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Shanghai Women Health - Yu 2014 - bananas	67,211	148	43.6%	0.94 [0.59, 1.51]
Shanghai Men Health - Yu 2014 - bananas	55,424	217	56.4%	0.65 [0.44, 0.96]
Total (95% CI) [Random Effects]	**122,635**	**365**	**100.0%**	**0.76 [0.53, 1.10]**

Heterogeneity: Tau² = 0.02; Chi² = 1.40, df = 1 (P = 0.24); I² = 29%
Test for overall effect: Z = 1.47 (P = 0.14)

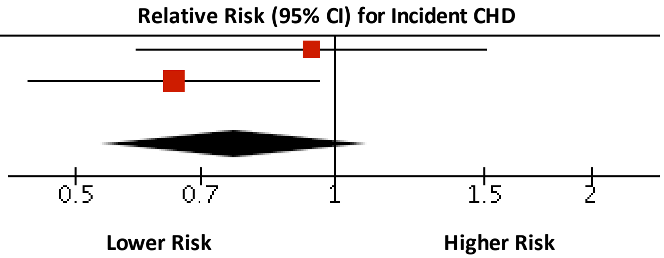


Figure S59. Relation between intake of bananas and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

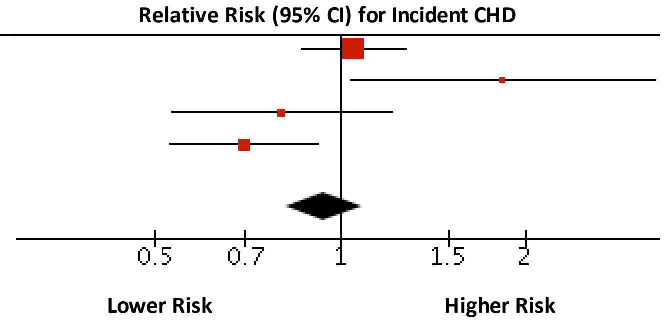
BERRIES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
ATBC - Hirvonen 2001	25,373	1,122	53.9%	1.05 [0.86, 1.28]
WHS - Sesso 2007	38,176	289	6.4%	1.84 [1.04, 3.25]
MORGEN - Oude Griep 2011 (b)	20,069	233	12.2%	0.80 [0.53, 1.21]
REGARDS - Goetz 2016 (a)	16,678	589	27.5%	0.70 [0.53, 0.92]
Total (95% CI)	**100,296**	**2,233**	**100.0%**	**0.94 [0.82, 1.09]**

Heterogeneity: $Chi^2 = 11.72$, df = 3 (P = 0.008); $I^2 = 74\%$

Test for overall effect: Z = 0.81 (P = 0.42)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
ATBC - Hirvonen 2001	25,373	1,122	31.7%	1.05 [0.86, 1.28]
WHS - Sesso 2007	38,176	289	17.1%	1.84 [1.04, 3.25]
MORGEN - Oude Griep 2011 (b)	20,069	233	22.7%	0.80 [0.53, 1.21]
REGARDS - Goetz 2016 (a)	16,678	589	28.5%	0.70 [0.53, 0.92]
Total (95% CI) [Random Effects]	**100,296**	**2,233**	**100.0%**	**0.97 [0.70, 1.34]**

Heterogeneity: $Tau^2 = 0.08$; $Chi^2 = 11.72$, df = 3 (P = 0.008); $I^2 = 74\%$

Test for overall effect: Z = 0.20 (P = 0.84)

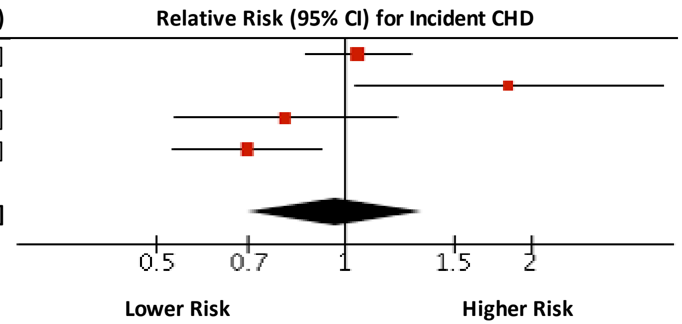


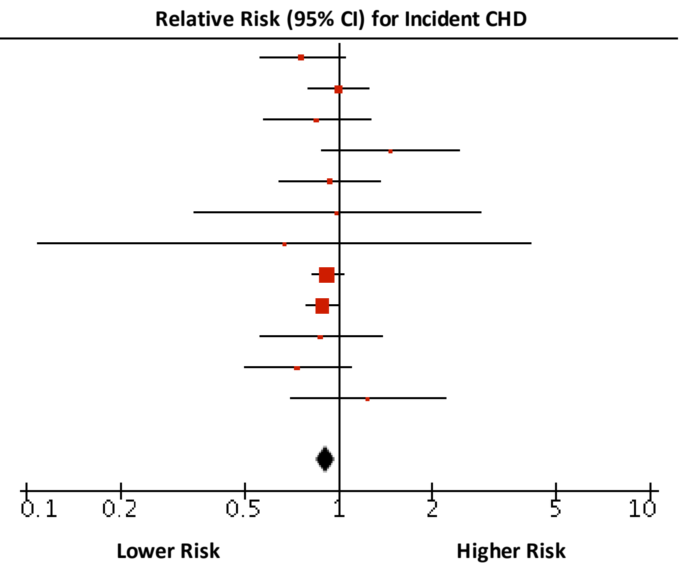
Figure S60. Relation between intake of berries and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CITRUS FRUIT AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
PRIME - Dauchet 2004	8,087	133	4.9%	0.76 [0.56, 1.04]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	10.3%	1.00 [0.81, 1.24]
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	3.1%	0.85 [0.58, 1.26]
EPIC Italy - Bendinelli 2011	29,689	144	1.8%	1.48 [0.89, 2.46]
MORGEN - Oude Griep 2011 (b)	20,069	233	3.4%	0.94 [0.65, 1.37]
Jidni Medical School - Yamada 2011 - M	4,147	53	0.4%	0.99 [0.34, 2.85]
Jidni Medical School - Yamada 2011 - F	6,476	23	0.1%	0.67 [0.11, 4.15]
HPFS - Bhupathiraju 2013	42,135	3,607	34.5%	0.92 [0.82, 1.04]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	34.5%	0.89 [0.79, 1.00]
Shanghai Women Health - Yu 2014	67,211	148	2.3%	0.88 [0.56, 1.38]
Shanghai Men Health - Yu 2014	55,424	217	3.1%	0.74 [0.50, 1.10]
PREDIMED- Buil-Cosiales 2016	7,216	118	1.5%	1.25 [0.71, 2.20]
Total (95% CI)	**364,978**	**8,333**	**100.0%**	**0.91 [0.85, 0.98]**

Heterogeneity: Chi² = 8.17, df = 11 (P = 0.70); I² = 0%
Test for overall effect: Z = 2.60 (P = 0.009)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
PRIME - Dauchet 2004	8,087	133	4.9%	0.76 [0.56, 1.04]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	10.3%	1.00 [0.81, 1.24]
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	3.1%	0.85 [0.58, 1.26]
MORGEN - Oude Griep 2011 (b)	20,069	233	3.4%	0.94 [0.65, 1.37]
Jidni Medical School - Yamada 2011 - M	4,147	53	0.4%	0.99 [0.34, 2.85]
Jidni Medical School - Yamada 2011 - F	6,476	23	0.1%	0.67 [0.11, 4.15]
EPIC Italy - Bendinelli 2011	29,689	144	1.8%	1.48 [0.89, 2.46]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	34.5%	0.89 [0.79, 1.00]
HPFS - Bhupathiraju 2013	42,135	3,607	34.5%	0.92 [0.82, 1.04]
Shanghai Women Health - Yu 2014	67,211	148	2.3%	0.88 [0.56, 1.38]
Shanghai Men Health - Yu 2014	55,424	217	3.1%	0.74 [0.50, 1.10]
PREDIMED- Buil-Cosiales 2016	7,216	118	1.5%	1.25 [0.71, 2.20]
Total (95% CI) [Random Effects]	**364,978**	**8,333**	**100.0%**	**0.91 [0.85, 0.98]**

Heterogeneity: $Chi^2 = 8.17$, df = 11 (P = 0.70); $I^2 = 0\%$

Test for overall effect: Z = 2.60 (P = 0.009)

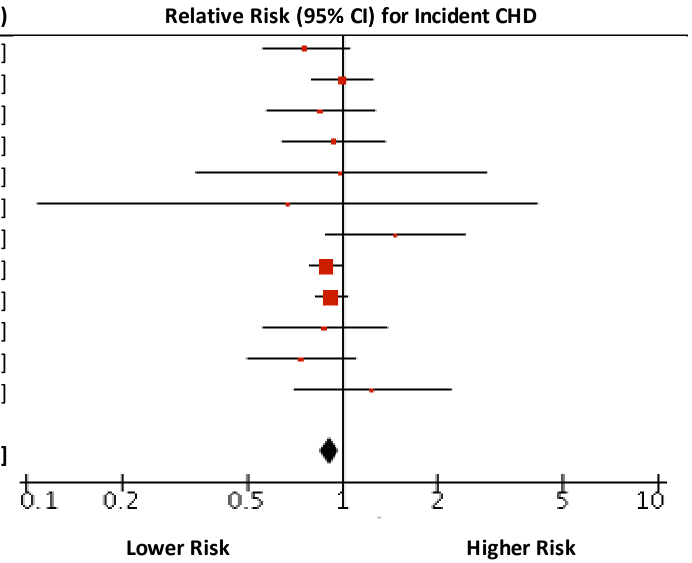


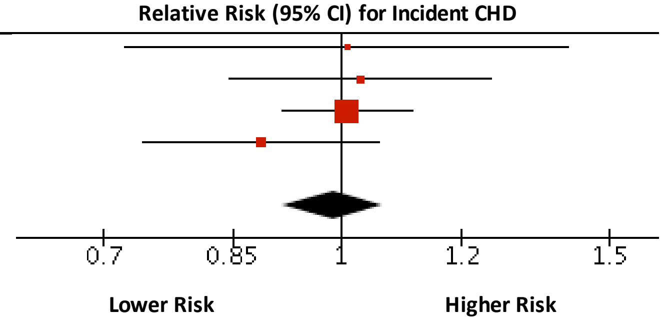
Figure S61. Relation between citrus fruit intake and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

FRUIT JUICE AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	5.3%	1.01 [0.72, 1.41]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	15.2%	1.03 [0.85, 1.25]
ATBC - Simila 2013	21,955	4,379	60.8%	1.01 [0.92, 1.11]
EPIC NL and MORGEN - Scheffers 2019	34,560	2,135	18.8%	0.89 [0.74, 1.06]
Total (95% CI)	**109,898**	**7,589**	**100.0%**	**0.99 [0.92, 1.07]**

Heterogeneity: Chi² = 1.83, df = 3 (P = 0.61); I² = 0%
Test for overall effect: Z = 0.29 (P = 0.77)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	5.3%	1.01 [0.72, 1.41]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	15.2%	1.03 [0.85, 1.25]
ATBC - Simila 2013	21,955	4,379	60.8%	1.01 [0.92, 1.11]
EPIC NL and MORGEN - Scheffers 2019	34,560	2,135	18.8%	0.89 [0.74, 1.06]
Total (95% CI) [Random Effects]	**109,898**	**7,589**	**100.0%**	**0.99 [0.92, 1.07]**

Heterogeneity: Tau² = 0.00; Chi² = 1.83, df = 3 (P = 0.61); I² = 0%
Test for overall effect: Z = 0.29 (P = 0.77)

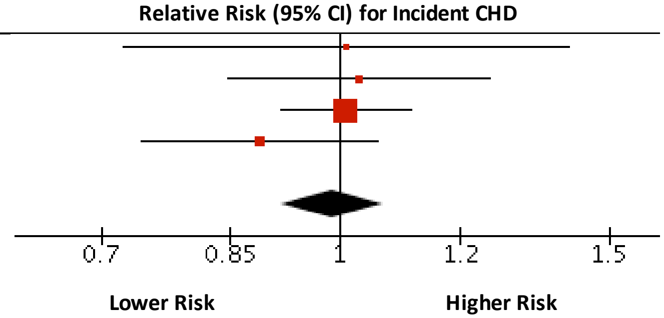


Figure S62. Relation between intake of fruit juice and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

GRAPES AND CORONARY HEART DISEASE INCIDENCE

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Lin 2007	66,360	938	100.0%	1.13 [0.78, 1.64]
Total (95% CI)	**66,360**	**938**	**100.0%**	**1.13 [0.78, 1.64]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.63 (P = 0.53)				

Relative Risk (95% CI) for incident CHD

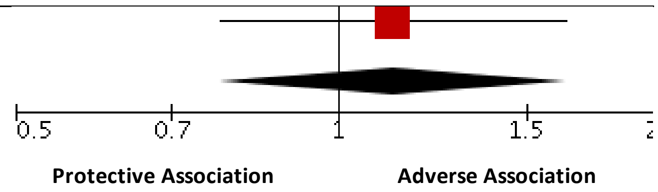


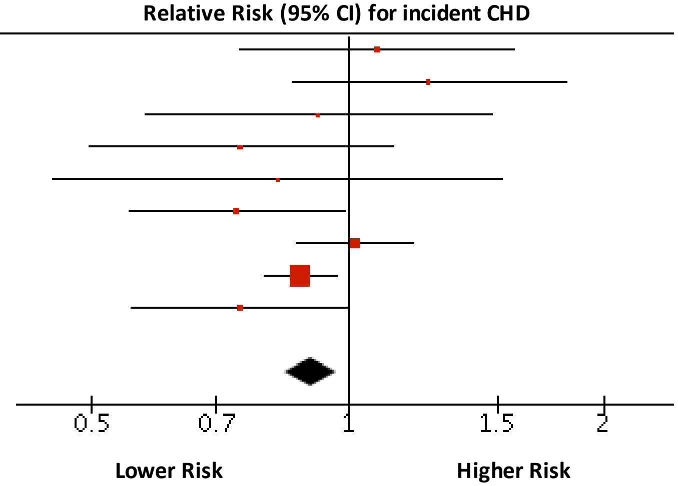
Figure S63. Relation between intake of grapes and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

POMMES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Lin 2007	66,360	938	3.7%	1.08 [0.75, 1.57]
MORGEN - Oude Griep 2011 (b)	20,069	245	3.7%	1.25 [0.86, 1.81]
Shanghai Women Health - Yu 2014	67,211	148	2.3%	0.92 [0.58, 1.48]
Shanghai Men Health - Yu 2014	55,424	217	3.0%	0.75 [0.50, 1.13]
PREDIMED- Buil-Cosiales 2016	7,216	118	1.4%	0.83 [0.45, 1.52]
REGARDS - Goetz 2016 (a)	16,678	589	5.9%	0.74 [0.55, 0.99]
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	20.8%	1.02 [0.87, 1.19]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	53.3%	0.88 [0.80, 0.97]
NutriNet-Sante - Adriouch 2018	84,158	309	5.9%	0.75 [0.56, 1.00]
Total (95% CI)	**371,684**	**4,886**	**100.0%**	**0.90 [0.84, 0.97]**

Heterogeneity: Chi² = 10.63, df = 8 (P = 0.22); I² = 25%
Test for overall effect: Z = 2.80 (P = 0.005)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Lin 2007	66,360	938	6.4%	1.08 [0.75, 1.57]
MORGEN - Oude Griep 2011 (b)	20,069	245	6.4%	1.25 [0.86, 1.81]
Shanghai Women Health - Yu 2014	67,211	148	4.2%	0.92 [0.58, 1.48]
Shanghai Men Health - Yu 2014	55,424	217	5.3%	0.75 [0.50, 1.13]
PREDIMED- Buil-Cosiales 2016	7,216	118	2.6%	0.83 [0.45, 1.52]
REGARDS - Goetz 2016 (a)	16,678	589	9.5%	0.74 [0.55, 0.99]
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	22.5%	1.02 [0.87, 1.19]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	33.7%	0.88 [0.80, 0.97]
NutriNet-Sante - Adriouch 2018	84,158	309	9.5%	0.75 [0.56, 1.00]
Total (95% CI) [Random Effects]	**371,684**	**4,886**	**100.0%**	**0.90 [0.82, 1.00]**

Heterogeneity: Tau² = 0.01; Chi² = 10.63, df = 8 (P = 0.22); I² = 25%
Test for overall effect: Z = 1.95 (P = 0.05)

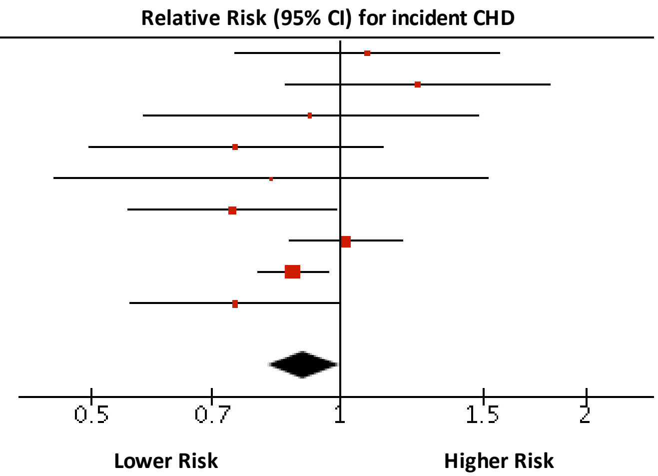


Figure S64. Relation between intake of pommes fruit and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

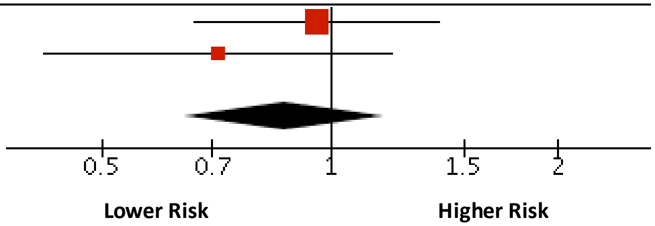
WATERMELON AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Shanghai Men Health - Yu 2014 - Watermelon	55,424	217	66.9%	0.96 [0.66, 1.39]
Shanghai Women Health - Yu 2014 - Watermelon	67,211	148	33.1%	0.71 [0.42, 1.21]
Total (95% CI)	**122,635**	**365**	**100.0%**	**0.87 [0.64, 1.18]**

Heterogeneity: Chi² = 0.83, df = 1 (P = 0.36); I² = 0%
Test for overall effect: Z = 0.90 (P = 0.37)

Relative Risk (95% CI) for Incident CHD



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Shanghai Men Health - Yu 2014 - Watermelon	55,424	217	66.9%	0.96 [0.66, 1.39]
Shanghai Women Health - Yu 2014 - Watermelon	67,211	148	33.1%	0.71 [0.42, 1.21]
Total (95% CI) [Random Effects]	**122,635**	**365**	**100.0%**	**0.87 [0.64, 1.18]**

Heterogeneity: Tau² = 0.00; Chi² = 0.83, df = 1 (P = 0.36); I² = 0%
Test for overall effect: Z = 0.90 (P = 0.37)

Relative Risk (95% CI) for Incident CHD

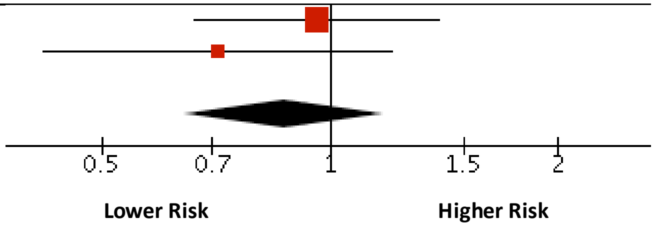


Figure S65. Relation between watermelon intake and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

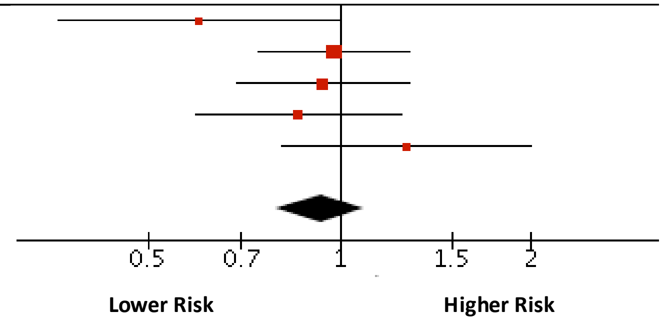
ALLIUM VEGETABLES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Caerphilly Prospective Study - Hertog 1997	1,900	186	9.8%	0.60 [0.36, 1.00]
Nurses' Health Study - Lin 2007	66,360	938	33.7%	0.98 [0.74, 1.29]
MORGEN - Oude Griep 2011 (b)	20,069	245	25.8%	0.94 [0.69, 1.29]
Shanghai Men Health - Yu 2014	55,424	217	18.3%	0.86 [0.59, 1.25]
Shanghai Women Health - Yu 2014	67,211	148	12.5%	1.27 [0.81, 2.00]
Total (95% CI)	**210,964**	**1,734**	**100.0%**	**0.93 [0.80, 1.09]**

Heterogeneity: Chi² = 4.99, df = 4 (P = 0.29); I² = 20%
Test for overall effect: Z = 0.86 (P = 0.39)

Relative Risk (95% CI) for Incident CHD



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Caerphilly Prospective Study - Hertog 1997	1,900	186	11.3%	0.60 [0.36, 1.00]
Nurses' Health Study - Lin 2007	66,360	938	30.5%	0.98 [0.74, 1.29]
MORGEN - Oude Griep 2011 (b)	20,069	245	25.1%	0.94 [0.69, 1.29]
Shanghai Women Health - Yu 2014	67,211	148	14.0%	1.27 [0.81, 2.00]
Shanghai Men Health - Yu 2014	55,424	217	19.2%	0.86 [0.59, 1.25]
Total (95% CI) [Random Effects]	**210,964**	**1,734**	**100.0%**	**0.93 [0.77, 1.11]**

Heterogeneity: Tau² = 0.01; Chi² = 4.99, df = 4 (P = 0.29); I² = 20%
Test for overall effect: Z = 0.80 (P = 0.42)

Relative Risk (95% CI) for Incident CHD

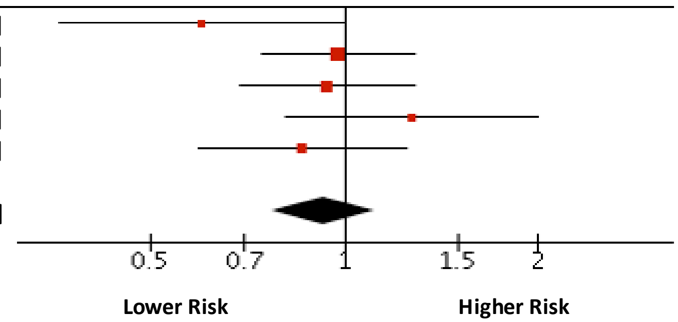


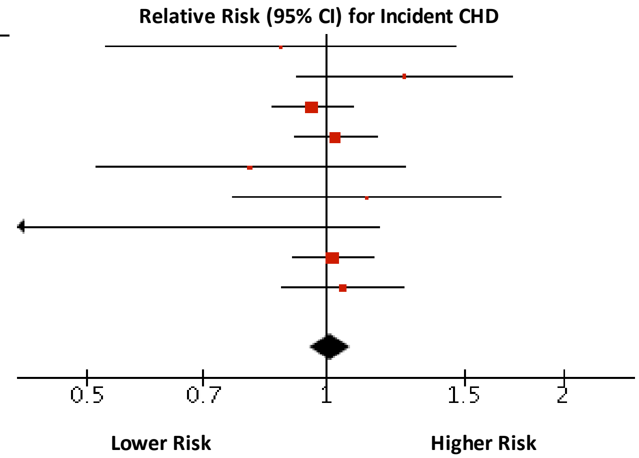
Figure S66. Relation between intake of allium vegetables and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CRUCIFEROUS VEGETABLES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
EPIC Italy - Bendinelli 2011	29,689	144	1.4%	0.88 [0.53, 1.46]
MORGEN - Oude Griep 2011(b)-green cabbage ve	20,069	245	3.7%	1.26 [0.92, 1.72]
HPFS - Bhupathiraju 2013	42,135	3,607	26.3%	0.96 [0.85, 1.08]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	26.3%	1.03 [0.92, 1.16]
Shanghai Women Health - Yu 2014	67,211	148	1.8%	0.80 [0.51, 1.26]
Shanghai Men Health - Yu 2014	55,424	217	2.4%	1.13 [0.76, 1.67]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.2%	0.32 [0.09, 1.17]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	26.3%	1.02 [0.91, 1.15]
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	11.7%	1.05 [0.88, 1.25]
Total (95% CI)	**347,453**	**9,383**	**100.0%**	**1.01 [0.95, 1.07]**

Heterogeneity: Chi² = 7.55, df = 8 (P = 0.48); I² = 0%
Test for overall effect: Z = 0.38 (P = 0.71)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
MORGEN - Oude Griep 2011(b)-green cabbage ve	20,069	245	3.7%	1.26 [0.92, 1.72]
EPIC Italy - Bendinelli 2011	29,689	144	1.4%	0.88 [0.53, 1.46]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	26.3%	1.03 [0.92, 1.16]
HPFS - Bhupathiraju 2013	42,135	3,607	26.3%	0.96 [0.85, 1.08]
Shanghai Men Health - Yu 2014	55,424	217	2.4%	1.13 [0.76, 1.67]
Shanghai Women Health - Yu 2014	67,211	148	1.8%	0.80 [0.51, 1.26]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.2%	0.32 [0.09, 1.17]
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	11.7%	1.05 [0.88, 1.25]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	26.3%	1.02 [0.91, 1.15]
Total (95% CI) [Random Effects]	**347,453**	**9,383**	**100.0%**	**1.01 [0.95, 1.07]**

Heterogeneity: Tau² = 0.00; Chi² = 7.55, df = 8 (P = 0.48); I² = 0%
Test for overall effect: Z = 0.38 (P = 0.71)

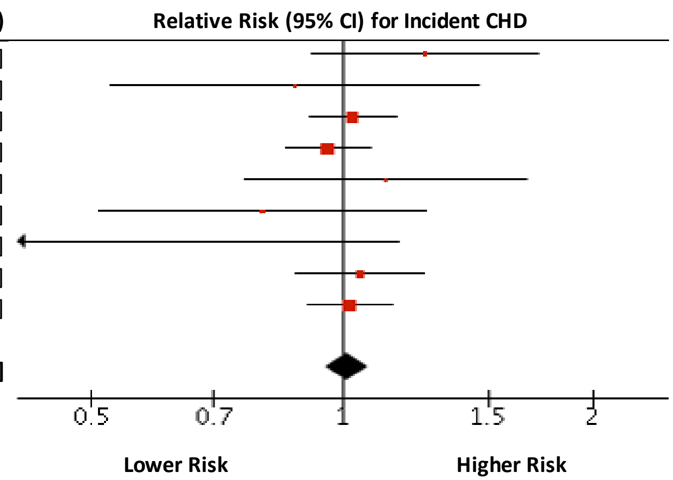


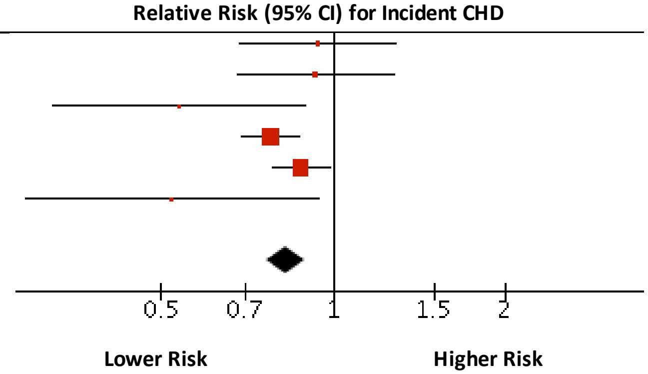
Figure S67. Relation between intake of cruciferous vegetables and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values $\geq 50\%$ indicating substantial heterogeneity.

GREEN LEAFY VEGETABLES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
MORGEN - Oude Griep 2011(b) -dark green leafy	20,069	245	5.9%	0.94 [0.69, 1.29]
MORGEN - Oude Griep 2011(b)- lettuce	-	-	5.9%	0.93 [0.68, 1.28]
EPIC Italy - Bendinelli 2011	29,689	144	2.2%	0.54 [0.32, 0.90]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	42.1%	0.78 [0.69, 0.88]
HPFS - Bhupathiraju 2013	42,135	3,607	42.1%	0.88 [0.78, 0.99]
PREDIMED- Buil-Cosiales 2016	7,216	118	1.7%	0.52 [0.29, 0.94]
Total (95% CI)	**170,250**	**6,696**	**100.0%**	**0.82 [0.76, 0.89]**

Heterogeneity: $Chi^2 = 8.30$, df = 5 (P = 0.14); $I^2 = 40\%$
Test for overall effect: Z = 4.95 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
MORGEN - Oude Griep 2011(b) - lettuce	20,069	245	11.6%	0.93 [0.68, 1.28]
MORGEN - Oude Griep 2011(b) - dark green leafy	-	-	11.6%	0.94 [0.69, 1.29]
EPIC Italy - Bendinelli 2011	29,689	144	5.1%	0.54 [0.32, 0.90]
HPFS - Bhupathiraju 2013	42,135	3,607	33.9%	0.88 [0.78, 0.99]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	33.9%	0.78 [0.69, 0.88]
PREDIMED- Buil-Cosiales 2016	7,216	118	4.0%	0.52 [0.29, 0.94]
Total (95% CI) [Random Effects]	**170,250**	**6,696**	**100.0%**	**0.82 [0.72, 0.92]**

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 8.30$, df = 5 (P = 0.14); $I^2 = 40\%$
Test for overall effect: Z = 3.23 (P = 0.001)

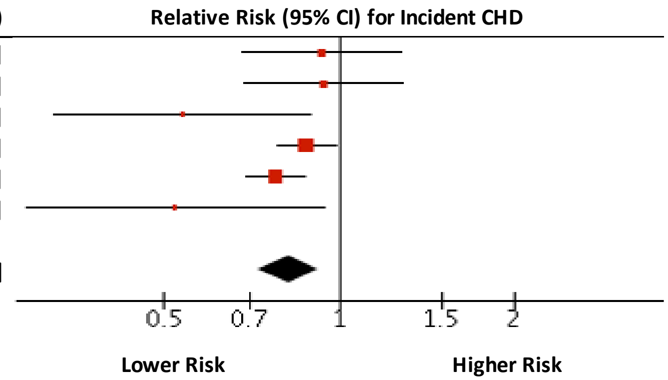


Figure S68. Relation between intake of green leafy vegetables and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

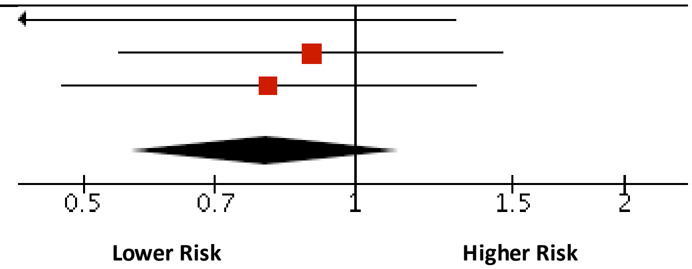
TOMATOES AND CORONARY HEART DISEASE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Incident CHD
WHS - Sesso 2003 (a)	38,445	201	8.3%	0.39 [0.12, 1.29]	
Nurses' Health Study - Lin 2007	66,360	938	49.4%	0.90 [0.55, 1.46]	
EPIC Italy - Bendinelli 2011	29,689	144	42.3%	0.80 [0.47, 1.36]	
Total (95% CI)	**134,494**	**1,283**	**100.0%**	**0.80 [0.57, 1.13]**	

Heterogeneity: $Chi^2 = 1.59$, df = 2 (P = 0.45); $I^2 = 0\%$

Test for overall effect: Z = 1.28 (P = 0.20)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Incident CHD
WHS - Sesso 2003 (a)	38,445	201	8.3%	0.39 [0.12, 1.29]	
Nurses' Health Study - Lin 2007	66,360	938	49.4%	0.90 [0.55, 1.46]	
EPIC Italy - Bendinelli 2011	29,689	144	42.3%	0.80 [0.47, 1.36]	
Total (95% CI) [Random Effects]	**134,494**	**1,283**	**100.0%**	**0.80 [0.57, 1.13]**	

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 1.59$, df = 2 (P = 0.45); $I^2 = 0\%$

Test for overall effect: Z = 1.28 (P = 0.20)

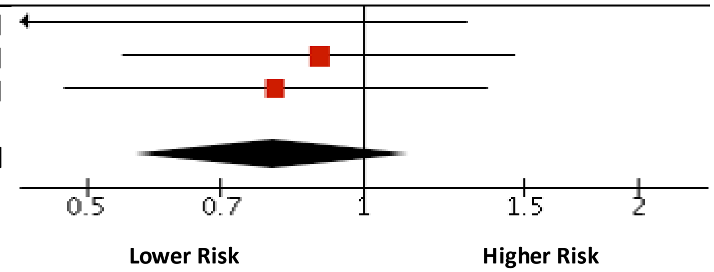
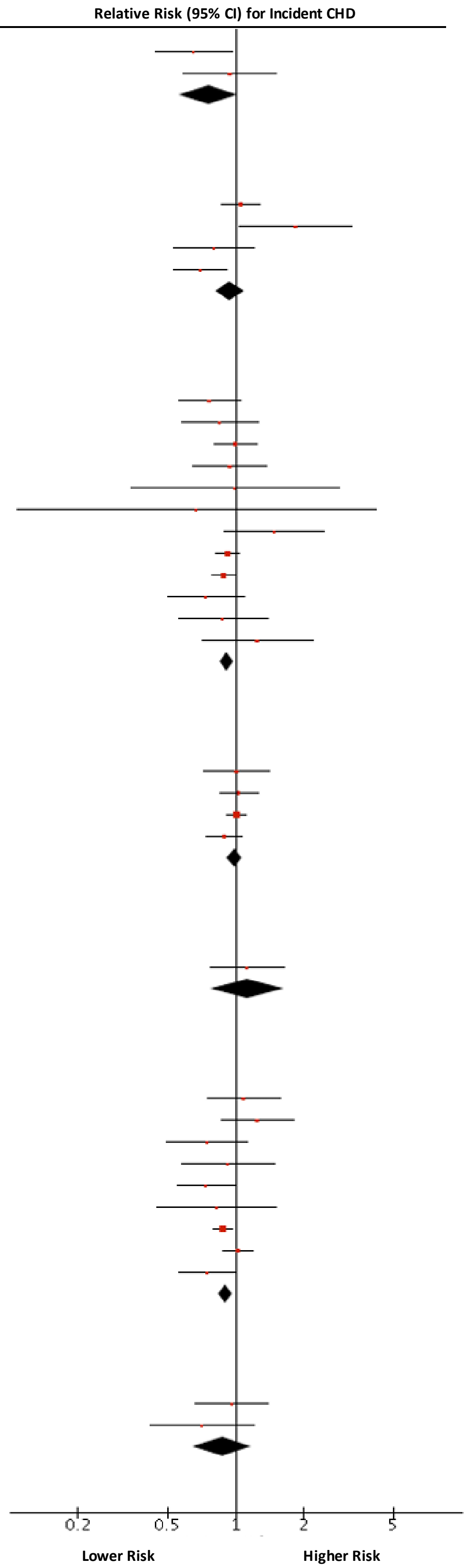


Figure S69. Relation between intake of tomatoes and coronary heart disease incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Bananas				
Shanghai Men Health - Yu 2014 - bananas	55,424	217	1.0%	0.65 [0.44, 0.96]
Shanghai Women Health - Yu 2014 - bananas	67,211	148	0.7%	0.94 [0.59, 1.51]
Subtotal (95% CI)	122,635	365	1.7%	0.76 [0.56, 1.02]
Heterogeneity: Chi² = 1.40, df = 1 (P = 0.24); I² = 29%				
Test for overall effect: Z = 1.81 (P = 0.07)				
Berries				
ATBC - Hirvonen 2001	25,373	1,122	4.0%	1.05 [0.86, 1.28]
WHS - Sesso 2007	38,176	289	0.5%	1.84 [1.04, 3.25]
MORGEN - Oude Griep 2011 (b)	20,069	233	0.9%	0.80 [0.53, 1.21]
REGARDS - Goetz 2016 (a)	16,678	589	2.0%	0.70 [0.53, 0.92]
Subtotal (95% CI)	100,296	2,233	7.4%	0.94 [0.82, 1.09]
Heterogeneity: Chi² = 11.72, df = 3 (P = 0.008); I² = 74%				
Test for overall effect: Z = 0.81 (P = 0.42)				
Citrus				
PRIME - Dauchet 2004	8,087	133	1.6%	0.76 [0.56, 1.04]
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	1.0%	0.85 [0.58, 1.26]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	3.3%	1.00 [0.81, 1.24]
MORGEN - Oude Griep 2011 (b)	20,069	233	1.1%	0.94 [0.65, 1.37]
Jidni Medical School - Yamada 2011 - M	4,147	53	0.1%	0.99 [0.34, 2.85]
Jidni Medical School - Yamada 2011 - F	6,476	23	0.0%	0.67 [0.11, 4.15]
EPIC Italy - Bendinelli 2011	29,689	144	0.6%	1.48 [0.89, 2.46]
HPFS - Bhupathiraju 2013	42,135	3,607	11.1%	0.92 [0.82, 1.04]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	11.1%	0.89 [0.79, 1.00]
Shanghai Men Health - Yu 2014	55,424	217	1.0%	0.74 [0.50, 1.10]
Shanghai Women Health - Yu 2014	67,211	148	0.8%	0.88 [0.56, 1.38]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.5%	1.25 [0.71, 2.20]
Subtotal (95% CI)	364,978	8,333	32.1%	0.91 [0.85, 0.98]
Heterogeneity: Chi² = 8.17, df = 11 (P = 0.70); I² = 0%				
Test for overall effect: Z = 2.60 (P = 0.009)				
Fruit Juice				
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	1.4%	1.01 [0.72, 1.41]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	4.0%	1.03 [0.85, 1.25]
ATBC - Simila 2013	21,955	4,379	15.9%	1.01 [0.92, 1.11]
EPIC NL and MORGEN - Scheffers 2019	34,560	2,135	4.9%	0.89 [0.74, 1.06]
Subtotal (95% CI)	109,898	7,589	26.2%	0.99 [0.92, 1.07]
Heterogeneity: Chi² = 1.83, df = 3 (P = 0.61); I² = 0%				
Test for overall effect: Z = 0.29 (P = 0.77)				
Grapes				
Nurses' Health Study - Lin 2007	66,360	938	1.1%	1.13 [0.78, 1.64]
Subtotal (95% CI)	66,360	938	1.1%	1.13 [0.78, 1.64]
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.63 (P = 0.53)				
Pommes				
Nurses' Health Study - Lin 2007	66,360	938	1.1%	1.08 [0.75, 1.57]
MORGEN - Oude Griep 2011 (b)	20,069	245	1.1%	1.25 [0.86, 1.81]
Shanghai Men Health - Yu 2014	55,424	217	0.9%	0.75 [0.50, 1.13]
Shanghai Women Health - Yu 2014	67,211	148	0.7%	0.92 [0.58, 1.48]
REGARDS - Goetz 2016 (a)	16,678	589	1.8%	0.74 [0.55, 0.99]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.4%	0.83 [0.45, 1.52]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	15.9%	0.88 [0.80, 0.97]
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	6.2%	1.02 [0.87, 1.19]
NutriNet-Sante - Adriouch 2018	84,158	309	1.8%	0.75 [0.56, 1.00]
Subtotal (95% CI)	371,684	4,886	29.9%	0.90 [0.84, 0.97]
Heterogeneity: Chi² = 10.63, df = 8 (P = 0.22); I² = 25%				
Test for overall effect: Z = 2.80 (P = 0.005)				
Watermelon				
Shanghai Men Health - Yu 2014 - Watermelon	55,424	217	1.1%	0.96 [0.66, 1.39]
Shanghai Women Health - Yu 2014 - Watermel	67,211	148	0.5%	0.71 [0.42, 1.21]
Subtotal (95% CI)	122,635	365	1.6%	0.87 [0.64, 1.18]
Heterogeneity: Chi² = 0.83, df = 1 (P = 0.36); I² = 0%				
Test for overall effect: Z = 0.90 (P = 0.37)				
Test for subgroup differences: Chi² = 6.45, df = 6 (P = 0.37), I² = 7.0%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Bananas				
Shanghai Men Health - Yu 2014 - bananas	55,424	217	1.6%	0.65 [0.44, 0.96]
Shanghai Women Health - Yu 2014 - bananas	67,211	148	1.2%	0.94 [0.59, 1.51]
Subtotal (95% CI)	**122,635**	**365**	**2.8%**	**0.76 [0.53, 1.10]**
Heterogeneity: Tau² = 0.02; Chi² = 1.40, df = 1 (P = 0.24); I² = 29%				
Test for overall effect: Z = 1.47 (P = 0.14)				
Berries				
ATBC - Hirvonen 2001	25,373	1,122	5.2%	1.05 [0.86, 1.28]
MORGEN - Oude Griep 2011 (b)	20,069	233	1.5%	0.80 [0.53, 1.21]
REGARDS - Goetz 2016 (a)	16,678	589	3.0%	0.70 [0.53, 0.92]
WHS - Sesso 2007	38,176	289	0.8%	1.84 [1.04, 3.25]
Subtotal (95% CI)	**100,296**	**2,233**	**10.5%**	**0.97 [0.70, 1.34]**
Heterogeneity: Tau² = 0.08; Chi² = 11.72, df = 3 (P = 0.008); I² = 74%				
Test for overall effect: Z = 0.20 (P = 0.84)				
Citrus				
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	1.6%	0.85 [0.58, 1.26]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	4.5%	1.00 [0.81, 1.24]
EPIC Italy - Bendinelli 2011	29,689	144	1.0%	1.48 [0.89, 2.46]
HPFS - Bhupathiraju 2013	42,135	3,607	9.8%	0.92 [0.82, 1.04]
Jidni Medical School - Yamada 2011 - F	6,476	23	0.1%	0.67 [0.11, 4.15]
Jidni Medical School - Yamada 2011 - M	4,147	53	0.2%	0.99 [0.34, 2.85]
MORGEN - Oude Griep 2011 (b)	20,069	233	1.8%	0.94 [0.65, 1.37]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	9.8%	0.89 [0.79, 1.00]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.8%	1.25 [0.71, 2.20]
PRIME - Dauchet 2004	8,087	133	2.4%	0.76 [0.56, 1.04]
Shanghai Men Health - Yu 2014	55,424	217	1.6%	0.74 [0.50, 1.10]
Shanghai Women Health - Yu 2014	67,211	148	1.2%	0.88 [0.56, 1.38]
Subtotal (95% CI)	**364,978**	**8,333**	**35.0%**	**0.91 [0.85, 0.98]**
Heterogeneity: Tau² = 0.00; Chi² = 8.17, df = 11 (P = 0.70); I² = 0%				
Test for overall effect: Z = 2.60 (P = 0.009)				
Fruit Juice				
EPIC NL and MORGEN - Scheffers 2019	34,560	2,135	5.6%	0.89 [0.74, 1.06]
Danish Diet Cancer Health - Hansen 2010 - M	25,065	820	4.8%	1.03 [0.85, 1.25]
Danish Diet Cancer Health - Hansen 2010 - F	28,318	255	2.0%	1.01 [0.72, 1.41]
ATBC - Simila 2013	21,955	4,379	10.7%	1.01 [0.92, 1.11]
Subtotal (95% CI)	**109,898**	**7,589**	**23.0%**	**0.99 [0.92, 1.07]**
Heterogeneity: Tau² = 0.00; Chi² = 1.83, df = 3 (P = 0.61); I² = 0%				
Test for overall effect: Z = 0.29 (P = 0.77)				
Grapes				
Nurses' Health Study - Lin 2007	66,360	938	1.6%	1.13 [0.78, 1.64]
Subtotal (95% CI)	**66,360**	**938**	**1.6%**	**1.13 [0.78, 1.64]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.63 (P = 0.53)				
Pommes				
NutriNet-Sante - Adriouch 2018	84,158	309	2.5%	0.75 [0.56, 1.00]
Nurses' Health Study - Lin 2007	66,360	938	1.6%	1.08 [0.75, 1.57]
MORGEN - Oude Griep 2011 (b)	20,069	245	1.6%	1.25 [0.86, 1.81]
Shanghai Women Health - Yu 2014	67,211	148	1.1%	0.92 [0.58, 1.48]
Shanghai Men Health - Yu 2014	55,424	217	1.4%	0.75 [0.50, 1.13]
REGARDS - Goetz 2016 (a)	16,678	589	2.5%	0.74 [0.55, 0.99]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.6%	0.83 [0.45, 1.52]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	10.7%	0.88 [0.80, 0.97]
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	6.5%	1.02 [0.87, 1.19]
Subtotal (95% CI)	**371,684**	**4,886**	**28.5%**	**0.90 [0.82, 1.00]**
Heterogeneity: Tau² = 0.01; Chi² = 10.63, df = 8 (P = 0.22); I² = 25%				
Test for overall effect: Z = 1.95 (P = 0.05)				
Watermelon				
Shanghai Men Health - Yu 2014 - Watermelon	55,424	217	1.6%	0.96 [0.66, 1.39]
Shanghai Women Health - Yu 2014 - Watermel	67,211	148	0.8%	0.71 [0.42, 1.21]
Subtotal (95% CI)	**122,635**	**365**	**2.5%**	**0.87 [0.64, 1.18]**
Heterogeneity: Tau² = 0.00; Chi² = 0.83, df = 1 (P = 0.36); I² = 0%				
Test for overall effect: Z = 0.90 (P = 0.37)				
Test for subgroup differences: Chi² = 5.38, df = 6 (P = 0.50), I² = 0%				

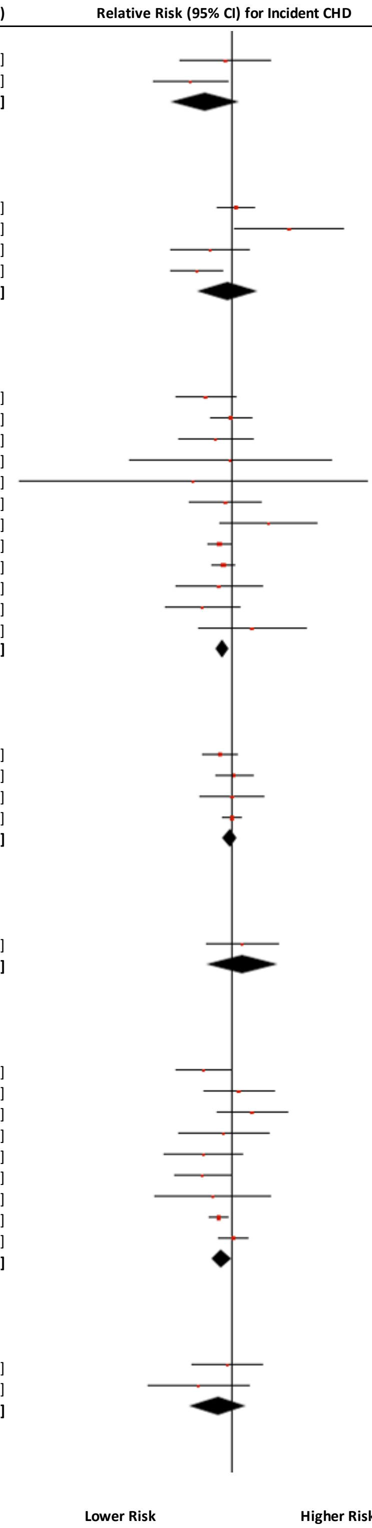
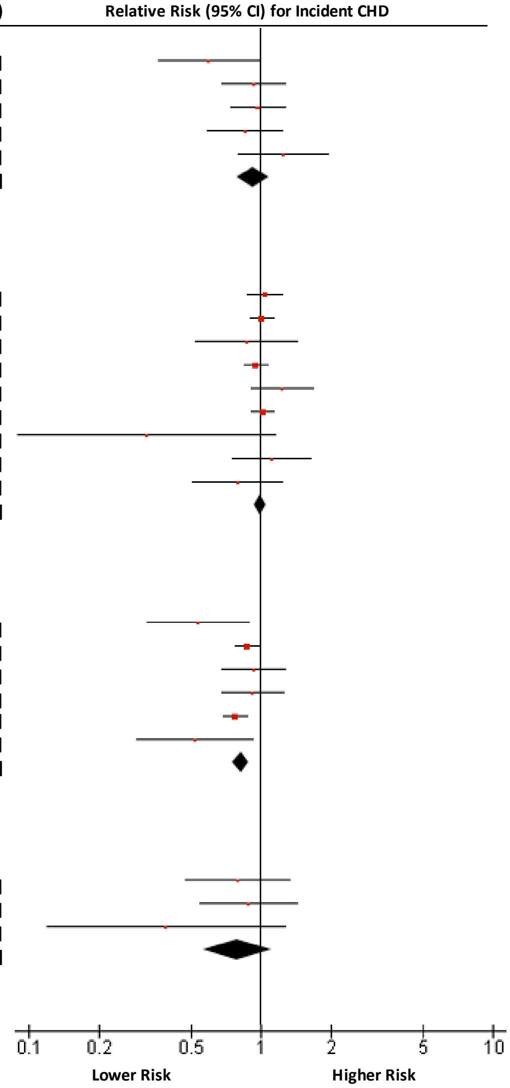


Figure S70. Relation between sources of fruit and CHD incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Caerphilly Prospective Study - Hertog 1997	1,900	186	0.8%	0.60 [0.36, 1.00]
MORGEN - Oude Griep 2011 (b)	20,069	245	2.1%	0.94 [0.69, 1.29]
Nurses' Health Study - Lin 2007	66,360	938	2.7%	0.98 [0.74, 1.29]
Shanghai Men Health - Yu 2014	55,424	217	1.5%	0.86 [0.59, 1.25]
Shanghai Women Health - Yu 2014	67,211	148	1.0%	1.27 [0.81, 2.00]
Subtotal (95% CI)	**210,964**	**1,734**	**8.0%**	**0.93 [0.80, 1.09]**
Heterogeneity: Chi² = 4.99, df = 4 (P = 0.29); I² = 20%				
Test for overall effect: Z = 0.86 (P = 0.39)				
Cruciferous				
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	6.5%	1.05 [0.88, 1.25]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	14.6%	1.02 [0.91, 1.15]
EPIC Italy - Bendinelli 2011	29,689	144	0.8%	0.88 [0.53, 1.46]
HPFS - Bhupathiraju 2013	42,135	3,607	14.6%	0.96 [0.85, 1.08]
MORGEN - Oude Griep 2011(b)-green cabbage	20,069	245	2.1%	1.26 [0.92, 1.72]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	14.6%	1.03 [0.92, 1.16]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.1%	0.32 [0.09, 1.17]
Shanghai Men Health - Yu 2014	55,424	217	1.3%	1.13 [0.76, 1.67]
Shanghai Women Health - Yu 2014	67,211	148	1.0%	0.80 [0.51, 1.26]
Subtotal (95% CI)	**347,453**	**9,383**	**55.6%**	**1.01 [0.95, 1.07]**
Heterogeneity: Chi² = 7.55, df = 8 (P = 0.48); I² = 0%				
Test for overall effect: Z = 0.38 (P = 0.71)				
Green leafy				
EPIC Italy - Bendinelli 2011	29,689	144	0.8%	0.54 [0.32, 0.90]
HPFS - Bhupathiraju 2013	42,135	3,607	14.6%	0.88 [0.78, 0.99]
MORGEN - Oude Griep 2011(b) -dark green lea	20,069	245	2.1%	0.94 [0.69, 1.29]
MORGEN - Oude Griep 2011(b)- lettuce	-	-	2.1%	0.93 [0.68, 1.28]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	14.6%	0.78 [0.69, 0.88]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.6%	0.52 [0.29, 0.94]
Subtotal (95% CI)	**170,250**	**6,696**	**34.7%**	**0.82 [0.76, 0.89]**
Heterogeneity: Chi² = 8.30, df = 5 (P = 0.14); I² = 40%				
Test for overall effect: Z = 4.95 (P < 0.00001)				
Tomatoes				
EPIC Italy - Bendinelli 2011	29,689	144	0.7%	0.80 [0.47, 1.36]
Nurses' Health Study - Lin 2007	66,360	938	0.8%	0.90 [0.55, 1.46]
WHS - Sesso 2003 (a)	38,445	201	0.1%	0.39 [0.12, 1.29]
Subtotal (95% CI)	**134,494**	**1,283**	**1.7%**	**0.80 [0.57, 1.13]**
Heterogeneity: Chi² = 1.59, df = 2 (P = 0.45); I² = 0%				
Test for overall effect: Z = 1.28 (P = 0.20)				
Test for subgroup differences: Chi² = 17.73, df = 3 (P = 0.0005), I² = 83.1%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Caerphilly Prospective Study - Hertog 1997	1,900	186	1.8%	0.60 [0.36, 1.00]
MORGEN - Oude Griep 2011 (b)	20,069	245	4.0%	0.94 [0.69, 1.29]
Nurses' Health Study - Lin 2007	66,360	938	4.7%	0.98 [0.74, 1.29]
Shanghai Men Health - Yu 2014	55,424	217	3.1%	0.86 [0.59, 1.25]
Shanghai Women Health - Yu 2014	67,211	148	2.3%	1.27 [0.81, 2.00]
Subtotal (95% CI)	**210,964**	**1,734**	**15.9%**	**0.93 [0.77, 1.11]**
Heterogeneity: Tau² = 0.01; Chi² = 4.99, df = 4 (P = 0.29); I² = 20%				
Test for overall effect: Z = 0.80 (P = 0.42)				
Cruciferous				
Danish Diet Cancer Health - Gunge 2017 - F	28,809	653	7.6%	1.05 [0.88, 1.25]
Danish Diet Cancer Health - Gunge 2017 - M	25,759	1,669	10.0%	1.02 [0.91, 1.15]
EPIC Italy - Bendinelli 2011	29,689	144	1.8%	0.88 [0.53, 1.46]
HPFS - Bhupathiraju 2013	42,135	3,607	10.0%	0.96 [0.85, 1.08]
MORGEN - Oude Griep 2011(b)-green cabbage	20,069	245	4.0%	1.26 [0.92, 1.72]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	10.0%	1.03 [0.92, 1.16]
PREDIMED- Buil-Cosiales 2016	7,216	118	0.3%	0.32 [0.09, 1.17]
Shanghai Men Health - Yu 2014	55,424	217	2.8%	1.13 [0.76, 1.67]
Shanghai Women Health - Yu 2014	67,211	148	2.3%	0.80 [0.51, 1.26]
Subtotal (95% CI)	**347,453**	**9,383**	**48.9%**	**1.01 [0.95, 1.07]**
Heterogeneity: Tau² = 0.00; Chi² = 7.55, df = 8 (P = 0.48); I² = 0%				
Test for overall effect: Z = 0.38 (P = 0.71)				
Green leafy				
EPIC Italy - Bendinelli 2011	29,689	144	1.8%	0.54 [0.32, 0.90]
HPFS - Bhupathiraju 2013	42,135	3,607	10.0%	0.88 [0.78, 0.99]
MORGEN - Oude Griep 2011(b) -dark green lea	20,069	245	4.0%	0.94 [0.69, 1.29]
MORGEN - Oude Griep 2011(b)- lettuce	-	-	4.0%	0.93 [0.68, 1.28]
Nurses' Health Study - Bhupathiraju 2013	71,141	2,582	10.0%	0.78 [0.69, 0.88]
PREDIMED- Buil-Cosiales 2016	7,216	118	1.4%	0.52 [0.29, 0.94]
Subtotal (95% CI)	**170,250**	**6,696**	**31.2%**	**0.82 [0.72, 0.92]**
Heterogeneity: Tau² = 0.01; Chi² = 8.30, df = 5 (P = 0.14); I² = 40%				
Test for overall effect: Z = 3.23 (P = 0.001)				
Tomatoes				
EPIC Italy - Bendinelli 2011	29,689	144	1.7%	0.80 [0.47, 1.36]
Nurses' Health Study - Lin 2007	66,360	938	2.0%	0.90 [0.55, 1.46]
WHS - Sesso 2003 (a)	38,445	201	0.4%	0.39 [0.12, 1.29]
Subtotal (95% CI)	**134,494**	**1,283**	**4.1%**	**0.80 [0.57, 1.13]**
Heterogeneity: Tau² = 0.00; Chi² = 1.59, df = 2 (P = 0.45); I² = 0%				
Test for overall effect: Z = 1.28 (P = 0.20)				
Test for subgroup differences: Chi² = 10.76, df = 3 (P = 0.01), I² = 72.1%				

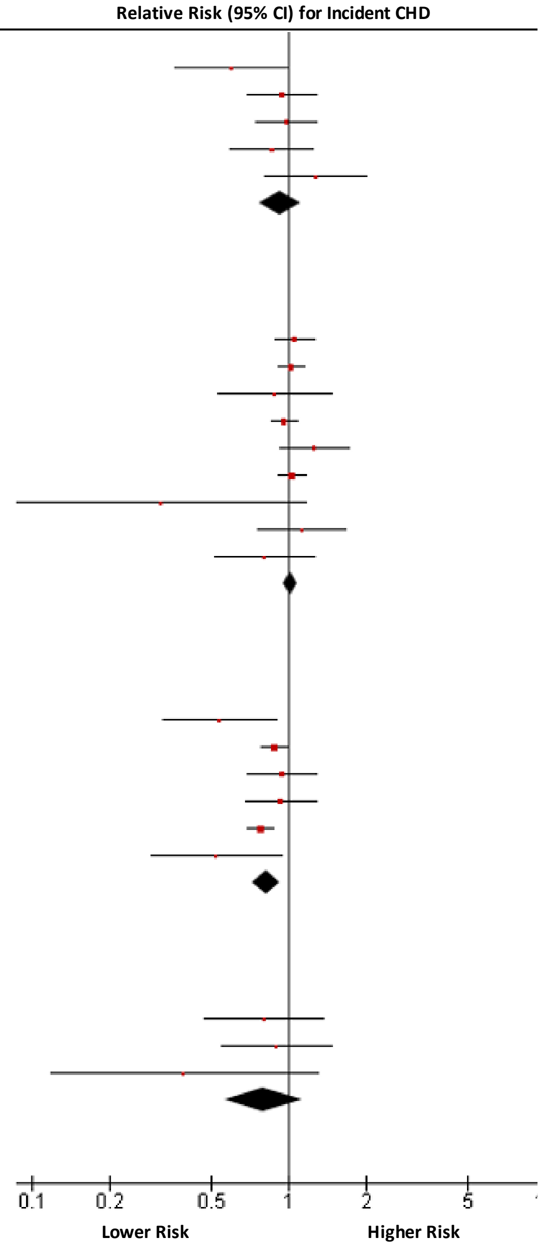


Figure S71. Relation between sources of vegetables and CHD incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

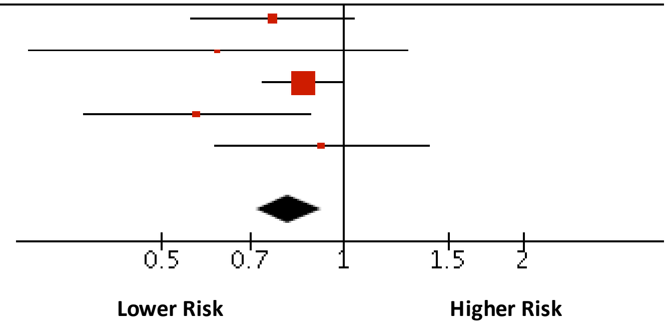
TOTAL FRUIT AND VEGETABLES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
National Health & Nutrition - Bazzano 2002	9,608	639	15.9%	0.76 [0.56, 1.04]
Baltimore Longitudinal Study Aging - Tucker 2005	501	71	3.0%	0.62 [0.30, 1.28]
EPIC - Leenders 2014	451,151	2,139	63.5%	0.86 [0.74, 1.01]
NIPPON DATA80 - Okuda 2015	9,112	165	8.4%	0.57 [0.37, 0.88]
HAPIEE - Stefler 2016	19,263	226	9.2%	0.92 [0.61, 1.39]
Total (95% CI)	**489,635**	**3,240**	**100.0%**	**0.81 [0.72, 0.92]**

Heterogeneity: Chi² = 4.15, df = 4 (P = 0.39); I² = 4%
Test for overall effect: Z = 3.24 (P = 0.001)

Relative Risk (95% CI) for CHD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
National Health & Nutrition - Bazzano 2002	9,608	639	17.0%	0.76 [0.56, 1.04]
Baltimore Longitudinal Study Aging - Tucker 2005	501	71	3.3%	0.62 [0.30, 1.28]
EPIC - Leenders 2014	451,151	2,139	60.6%	0.86 [0.74, 1.01]
NIPPON DATA80 - Okuda 2015	9,112	165	9.2%	0.57 [0.37, 0.88]
HAPIEE - Stefler 2016	19,263	226	10.0%	0.92 [0.61, 1.39]
Total (95% CI) [Random Effects]	**489,635**	**3,240**	**100.0%**	**0.81 [0.71, 0.92]**

Heterogeneity: Tau² = 0.00; Chi² = 4.15, df = 4 (P = 0.39); I² = 4%
Test for overall effect: Z = 3.15 (P = 0.002)

Relative Risk (95% CI) for CHD Mortality

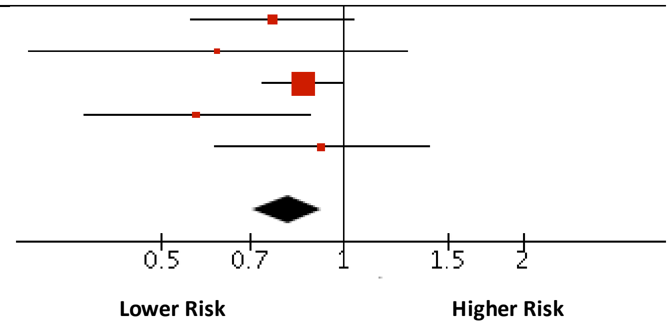


Figure S72. Relation between total fruit and vegetable intake and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

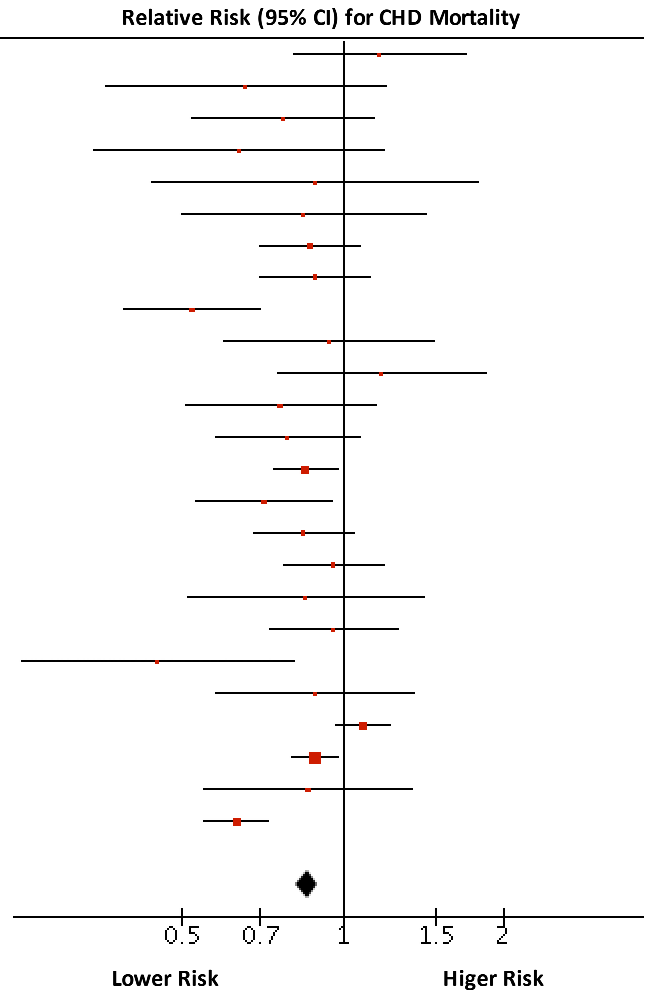
FRUIT AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Adventis Health Study - Fraser -1992	26,473	463	1.5%	1.17 [0.81, 1.70]
Finish Mobile Clinic Health - Knekt 1994 - F	2,748	58	0.6%	0.77 [0.52, 1.14]
Finish Mobile Clinic Health - Knekt 1994 - M	2,385	186	1.4%	0.66 [0.36, 1.21]
Nutrition Status Study - Sahyoun 1996	680	101	0.5%	0.64 [0.34, 1.19]
Oxford Vegetarian - Mann 1997	10,802	64	0.4%	0.89 [0.44, 1.80]
OXCHECK - Whiteman 1999	10,522	144	0.8%	0.84 [0.50, 1.43]
ATBC - Hirvonen 2001	25,373	815	4.6%	0.87 [0.70, 1.08]
Health Food Shoppers - Appleby 2002 - M	6,416	258	3.9%	0.52 [0.39, 0.70]
Health Food Shoppers - Appleby 2002 - F	4,325	347	2.5%	0.89 [0.70, 1.12]
Baltimore Longitudinal Study Aging - Tucker 2005	4,028	298	1.0%	1.19 [0.76, 1.86]
Boyd Orr Cohort - Ness 2005	501	71	1.0%	0.94 [0.60, 1.48]
Melbourne Collaborative Cohort - Harriss 2007	40,653	407	1.3%	0.76 [0.51, 1.15]
JACC - Nagura 2009	59,485	452	2.2%	0.79 [0.57, 1.08]
EPIC - Leenders 2014	1,849	64	11.3%	0.85 [0.51, 1.42]
Singapore Chinese Health - Rebello 2014 - F	451,151	2,139	2.5%	0.85 [0.74, 0.98]
Singapore Chinese Health - Rebello 2014 - M	29,968	638	4.6%	0.71 [0.53, 0.96]
Multiethnic Cohort - Sharma 2014 - F	23,501	1,022	4.6%	0.84 [0.68, 1.05]
MONICA Danish - Tognon 2014	91,751	811	0.8%	0.96 [0.77, 1.19]
Multiethnic Cohort - Sharma 2014 - M	72,866	1,140	2.8%	0.96 [0.73, 1.26]
UK Women's Cohort - Lai 2015	30,458	138	0.6%	0.45 [0.25, 0.81]
NIPPON DATA80 - Okuda 2015	9,112	165	1.1%	0.89 [0.58, 1.37]
Migrant Study - Hjartaker 2015	9,766	2,386	15.4%	1.09 [0.97, 1.23]
Linxian Nutrition - Wang 2016	2,445	355	22.2%	0.89 [0.80, 0.98]
HAPIEE - Stefler 2016	19,263	226	1.0%	0.86 [0.55, 1.35]
China Kadoorie Biobank- Du 2017	462,342	2,038	11.3%	0.63 [0.55, 0.72]
Total (95% CI)	**1,398,863**	**14,786**	**100.0%**	**0.86 [0.82, 0.90]**

Heterogeneity: $Chi^2 = 62.47$, $df = 24$ ($P < 0.0001$); $I^2 = 62\%$

Test for overall effect: $Z = 6.52$ ($P < 0.00001$)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Adventis Health Study - Fraser -1992	26,473	463	3.4%	1.17 [0.81, 1.70]
Finish Mobile Clinic Health - Knekt 1994 - M	2,748	58	3.2%	0.77 [0.52, 1.14]
Finish Mobile Clinic Health - Knekt 1994 - F	2,385	186	1.7%	0.66 [0.36, 1.21]
Nutrition Status Study - Sahyoun 1996	680	101	1.6%	0.64 [0.34, 1.19]
Oxford Vegetarian - Mann 1997	10,802	64	1.3%	0.89 [0.44, 1.80]
OXCHECK - Whiteman 1999	10,522	144	2.1%	0.84 [0.50, 1.43]
ATBC - Hirvonen 2001	25,373	815	5.6%	0.87 [0.70, 1.08]
Health Food Shoppers - Appleby 2002 - F	6,416	258	4.4%	0.52 [0.39, 0.70]
Health Food Shoppers - Appleby 2002 - M	4,325	347	5.3%	0.89 [0.70, 1.12]
Boyd Orr Cohort - Ness 2005	4,028	298	2.6%	1.19 [0.76, 1.86]
Baltimore Longitudinal Study Aging - Tucker 2005	501	71	2.6%	0.94 [0.60, 1.48]
Melbourne Collaborative Cohort - Harriss 2007	40,653	407	3.0%	0.76 [0.51, 1.15]
JACC - Nagura 2009	59,485	452	4.1%	0.79 [0.57, 1.08]
MONICA Danish - Tognon 2014	1,849	64	2.2%	0.85 [0.51, 1.42]
EPIC - Leenders 2014	451,151	2,139	7.0%	0.85 [0.74, 0.98]
Singapore Chinese Health - Rebello 2014 - F	29,968	638	4.4%	0.71 [0.53, 0.96]
Singapore Chinese Health - Rebello 2014 - M	23,501	1,022	5.6%	0.84 [0.68, 1.05]
Multiethnic Cohort - Sharma 2014 - F	91,751	811	5.6%	0.96 [0.77, 1.19]
Multiethnic Cohort - Sharma 2014 - M	72,866	1,140	4.7%	0.96 [0.73, 1.26]
UK Women's Cohort - Lai 2015	30,458	138	1.8%	0.45 [0.25, 0.81]
NIPPON DATA80 - Okuda 2015	9,112	165	2.8%	0.89 [0.58, 1.37]
Migrant Study - Hjartaker 2015	9,766	2,386	7.4%	1.09 [0.97, 1.23]
Linxian Nutrition - Wang 2016	2,445	355	7.7%	0.89 [0.80, 0.98]
HAPIEE - Stefler 2016	19,263	226	2.6%	0.86 [0.55, 1.35]
China Kadoorie Biobank- Du 2017	462,342	2,038	7.0%	0.63 [0.55, 0.72]
Total (95% CI) [Random Effects]	**1,398,863**	**14,786**	**100.0%**	**0.84 [0.76, 0.91]**

Heterogeneity: $Tau^2 = 0.02$; $Chi^2 = 62.47$, df = 24 ($P < 0.0001$); $I^2 = 62\%$

Test for overall effect: Z = 3.99 ($P < 0.0001$)

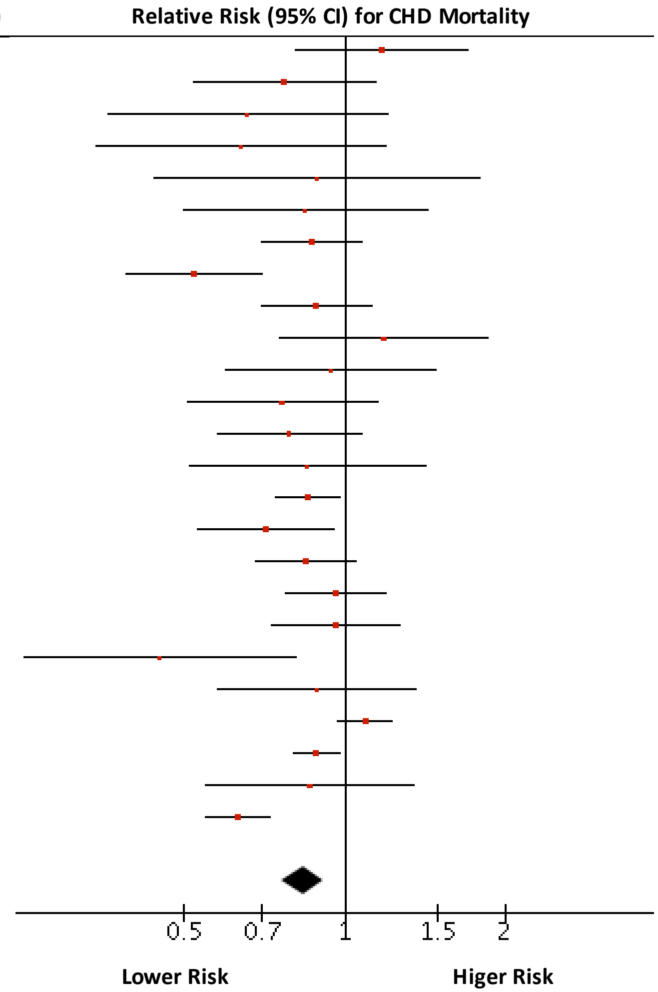


Figure S73. Relation between fruit intake and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

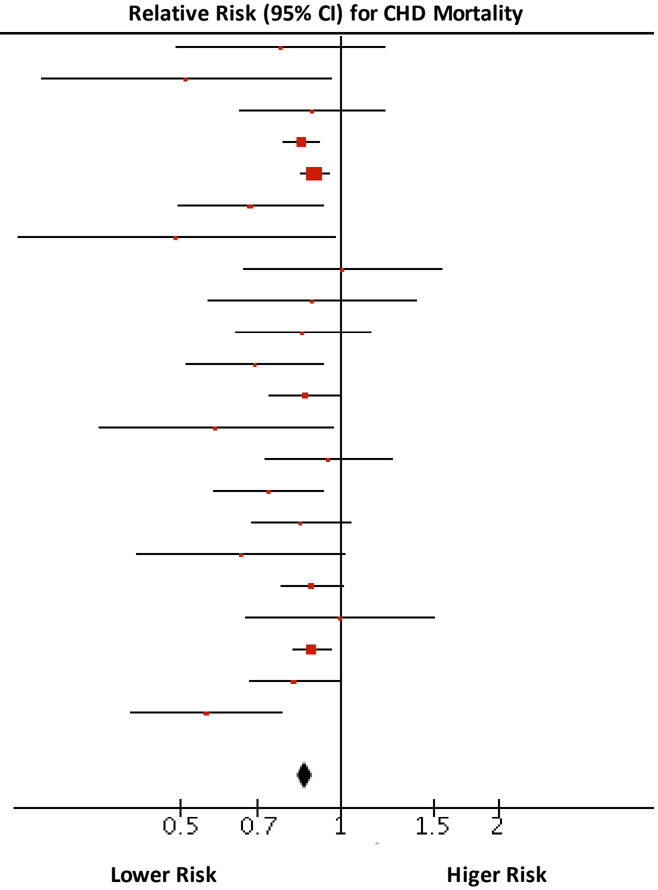
VEGETABLES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	1.1%	0.77 [0.49, 1.21]
Nutrition Status Study - Sahyoun 1996	680	101	0.6%	0.51 [0.27, 0.96]
Finish Mobile Clinic Health - Knekt 1996 - M	29,968	324	2.1%	0.89 [0.65, 1.21]
CPS 11 - Watkins 2000 - F	609,061	4,605	15.8%	0.84 [0.78, 0.91]
CPS 11 - Watkins 2000- M	453,962	9,156	19.5%	0.90 [0.84, 0.95]
ATBC - Hirvonen 2001	25,373	815	2.1%	0.68 [0.49, 0.93]
Baltimore Longitudinal Study Aging - Tucker 2005	501	71	0.5%	0.49 [0.25, 0.98]
Boyd Orr Cohort - Ness 2005	4,028	298	1.2%	1.01 [0.66, 1.55]
Melbourne Collaborative Cohort - Harriss 2007	40,653	407	1.1%	0.89 [0.57, 1.39]
JACC - Nagura 2009	59,485	452	2.4%	0.85 [0.64, 1.14]
Singapore Chinese Health - Rebello 2014 - F	29,968	638	2.4%	0.69 [0.51, 0.93]
EPIC - Leenders 2014	451,151	2,139	6.9%	0.86 [0.74, 1.01]
MONICA Danish - Tognon 2014	1,849	64	0.8%	0.58 [0.35, 0.97]
Multiethnic Cohort - Sharma 2014 - F	91,751	811	2.7%	0.95 [0.72, 1.25]
Multiethnic Cohort - Sharma 2014 - M	72,866	1,140	3.5%	0.73 [0.58, 0.93]
Singapore Chinese Health - Rebello 2014 - M	23,501	1,022	4.1%	0.84 [0.68, 1.05]
NIPPON DATA80 - Okuda 2015	9,112	165	1.1%	0.65 [0.41, 1.02]
Migrant Study - Hjartaker 2015	9,964	2,386	8.4%	0.89 [0.77, 1.02]
HAPIEE - Stefler 2016	19,263	225	1.3%	1.00 [0.66, 1.51]
Linxian Nutrition - Wang 2016	2,445	355	15.8%	0.89 [0.82, 0.96]
PLSAW - Blekkenhorst 2017	1,226	128	4.8%	0.82 [0.67, 1.00]
NHANES - Conrad 2018	29,133	556	2.0%	0.56 [0.40, 0.78]
Total (95% CI)	**1,968,325**	**26,007**	**100.0%**	**0.86 [0.83, 0.89]**

Heterogeneity: $Chi^2 = 26.70$, df = 21 (P = 0.18); $I^2 = 21\%$

Test for overall effect: Z = 8.79 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	1.1%	0.77 [0.49, 1.21]
Nutrition Status Study - Sahyoun 1996	680	101	0.6%	0.51 [0.27, 0.96]
Finish Mobile Clinic Health - Knekt 1996 - M	29,968	324	2.1%	0.89 [0.65, 1.21]
CPS 11 - Watkins 2000 - F	609,061	4,605	15.8%	0.84 [0.78, 0.91]
CPS 11 - Watkins 2000- M	453,962	9,156	19.5%	0.90 [0.84, 0.95]
ATBC - Hirvonen 2001	25,373	815	2.1%	0.68 [0.49, 0.93]
Baltimore Longitudinal Study Aging - Tucker 2005	501	71	0.5%	0.49 [0.25, 0.98]
Boyd Orr Cohort - Ness 2005	4,028	298	1.2%	1.01 [0.66, 1.55]
Melbourne Collaborative Cohort - Harriss 2007	40,653	407	1.1%	0.89 [0.57, 1.39]
JACC - Nagura 2009	59,485	452	2.4%	0.85 [0.64, 1.14]
Singapore Chinese Health - Rebello 2014 - F	29,968	638	2.4%	0.69 [0.51, 0.93]
EPIC - Leenders 2014	451,151	2,139	6.9%	0.86 [0.74, 1.01]
MONICA Danish - Tognon 2014	1,849	64	0.8%	0.58 [0.35, 0.97]
Multiethnic Cohort - Sharma 2014 - F	91,751	811	2.7%	0.95 [0.72, 1.25]
Multiethnic Cohort - Sharma 2014 - M	72,866	1,140	3.5%	0.73 [0.58, 0.93]
Singapore Chinese Health - Rebello 2014 - M	23,501	1,022	4.1%	0.84 [0.68, 1.05]
NIPPON DATA80 - Okuda 2015	9,112	165	1.1%	0.65 [0.41, 1.02]
Migrant Study - Hjartaker 2015	9,964	2,386	8.4%	0.89 [0.77, 1.02]
HAPIEE - Stefler 2016	19,263	225	1.3%	1.00 [0.66, 1.51]
Linxian Nutrition - Wang 2016	2,445	355	15.8%	0.89 [0.82, 0.96]
PLSAW - Blekkenhorst 2017	1,226	128	4.8%	0.82 [0.67, 1.00]
NHANES - Conrad 2018	29,133	556	2.0%	0.56 [0.40, 0.78]
Total (95% CI) [Random Effects]	**1,968,325**	**26,007**	**100.0%**	**0.84 [0.80, 0.88]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 26.70$, df = 21 (P = 0.18); $I^2 = 21\%$

Test for overall effect: Z = 7.10 (P < 0.00001)

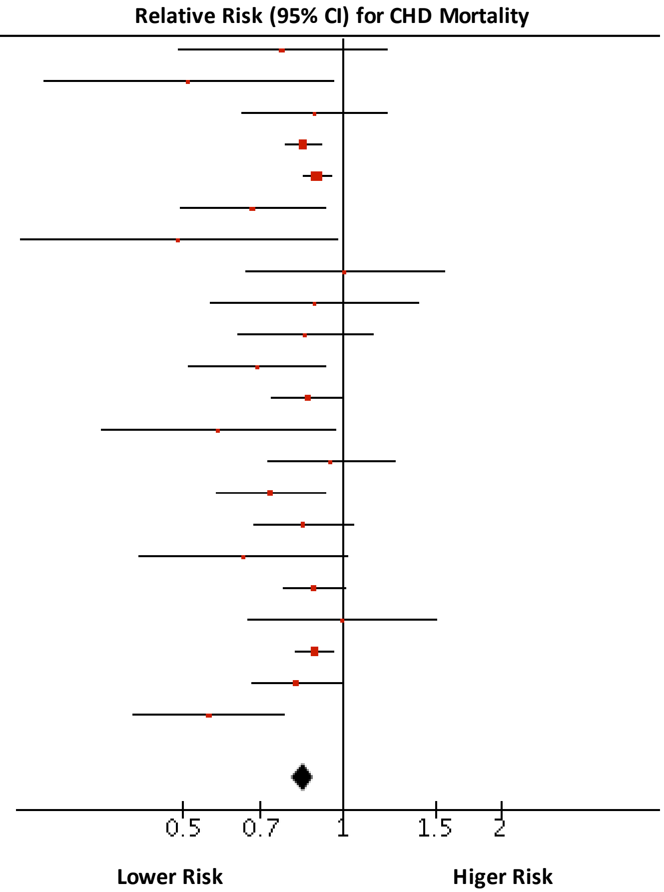


Figure S74. Relation between intake of vegetables and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BANANAS AND CORONARY HEART DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Migrant Study - Hjartaker 2015	9,964	2,384	100.0%	1.04 [0.81, 1.34]
Total (95% CI)	**9,964**	**2,384**	**100.0%**	**1.04 [0.81, 1.34]**

Heterogeneity: Not applicable
Test for overall effect: Z = 0.31 (P = 0.76)

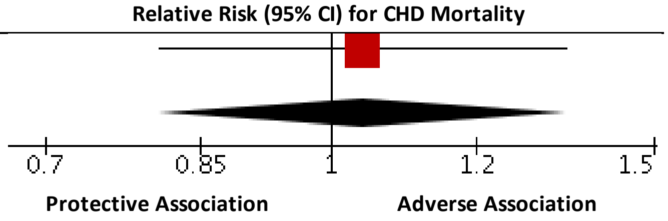


Figure S75. Relation between intake of bananas and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BERRIES AND CORONARY HEART DISEASE MORTALITY

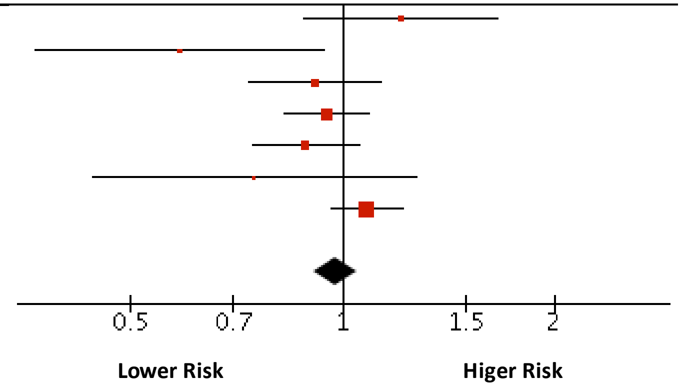
A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	5.2%	1.21 [0.88, 1.65]
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	2.3%	0.59 [0.37, 0.94]
ATBC - Hirvonen 2001	25,373	815	10.9%	0.91 [0.74, 1.13]
Iowa WHS - Mink 2007 - strawberries	-	-	26.9%	0.95 [0.83, 1.09]
Iowa WHS - Mink 2007 - blueberries	34,492	1,329	16.3%	0.89 [0.74, 1.06]
UK Women's Cohort - Lai 2015	30,458	138	1.8%	0.75 [0.44, 1.27]
Migrant Study - Hjartaker 2015	9,964	2,386	36.6%	1.08 [0.96, 1.22]
Total (95% CI)	**105,420**	**5,141**	**100.0%**	**0.98 [0.91, 1.05]**

Heterogeneity: $Chi^2 = 11.84$, df = 6 (P = 0.07); $I^2 = 49\%$

Test for overall effect: Z = 0.58 (P = 0.56)

Relative Risk (95% CI) for CHD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	5.00%	0.59 [0.37, 0.94]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	9.50%	1.21 [0.88, 1.65]
ATBC - Hirvonen 2001	25,373	815	15.30%	0.91 [0.74, 1.13]
Iowa WHS - Mink 2007 - blueberries	34,492	1,329	18.70%	0.89 [0.74, 1.06]
Iowa WHS - Mink 2007 - strawberries	-	-	22.60%	0.95 [0.83, 1.09]
Migrant Study - Hjartaker 2015	9,964	2,386	24.70%	1.08 [0.96, 1.22]
UK Women's Cohort - Lai 2015	30,458	138	4.10%	0.75 [0.44, 1.27]
Total (95% CI) [Random Effects]	**105,420**	**5,141**	**100.00%**	**0.95 [0.85, 1.07]**

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 11.84$, df = 6 (P = 0.07); $I^2 = 49\%$

Test for overall effect: Z = 0.82 (P = 0.41)

Relative Risk (95% CI) for CHD Mortality

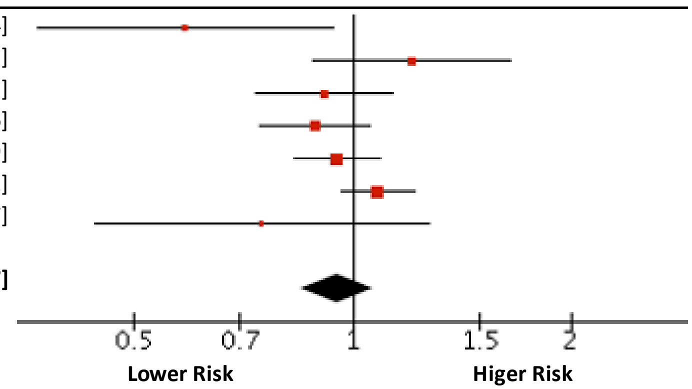


Figure S76. Relation between intake of berries and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

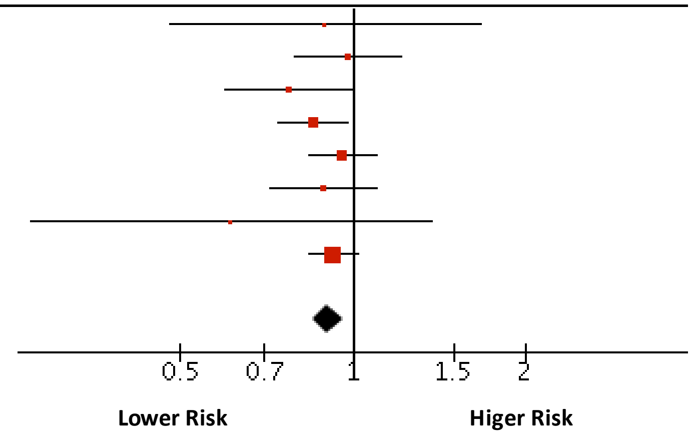
CITRUS FRUIT AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nutrition Status Study - Sahyoun 1996	680	101	0.9%	0.90 [0.48, 1.68]
JACC - Iso 2007 - M	43,031	602	7.9%	0.98 [0.79, 1.22]
JACC - Iso 2007 - F	59,504	398	5.6%	0.77 [0.60, 0.99]
Iowa WHS - Mink 2007 - grapefruit	34,492	1,329	19.5%	0.85 [0.74, 0.98]
Iowa WHS - Mink 2007 - oranges	-	-	19.5%	0.96 [0.84, 1.10]
Migrant Study - Hjartaker 2015	9,964	2,386	7.9%	0.89 [0.71, 1.10]
UK Women's Cohort - Lai 2015	30,458	138	0.6%	0.61 [0.27, 1.37]
Linxian Nutrition - Wang 2016	2,445	355	38.2%	0.92 [0.84, 1.02]
Total (95% CI)	**180,574**	**5,309**	**100.0%**	**0.91 [0.85, 0.96]**

Heterogeneity: Chi² = 4.61, df = 7 (P = 0.71); I² = 0%
Test for overall effect: Z = 3.20 (P = 0.001)

Relative Risk (95% CI) for CHD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nutrition Status Study - Sahyoun 1996	680	101	0.9%	0.90 [0.48, 1.68]
JACC - Iso 2007 - F	59,504	398	5.6%	0.77 [0.60, 0.99]
JACC - Iso 2007 - M	43,031	602	7.9%	0.98 [0.79, 1.22]
Iowa WHS - Mink 2007 - grapefruit	34,492	1,329	19.5%	0.85 [0.74, 0.98]
Iowa WHS - Mink 2007 - oranges	-	-	19.5%	0.96 [0.84, 1.10]
Migrant Study - Hjartaker 2015	9,964	2,386	7.9%	0.89 [0.71, 1.10]
UK Women's Cohort - Lai 2015	30,458	138	0.6%	0.61 [0.27, 1.37]
Linxian Nutrition - Wang 2016	2,445	355	38.2%	0.92 [0.84, 1.02]
Total (95% CI) [Random Effects]	**180,574**	**5,309**	**100.0%**	**0.91 [0.85, 0.96]**

Heterogeneity: Tau² = 0.00; Chi² = 4.61, df = 7 (P = 0.71); I² = 0%
Test for overall effect: Z = 3.20 (P = 0.001)

Relative Risk (95% CI) for CHD Mortality

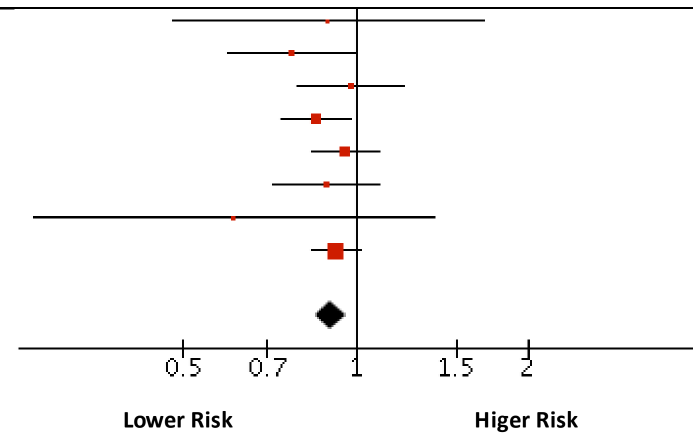


Figure S77. Relation between citrus fruit intake and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

DRIED FRUIT AND CORONARY HEART DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015	30,458	138	100.00%	0.79 [0.47, 1.31]
Total (95% CI)	**30,458**	**138**	**100.00%**	**0.79 [0.47, 1.31]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.92 (P = 0.36)				

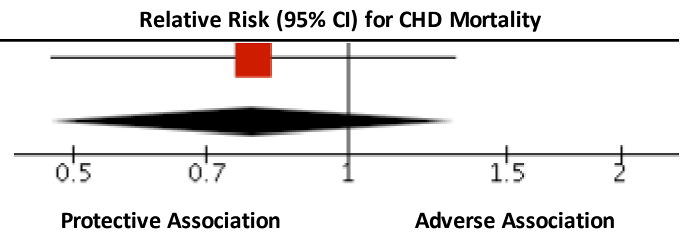


Figure S78. Relation between dried fruit intake and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

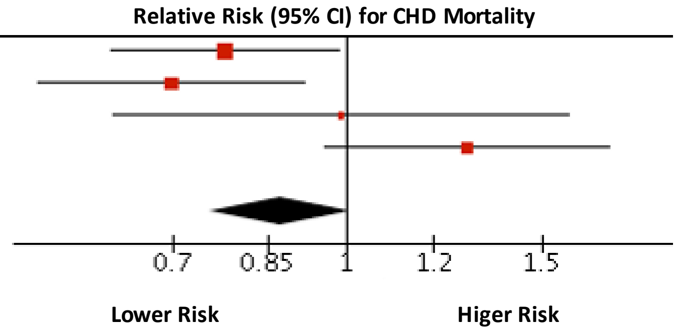
FRUIT JUICE AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - M	41,330	573	38.1%	0.78 [0.62, 0.99]
JACC - Iso 2007 - F	56,482	370	28.0%	0.70 [0.53, 0.92]
UK Women's Cohort - Lai 2015	30,458	138	9.5%	0.99 [0.62, 1.58]
REGARDS - Colin 2019	13,440	168	24.4%	1.32 [1.08 1.62]
Total (95% CI)	**141,710**	**1,249**	**100.0%**	**0.87 [0.75, 1.01]**

Heterogeneity: $Chi^2 = 10.36$, df = 3 (P = 0.02); $I^2 = 71\%$

Test for overall effect: Z = 1.84 (P = 0.07)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - M	41,330	573	26.9%	0.78 [0.62, 0.99]
JACC - Iso 2007 - F	56,482	370	25.7%	0.70 [0.53, 0.92]
UK Women's Cohort - Lai 2015	30,458	138	19.3%	0.99 [0.62, 1.58]
REGARDS - Colin 2019	13,440	168	28.1%	1.32 [1.08 1.62]
Total (95% CI) [Random Effects]	**141,710**	**1,249**	**100.0%**	**0.90 [0.68, 1.19]**

Heterogeneity: $Tau^2 = 0.06$; $Chi^2 = 10.36$, df = 3 (P = 0.02); $I^2 = 71\%$

Test for overall effect: Z = 0.74 (P = 0.46)

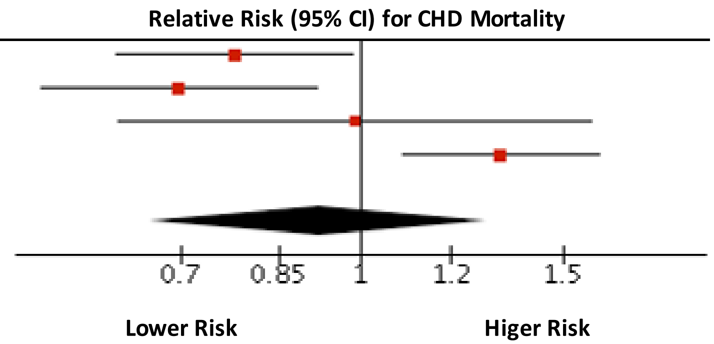


Figure S79. Relation between intake of fruit juice and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

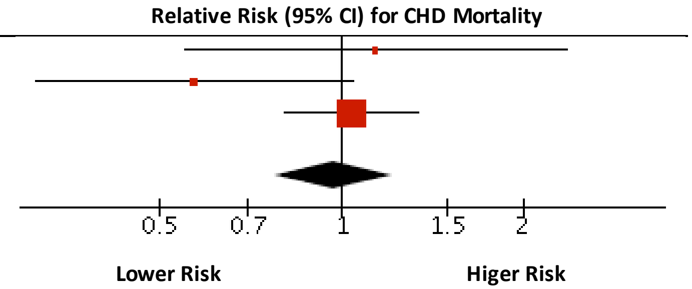
GRAPES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Lin 2007	66,360	324	9.5%	1.14 [0.55, 2.35]
UK Women's Cohort - Lai 2015 - grapes	30,458	138	13.5%	0.57 [0.31, 1.05]
Migrant Study - Hjartaker 2015	9,964	2,384	77.0%	1.04 [0.81, 1.34]
Total (95% CI)	**106,782**	**2,846**	**100.0%**	**0.97 [0.77, 1.21]**

Heterogeneity: Chi² = 3.40, df = 2 (P = 0.18); I² = 41%

Test for overall effect: Z = 0.29 (P = 0.77)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Lin 2007	66,360	324	19.5%	1.14 [0.55, 2.35]
UK Women's Cohort - Lai 2015 - grapes	30,458	138	25.0%	0.57 [0.31, 1.05]
Migrant Study - Hjartaker 2015	9,964	2,384	55.5%	1.04 [0.81, 1.34]
Total (95% CI) [Random Effects]	**106,782**	**2,846**	**100.0%**	**0.91 [0.63, 1.32]**

Heterogeneity: Tau² = 0.05; Chi² = 3.40, df = 2 (P = 0.18); I² = 41%

Test for overall effect: Z = 0.49 (P = 0.63)

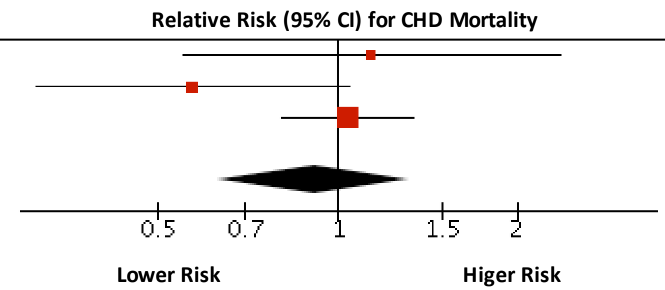


Figure S80. Relation between intake of grapes and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

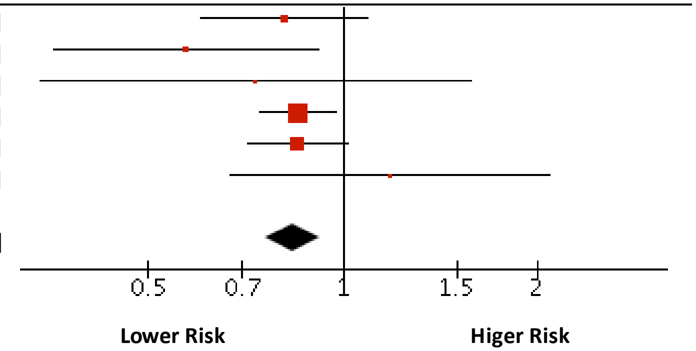
POMMES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	10.9%	0.81 [0.60, 1.09]
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	4.3%	0.57 [0.36, 0.91]
Nurses' Health Study - Lin 2007	66,360	324	1.6%	0.73 [0.34, 1.58]
Iowa WHS - Mink 2007	34,492	1,329	50.0%	0.85 [0.74, 0.98]
Migrant Study - Hjartaker 2015	9,964	2,386	30.3%	0.85 [0.71, 1.02]
UK Women's Cohort - Lai 2015	30,458	138	2.9%	1.19 [0.67, 2.09]
Total (95% CI)	**146,407**	**4,650**	**100.0%**	**0.84 [0.76, 0.92]**

Heterogeneity: $Chi^2 = 4.24$, df = 5 (P = 0.52); $I^2 = 0\%$
Test for overall effect: Z = 3.54 (P = 0.0004)

Relative Risk (95% CI) for CHD Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	4.3%	0.57 [0.36, 0.91]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	10.9%	0.81 [0.60, 1.09]
Iowa WHS - Mink 2007	34,492	1,329	50.0%	0.85 [0.74, 0.98]
Nurses' Health Study - Lin 2007	66,360	324	1.6%	0.73 [0.34, 1.58]
UK Women's Cohort - Lai 2015	30,458	138	2.9%	1.19 [0.67, 2.09]
Migrant Study - Hjartaker 2015	9,964	2,386	30.3%	0.85 [0.71, 1.02]
Total (95% CI) [Random Effects]	**146,407**	**4,650**	**100.0%**	**0.84 [0.76, 0.92]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 4.24$, df = 5 (P = 0.52); $I^2 = 0\%$
Test for overall effect: Z = 3.54 (P = 0.0004)

Relative Risk (95% CI) for CHD Mortality

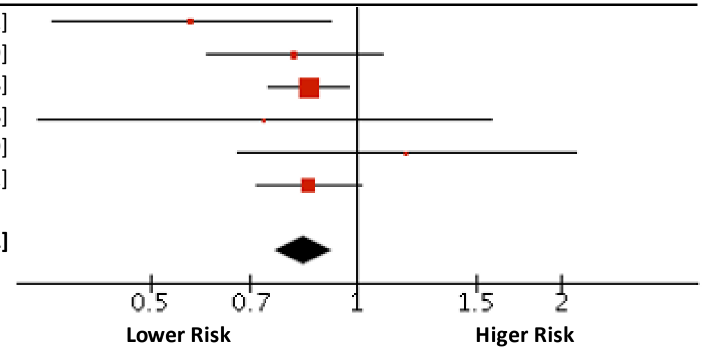


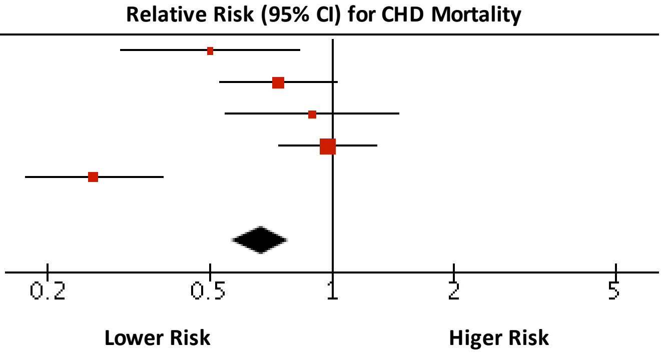
Figure S81. Relation between pommes fruit intake and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

ALLIUM VEGETABLES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	10.5%	0.50 [0.30, 0.83]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	24.5%	0.74 [0.53, 1.03]
Linxian Nutrition - Wang 2016	2,445	355	11.3%	0.98 [0.74, 1.29]
Nurses' Health Study - Lin 2007	66,630	324	36.1%	0.90 [0.55, 1.46]
PLSAW - Blekkenhorst 2017	1,226	128	17.7%	0.26 [0.18, 0.38]
Total (95% CI)	**75,434**	**1,280**	**100.0%**	**0.67 [0.57, 0.79]**

Heterogeneity: Chi² = 32.86, df = 4 (P < 0.00001); I² = 88%
Test for overall effect: Z = 4.80 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	18.5%	0.50 [0.30, 0.83]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	20.9%	0.74 [0.53, 1.03]
Linxian Nutrition - Wang 2016	2,445	355	21.6%	0.98 [0.74, 1.29]
Nurses' Health Study - Lin 2007	66,630	324	18.8%	0.90 [0.55, 1.46]
PLSAW - Blekkenhorst 2017	1,226	128	20.2%	0.26 [0.18, 0.38]
Total (95% CI) [Random Effects]	**75,434**	**1,280**	**100.0%**	**0.61 [0.38, 1.00]**

Heterogeneity: Tau² = 0.27; Chi² = 32.86, df = 4 (P < 0.00001); I² = 88%
Test for overall effect: Z = 1.95 (P = 0.05)

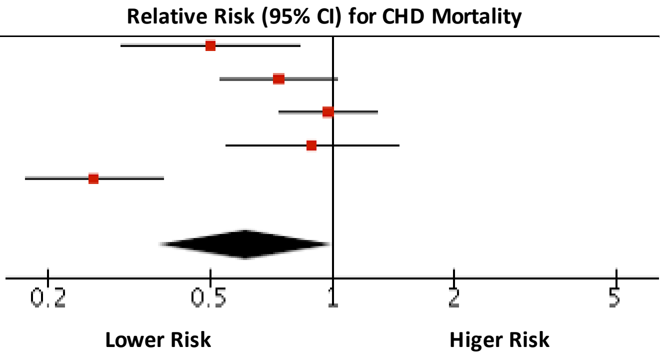
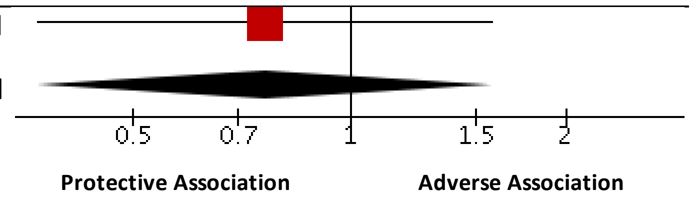


Figure S82. Relation between intake of allium vegetables and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CARROTS AND CORONARY HEART DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Oxford Vegetarian - Mann 1997 - carrots	10,802	64	100.0%	0.76 [0.37, 1.58]
Total (95% CI)	**10,802**	**64**	**100.0%**	**0.76 [0.37, 1.58]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.73 (P = 0.47)				

Relative Risk (95% CI) for CHD Mortality



Supplementary Figure 83. Relation between intake of carrots and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CELERY AND CORONARY HEART DISEASE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007 - celery	34,492	1,329	100.0%	0.92 [0.80, 1.06]
Total (95% CI)	**34,492**	**1,329**	**100.0%**	**0.92 [0.80, 1.06]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.14 (P = 0.25)				

Relative Risk (95% CI) for CHD Mortality

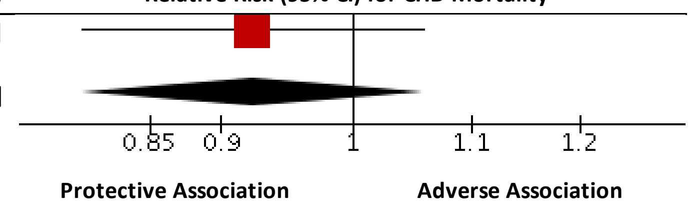


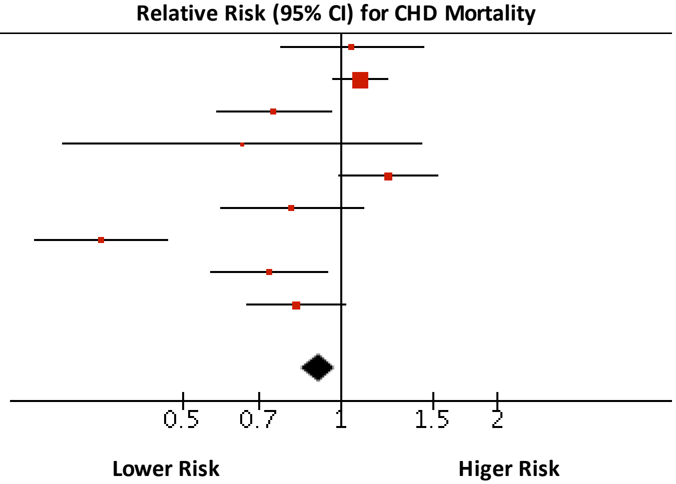
Figure S84. Relation between intake of celery and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CRUCIFEROUS VEGETABLES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	54,325	396	5.7%	1.05 [0.77, 1.44]
Iowa WHS - Mink 2007	34,492	1,329	40.2%	1.09 [0.97, 1.23]
JACC - Iso 2007 - M	39,486	534	8.6%	0.75 [0.58, 0.97]
Nurses' Health Study - Lin 2007	66,630	324	0.9%	0.65 [0.30, 1.42]
Migrant Study - Hjartaker 2015	9,964	2,386	12.0%	1.23 [0.99, 1.53]
Linxian Nutrition - Wang 2016	2,445	355	5.7%	0.81 [0.59, 1.11]
PLSAW - Blekkenhorst 2017	1,226	128	6.4%	0.35 [0.26, 0.47]
Japan Public Health Center - Mori 2018 - F	47,562	776	8.6%	0.73 [0.57, 0.95]
Japan Public Health Center - Mori 2018 - M	40,642	1,192	12.0%	0.83 [0.67, 1.03]
Total (95% CI)	**296,772**	**7,420**	**100.0%**	**0.91 [0.85, 0.98]**

Heterogeneity: Chi² = 65.50, df = 8 (P < 0.00001); I² = 88%
Test for overall effect: Z = 2.45 (P = 0.01)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	54,325	396	11.0%	1.05 [0.77, 1.44]
Iowa WHS - Mink 2007	34,492	1,329	13.2%	1.09 [0.97, 1.23]
JACC - Iso 2007 - M	39,486	534	11.8%	0.75 [0.58, 0.97]
Nurses' Health Study - Lin 2007	66,630	324	5.4%	0.65 [0.30, 1.42]
Migrant Study - Hjartaker 2015	9,964	2,386	12.3%	1.23 [0.99, 1.53]
Linxian Nutrition - Wang 2016	2,445	355	11.0%	0.81 [0.59, 1.11]
PLSAW - Blekkenhorst 2017	1,226	128	11.3%	0.35 [0.26, 0.47]
Japan Public Health Center - Mori 2018 - M	40,642	1,192	12.3%	0.83 [0.67, 1.03]
Japan Public Health Center - Mori 2018 - F	47,562	776	11.8%	0.73 [0.57, 0.95]
Total (95% CI) [Random Effects]	**296,772**	**7,420**	**100.0%**	**0.81 [0.64, 1.02]**

Heterogeneity: $Tau^2 = 0.11$; $Chi^2 = 65.50$, df = 8 (P < 0.00001); $I^2 = 88\%$

Test for overall effect: Z = 1.79 (P = 0.07)

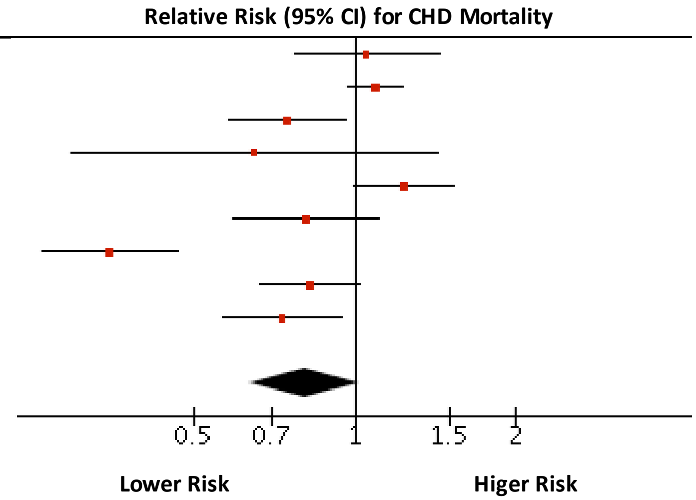
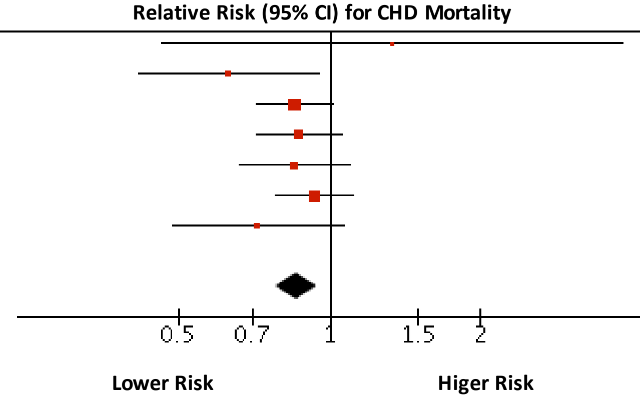


Figure S85. Relation between intake of cruciferous vegetables and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

GREEN LEAFY VEGETABLES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Oxford Vegetarian - Mann 1997	10,802	64	0.8%	1.34 [0.46, 3.85]
OXCHECK - Whiteman 1999	10,522	144	5.0%	0.63 [0.42, 0.95]
Health Food Shoppers - Appleby 2002	10,741	605	27.0%	0.85 [0.71, 1.02]
JACC - Iso 2007 - M	43,850	617	21.9%	0.87 [0.71, 1.06]
JACC - Iso 2007 - F	59,809	420	12.9%	0.85 [0.66, 1.10]
Migrant Study - Hjartaker 2015	9,964	2,386	27.0%	0.93 [0.78, 1.11]
Linxian Nutrition - Wang 2016	2,445	355	5.5%	0.72 [0.49, 1.06]
Total (95% CI)				
Heterogeneity: Chi² = 4.47, df = 6 (P = 0.61); I² = 0%	**148,133**	**4,591**	**100.0%**	**0.86 [0.78, 0.94]**
Test for overall effect: Z = 3.25 (P = 0.001)				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Oxford Vegetarian - Mann 1997	10,802	64	0.8%	1.34 [0.46, 3.85]
OXCHECK - Whiteman 1999	10,522	144	5.0%	0.63 [0.42, 0.95]
Health Food Shoppers - Appleby 2002	10,741	605	27.0%	0.85 [0.71, 1.02]
JACC - Iso 2007 - M	43,850	617	21.9%	0.87 [0.71, 1.06]
JACC - Iso 2007 - F	59,809	420	12.9%	0.85 [0.66, 1.10]
Migrant Study - Hjartaker 2015	9,964	2,386	27.0%	0.93 [0.78, 1.11]
Linxian Nutrition - Wang 2016	2,445	355	5.5%	0.72 [0.49, 1.06]
Total (95% CI) [Random Effects]	**148,133**	**4,591**	**100.0%**	**0.86 [0.78, 0.94]**
Heterogeneity: Tau² = 0.00; Chi² = 4.47, df = 6 (P = 0.61); I² = 0%				
Test for overall effect: Z = 3.25 (P = 0.001)				

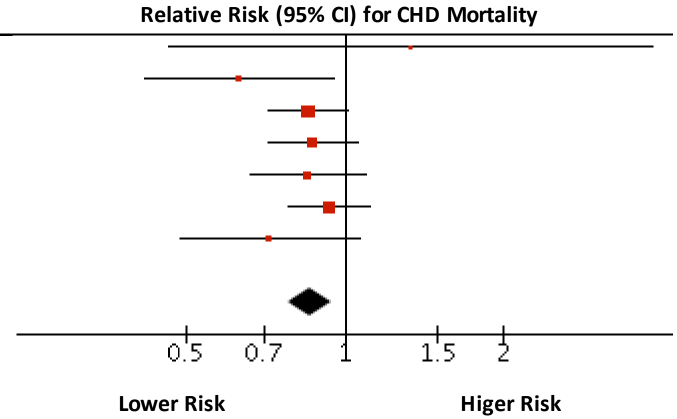


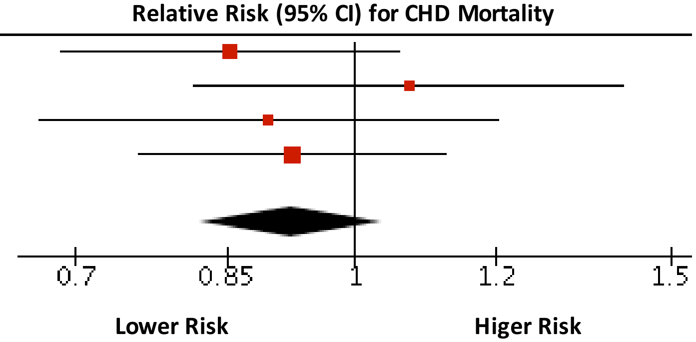
Figure S86. Relation between intake of green leafy vegetables and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

TOMATOES AND CORONARY HEART DISEASE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - tomatoes - M	41,547	568	29.7%	0.85 [0.69, 1.06]
JACC - Iso 2007 - tomatoes - F	56,947	379	18.3%	1.07 [0.82, 1.41]
Nurses' Health Study - Lin 2007	66,630	324	16.0%	0.90 [0.67, 1.20]
Migrant Study - Hjartaker 2015	9,964	2,386	36.0%	0.92 [0.76, 1.12]
Total (95% CI)	**175,088**	**3,657**	**100.0%**	**0.92 [0.82, 1.04]**

Heterogeneity: Chi² = 1.72, df = 3 (P = 0.63); I² = 0%
Test for overall effect: Z = 1.35 (P = 0.18)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - males - tomatoes	41,547	568	29.7%	0.85 [0.69, 1.06]
Nurses' Health Study - Lin 2007	66,630	324	16.0%	0.90 [0.67, 1.20]
JACC - Iso 2007 - tomatoes - F	56,947	379	18.3%	1.07 [0.82, 1.41]
Migrant Study - Hjartaker 2015	9,964	2,386	36.0%	0.92 [0.76, 1.12]
Total (95% CI) [Random Effects]	**175,088**	**3,657**	**100.0%**	**0.92 [0.82, 1.04]**

Heterogeneity: Tau² = 0.00; Chi² = 1.72, df = 3 (P = 0.63); I² = 0%
Test for overall effect: Z = 1.35 (P = 0.18)

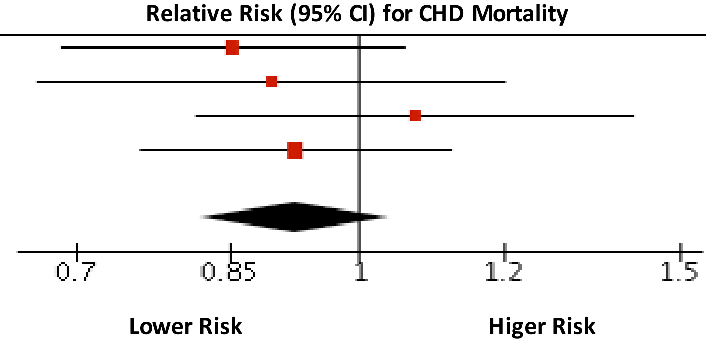
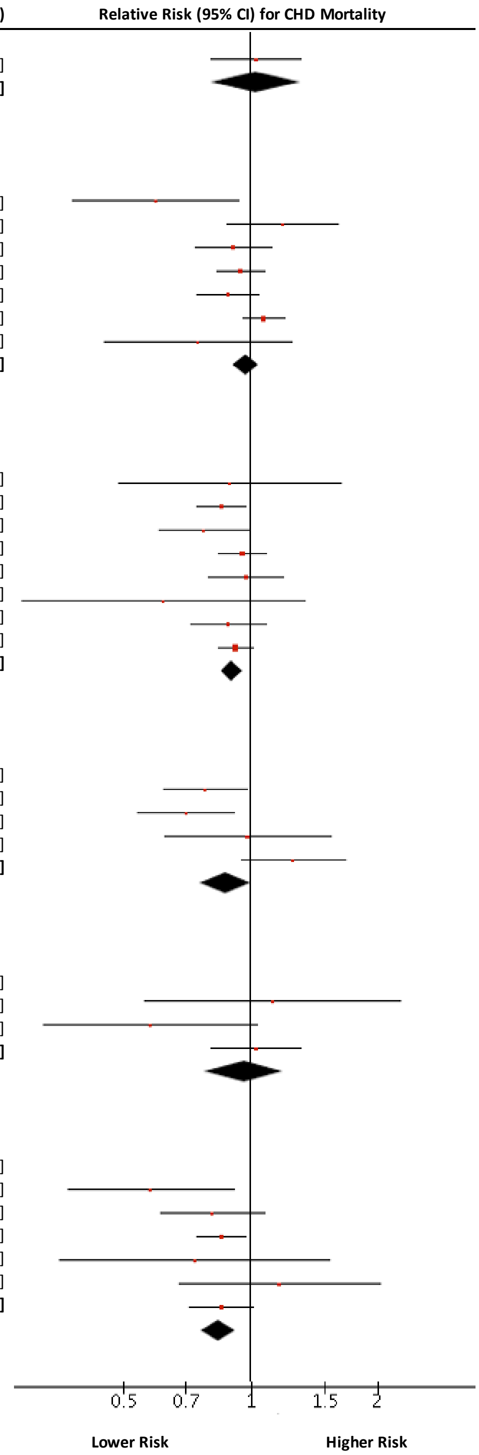


Figure S87. Relation between intake of tomatoes and coronary heart disease mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Bananas				
Migrant Study - Hjartaker 2015	9,964	2,384	2.3%	1.04 [0.81, 1.34]
Subtotal (95% CI)	**9,964**	**2,384**	**2.3%**	**1.04 [0.81, 1.34]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.31 (P = 0.76)				
Berries				
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	0.7%	0.59 [0.37, 0.94]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	1.5%	1.21 [0.88, 1.65]
ATBC - Hirvonen 2001	25,373	815	3.3%	0.91 [0.74, 1.13]
Iowa WHS - Mink 2007 - strawberries	-	-	8.1%	0.95 [0.83, 1.09]
Iowa WHS - Mink 2007 - blueberries	34,492	1,329	4.9%	0.89 [0.74, 1.06]
Migrant Study - Hjartaker 2015	9,964	2,386	11.0%	1.08 [0.96, 1.22]
UK Women's Cohort - Lai 2015	30,458	138	0.5%	0.75 [0.44, 1.27]
Subtotal (95% CI)	**105,420**	**5,141**	**29.9%**	**0.98 [0.91, 1.05]**
Heterogeneity: Tau² = 0.01; Chi² = 11.84, df = 6 (P = 0.07); I² = 49%				
Test for overall effect: Z = 0.82 (P = 0.41)				
Citrus				
Nutrition Status Study - Sahyoun 1996	680	101	0.4%	0.90 [0.48, 1.68]
Iowa WHS - Mink 2007 - grapefruit	34,492	1,329	8.1%	0.85 [0.74, 0.98]
JACC - Iso 2007 - F	59,504	398	2.3%	0.77 [0.60, 0.99]
Iowa WHS - Mink 2007 - oranges	-	-	8.1%	0.96 [0.84, 1.10]
JACC - Iso 2007 - M	43,031	602	3.3%	0.98 [0.79, 1.22]
UK Women's Cohort - Lai 2015	30,458	138	0.2%	0.61 [0.27, 1.37]
Migrant Study - Hjartaker 2015	9,964	2,386	3.3%	0.89 [0.71, 1.10]
Linxian Nutrition - Wang 2016	2,445	355	15.8%	0.92 [0.84, 1.02]
Subtotal (95% CI)	**180,574**	**5,309**	**41.4%**	**0.91 [0.85, 0.96]**
Heterogeneity: Tau² = 0.00; Chi² = 4.61, df = 7 (P = 0.71); I² = 0%				
Test for overall effect: Z = 3.20 (P = 0.001)				
Fruit Juice				
JACC - Iso 2007 - M	41,330	573	2.7%	0.78 [0.62, 0.99]
JACC - Iso 2007 - F	56,482	370	2.0%	0.70 [0.53, 0.92]
UK Women's Cohort - Lai 2015	30,458	138	0.7%	0.99 [0.62, 1.58]
REGARDS - Colin 2019	13,440	168	1.8%	1.28 [0.96, 1.72]
Subtotal (95% CI)	**141,710**	**1,249**	**7.2%**	**0.87 [0.75, 1.01]**
Heterogeneity: Tau² = 0.06; Chi² = 10.36, df = 3 (P = 0.02); I² = 71%				
Test for overall effect: Z = 0.74 (P = 0.46)				
Grapes				
Nurses' Health Study - Lin 2007	66,360	324	0.3%	1.14 [0.55, 2.35]
UK Women's Cohort - Lai 2015 - grapes	30,458	138	0.4%	0.57 [0.31, 1.05]
Migrant Study - Hjartaker 2015	9,964	2,384	2.3%	1.04 [0.81, 1.34]
Subtotal (95% CI)	**106,782**	**2,846**	**3.0%**	**0.97 [0.77, 1.21]**
Heterogeneity: Tau² = 0.05; Chi² = 3.40, df = 2 (P = 0.18); I² = 41%				
Test for overall effect: Z = 0.49 (P = 0.63)				
Pommes				
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	0.7%	0.57 [0.36, 0.91]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	1.8%	0.81 [0.60, 1.09]
Iowa WHS - Mink 2007	34,492	1,329	8.1%	0.85 [0.74, 0.98]
Nurses' Health Study - Lin 2007	66,360	324	0.3%	0.73 [0.34, 1.58]
UK Women's Cohort - Lai 2015	30,458	138	0.5%	1.19 [0.67, 2.09]
Migrant Study - Hjartaker 2015	9,964	2,386	4.9%	0.85 [0.71, 1.02]
Subtotal (95% CI)	**146,407**	**4,650**	**16.1%**	**0.84 [0.76, 0.92]**
Heterogeneity: Tau² = 0.00; Chi² = 4.24, df = 5 (P = 0.52); I² = 0%				
Test for overall effect: Z = 3.54 (P = 0.0004)				
Test for subgroup differences: Chi² = 8.23, df = 5 (P = 0.14), I² = 39.3%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Bananas				
Migrant Study - Hjartaker 2015	9,964	2,384	3.2%	1.04 [0.81, 1.34]
Subtotal (95% CI)	**9,964**	**2,384**	**3.2%**	**1.04 [0.81, 1.34]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.31 (P = 0.76)				
Berries				
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	1.1%	0.59 [0.37, 0.94]
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	2.3%	1.21 [0.88, 1.65]
ATBC - Hirvonen 2001	25,373	815	4.2%	0.91 [0.74, 1.13]
Iowa WHS - Mink 2007 - strawberries	-	-	7.3%	0.95 [0.83, 1.09]
Iowa WHS - Mink 2007 - blueberries	34,492	1,329	5.5%	0.89 [0.74, 1.06]
Migrant Study - Hjartaker 2015	9,964	2,386	8.5%	1.08 [0.96, 1.22]
UK Women's Cohort - Lai 2015	30,458	138	0.9%	0.75 [0.44, 1.27]
Subtotal (95% CI)	**105,420**	**5,141**	**29.8%**	**0.95 [0.85, 1.07]**
Heterogeneity: Tau² = 0.01; Chi² = 11.84, df = 6 (P = 0.07); I² = 49%				
Test for overall effect: Z = 0.82 (P = 0.41)				
Citrus				
Nutrition Status Study - Sahyoun 1996	680	101	0.7%	0.90 [0.48, 1.68]
JACC - Iso 2007 - M	43,031	602	4.2%	0.98 [0.79, 1.22]
JACC - Iso 2007 - F	59,504	398	3.2%	0.77 [0.60, 0.99]
Iowa WHS - Mink 2007 - oranges	-	-	7.3%	0.96 [0.84, 1.10]
Iowa WHS - Mink 2007 - grapefruit	34,492	1,329	7.3%	0.85 [0.74, 0.98]
UK Women's Cohort - Lai 2015	30,458	138	0.4%	0.61 [0.27, 1.37]
Migrant Study - Hjartaker 2015	9,964	2,386	4.2%	0.89 [0.71, 1.10]
Linxian Nutrition - Wang 2016	2,445	355	9.8%	0.92 [0.84, 1.02]
Subtotal (95% CI)	**180,574**	**5,309**	**37.1%**	**0.91 [0.85, 0.96]**
Heterogeneity: Tau² = 0.00; Chi² = 4.61, df = 7 (P = 0.71); I² = 0%				
Test for overall effect: Z = 3.20 (P = 0.001)				
Fruit Juice				
JACC - Iso 2007 - M	41,330	573	3.7%	0.78 [0.62, 0.99]
JACC - Iso 2007 - F	56,482	370	3.0%	0.70 [0.53, 0.92]
UK Women's Cohort - Lai 2015	30,458	138	1.2%	0.99 [0.62, 1.58]
REGARDS - Colin 2019	13,440	168	2.7%	1.28 [0.96, 1.72]
Subtotal (95% CI)	**141,710**	**1,249**	**10.6%**	**0.90 [0.68, 1.19]**
Heterogeneity: Tau² = 0.06; Chi² = 10.36, df = 3 (P = 0.02); I² = 71%				
Test for overall effect: Z = 0.74 (P = 0.46)				
Grapes				
Nurses' Health Study - Lin 2007	66,360	324	0.5%	1.14 [0.55, 2.35]
UK Women's Cohort - Lai 2015 - grapes	30,458	138	0.7%	0.57 [0.31, 1.05]
Migrant Study - Hjartaker 2015	9,964	2,384	3.2%	1.04 [0.81, 1.34]
Subtotal (95% CI)	**106,782**	**2,846**	**4.4%**	**0.91 [0.63, 1.32]**
Heterogeneity: Tau² = 0.05; Chi² = 3.40, df = 2 (P = 0.18); I² = 41%				
Test for overall effect: Z = 0.49 (P = 0.63)				
Pommes				
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	2.6%	0.81 [0.60, 1.09]
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	1.1%	0.57 [0.36, 0.91]
Nurses' Health Study - Lin 2007	66,360	324	0.4%	0.73 [0.34, 1.58]
Iowa WHS - Mink 2007	34,492	1,329	7.3%	0.85 [0.74, 0.98]
Migrant Study - Hjartaker 2015	9,964	2,386	5.5%	0.85 [0.71, 1.02]
UK Women's Cohort - Lai 2015	30,458	138	0.8%	1.19 [0.67, 2.09]
Subtotal (95% CI)	**146,407**	**4,650**	**17.7%**	**0.84 [0.76, 0.92]**
Heterogeneity: Tau² = 0.00; Chi² = 4.24, df = 5 (P = 0.52); I² = 0%				
Test for overall effect: Z = 3.54 (P = 0.0004)				
Test for subgroup differences: Chi² = 4.24, df = 5 (P = 0.52), I² = 0%				

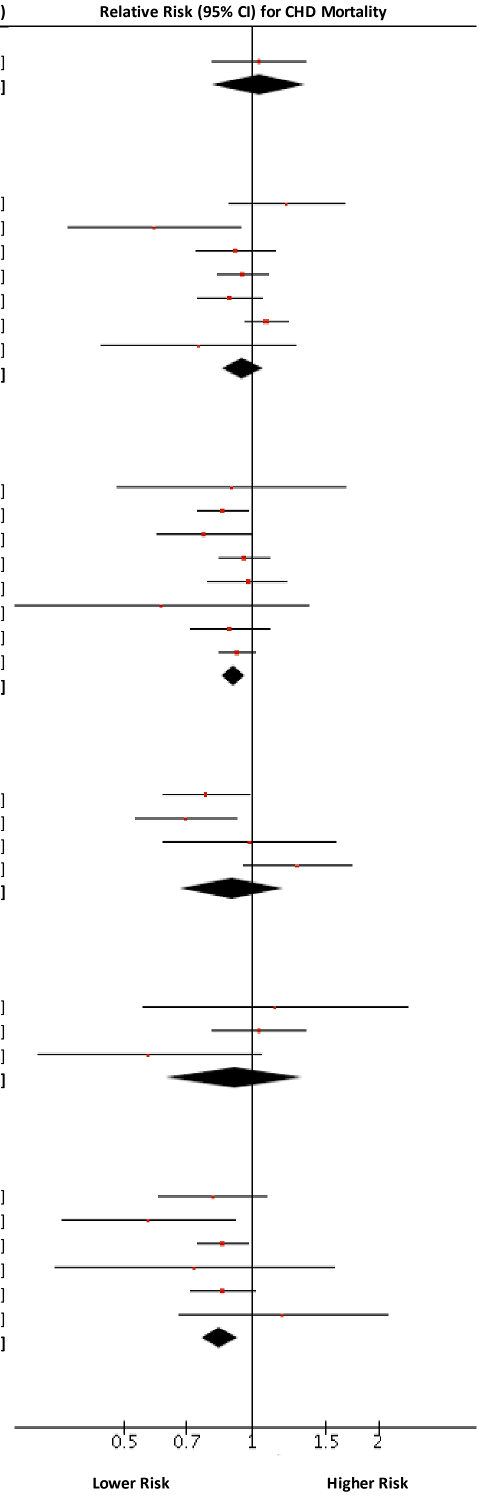
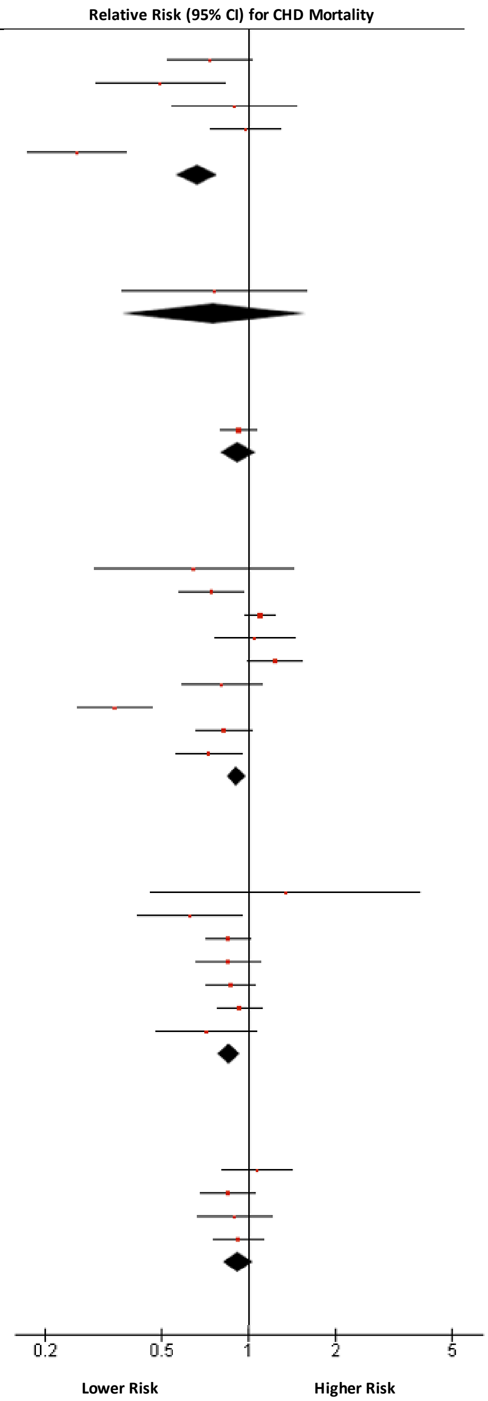


Figure S88. Relation between sources of fruit and CHD mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	1.9%	0.74 [0.53, 1.03]
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	0.8%	0.50 [0.30, 0.83]
Nurses' Health Study - Lin 2007	66,630	324	0.9%	0.90 [0.55, 1.46]
Linxian Nutrition - Wang 2016	2,445	355	2.9%	0.98 [0.74, 1.29]
PLSAW - Blekkenhorst 2017	1,226	128	1.4%	0.26 [0.18, 0.38]
Subtotal (95% CI)	**75,434**	**1,280**	**8.0%**	**0.67 [0.57, 0.79]**
Heterogeneity: Chi² = 32.86, df = 4 (P < 0.00001); I² = 88%				
Test for overall effect: Z = 4.80 (P < 0.00001)				
Carrots				
Oxford Vegetarian - Mann 1997 - carrots	10,802	64	0.4%	0.76 [0.37, 1.58]
Subtotal (95% CI)	**10,802**	**64**	**0.4%**	**0.76 [0.37, 1.58]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.73 (P = 0.47)				
Celery				
Iowa WHS - Mink 2007 - celery	34,492	1,329	11.5%	0.92 [0.80, 1.06]
Subtotal (95% CI)	**34,492**	**1,329**	**11.5%**	**0.92 [0.80, 1.06]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.14 (P = 0.25)				
Cruciferous				
Nurses' Health Study - Lin 2007	66,630	324	0.4%	0.65 [0.30, 1.42]
JACC - Iso 2007 - M	39,486	534	3.3%	0.75 [0.58, 0.97]
Iowa WHS - Mink 2007	34,492	1,329	15.6%	1.09 [0.97, 1.23]
JACC - Iso 2007 - F	54,325	396	2.2%	1.05 [0.77, 1.44]
Migrant Study - Hjartaker 2015	9,964	2,386	4.6%	1.23 [0.99, 1.53]
Linxian Nutrition - Wang 2016	2,445	355	2.2%	0.81 [0.59, 1.11]
PLSAW - Blekkenhorst 2017	1,226	128	2.5%	0.35 [0.26, 0.47]
Japan Public Health Center - Mori 2018 - M	40,642	1,192	4.6%	0.83 [0.67, 1.03]
Japan Public Health Center - Mori 2018 - F	47,562	776	3.3%	0.73 [0.57, 0.95]
Subtotal (95% CI)	**296,772**	**7,420**	**38.8%**	**0.91 [0.85, 0.98]**
Heterogeneity: Chi² = 65.50, df = 8 (P < 0.00001); I² = 88%				
Test for overall effect: Z = 2.45 (P = 0.01)				
Green leafy				
Oxford Vegetarian - Mann 1997	10,802	64	0.2%	1.34 [0.46, 3.85]
OXCHECK - Whiteman 1999	10,522	144	1.3%	0.63 [0.42, 0.95]
Health Food Shoppers - Appleby 2002	10,741	605	6.9%	0.85 [0.71, 1.02]
JACC - Iso 2007 - F	59,809	420	3.3%	0.85 [0.66, 1.10]
JACC - Iso 2007 - M	43,850	617	5.6%	0.87 [0.71, 1.06]
Migrant Study - Hjartaker 2015	9,964	2,386	6.9%	0.93 [0.78, 1.11]
Linxian Nutrition - Wang 2016	2,445	355	1.4%	0.72 [0.49, 1.06]
Subtotal (95% CI)	**148,133**	**4,591**	**25.7%**	**0.86 [0.78, 0.94]**
Heterogeneity: Chi² = 4.47, df = 6 (P = 0.61); I² = 0%				
Test for overall effect: Z = 3.25 (P = 0.001)				
Tomatoes				
JACC - Iso 2007 - tomatoes - F	56,947	379	2.9%	1.07 [0.82, 1.41]
JACC - Iso 2007 - tomatoes - M	41,547	568	4.6%	0.85 [0.69, 1.06]
Nurses' Health Study - Lin 2007	66,630	324	2.5%	0.90 [0.67, 1.20]
Migrant Study - Hjartaker 2015	9,964	2,386	5.6%	0.92 [0.76, 1.12]
Subtotal (95% CI)	**175,088**	**3,657**	**15.6%**	**0.92 [0.82, 1.04]**
Heterogeneity: Chi² = 1.72, df = 3 (P = 0.63); I² = 0%				
Test for overall effect: Z = 1.35 (P = 0.18)				
Test for subgroup differences: Chi² = 13.08, df = 5 (P = 0.02), I² = 61.8%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Finish Mobile Clinic Health - Knekt 1996 - M	2,748	324	3.6%	0.74 [0.53, 1.03]
Finish Mobile Clinic Health - Knekt 1996 - F	2,385	149	2.5%	0.50 [0.30, 0.83]
Nurses' Health Study - Lin 2007	66,630	324	2.6%	0.90 [0.55, 1.46]
Linxian Nutrition - Wang 2016	2,445	355	4.0%	0.98 [0.74, 1.29]
PLSAW - Blekkenhorst 2017	1,226	128	3.2%	0.26 [0.18, 0.38]
Subtotal (95% CI)	**75,434**	**1,280**	**15.8%**	**0.61 [0.38, 1.00]**
Heterogeneity: Tau² = 0.27; Chi² = 32.86, df = 4 (P < 0.00001); I² = 88%				
Test for overall effect: Z = 1.95 (P = 0.05)				
Carrots				
Oxford Vegetarian - Mann 1997 - carrots	10,802	64	1.6%	0.76 [0.37, 1.58]
Subtotal (95% CI)	**10,802**	**64**	**1.6%**	**0.76 [0.37, 1.58]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.73 (P = 0.47)				
Celery				
Iowa WHS - Mink 2007 - celery	34,492	1,329	5.0%	0.92 [0.80, 1.06]
Subtotal (95% CI)	**34,492**	**1,329**	**5.0%**	**0.92 [0.80, 1.06]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 1.14 (P = 0.25)				
Cruciferous				
JACC - Iso 2007 - M	39,486	534	4.2%	0.75 [0.58, 0.97]
Iowa WHS - Mink 2007	34,492	1,329	5.1%	1.09 [0.97, 1.23]
JACC - Iso 2007 - F	54,325	396	3.7%	1.05 [0.77, 1.44]
Nurses' Health Study - Lin 2007	66,630	324	1.4%	0.65 [0.30, 1.42]
Migrant Study - Hjartaker 2015	9,964	2,386	4.5%	1.23 [0.99, 1.53]
Linxian Nutrition - Wang 2016	2,445	355	3.7%	0.81 [0.59, 1.11]
PLSAW - Blekkenhorst 2017	1,226	128	3.9%	0.35 [0.26, 0.47]
Japan Public Health Center - Mori 2018 - F	47,562	776	4.2%	0.73 [0.57, 0.95]
Japan Public Health Center - Mori 2018 - M	40,642	1,192	4.5%	0.83 [0.67, 1.03]
Subtotal (95% CI)	**296,772**	**7,420**	**35.2%**	**0.81 [0.64, 1.02]**
Heterogeneity: Tau² = 0.11; Chi² = 65.50, df = 8 (P < 0.00001); I² = 88%				
Test for overall effect: Z = 1.79 (P = 0.07)				
Green leafy				
Oxford Vegetarian - Mann 1997	10,802	64	0.9%	1.34 [0.46, 3.85]
OXCHECK - Whiteman 1999	10,522	144	3.0%	0.63 [0.42, 0.95]
Health Food Shoppers - Appleby 2002	10,741	605	4.8%	0.85 [0.71, 1.02]
JACC - Iso 2007 - F	59,809	420	4.2%	0.85 [0.66, 1.10]
JACC - Iso 2007 - M	43,850	617	4.6%	0.87 [0.71, 1.06]
Migrant Study - Hjartaker 2015	9,964	2,386	4.8%	0.93 [0.78, 1.11]
Linxian Nutrition - Wang 2016	2,445	355	3.2%	0.72 [0.49, 1.06]
Subtotal (95% CI)	**148,133**	**4,591**	**25.4%**	**0.86 [0.78, 0.94]**
Heterogeneity: Tau² = 0.00; Chi² = 4.47, df = 6 (P = 0.61); I² = 0%				
Test for overall effect: Z = 3.25 (P = 0.001)				
Tomatoes				
Nurses' Health Study - Lin 2007	66,630	324	3.9%	0.90 [0.67, 1.20]
JACC - Iso 2007 - tomatoes - M	41,547	568	4.5%	0.85 [0.69, 1.06]
JACC - Iso 2007 - tomatoes - F	56,947	379	4.0%	1.07 [0.82, 1.41]
Migrant Study - Hjartaker 2015	9,964	2,386	4.6%	0.92 [0.76, 1.12]
Subtotal (95% CI)	**175,088**	**3,657**	**17.0%**	**0.92 [0.82, 1.04]**
Heterogeneity: Tau² = 0.00; Chi² = 1.72, df = 3 (P = 0.63); I² = 0%				
Test for overall effect: Z = 1.35 (P = 0.18)				
Test for subgroup differences: Chi² = 4.09, df = 5 (P = 0.54), I² = 0%				

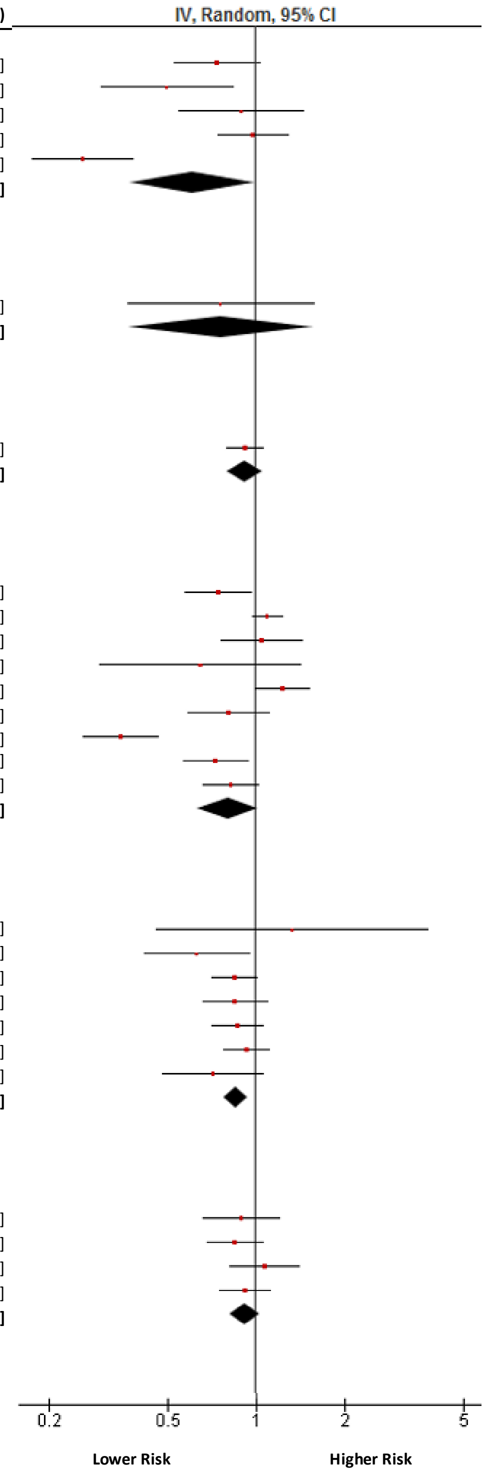


Figure S89. Relation between sources of vegetables and CHD mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

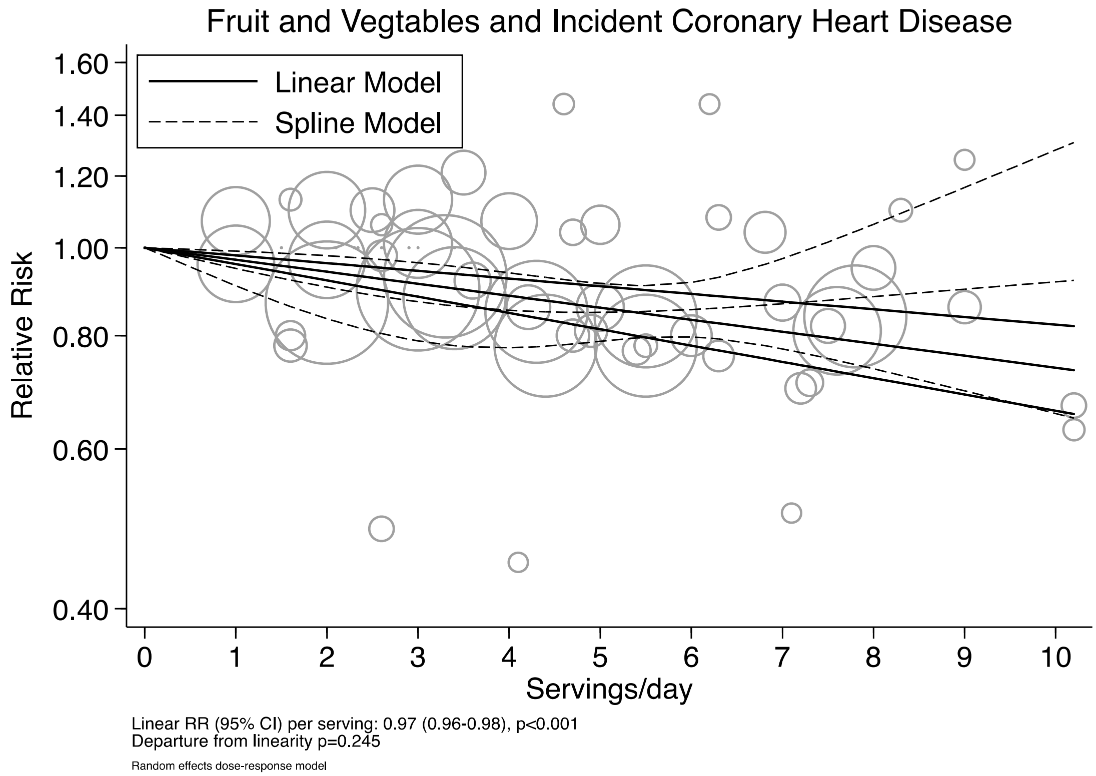


Figure S90. Linear and cubic-spline dose-response relation between increasing fruit and vegetable intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

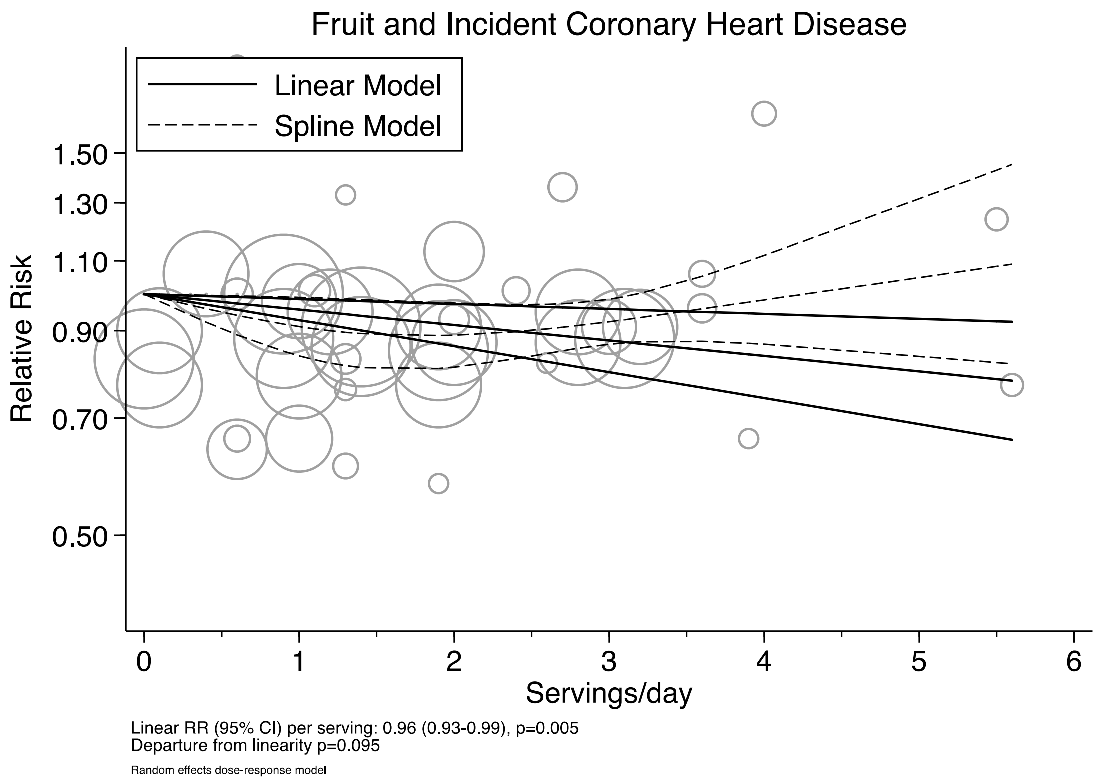


Figure S91. Linear and cubic-spline dose-response relation between increasing fruit intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

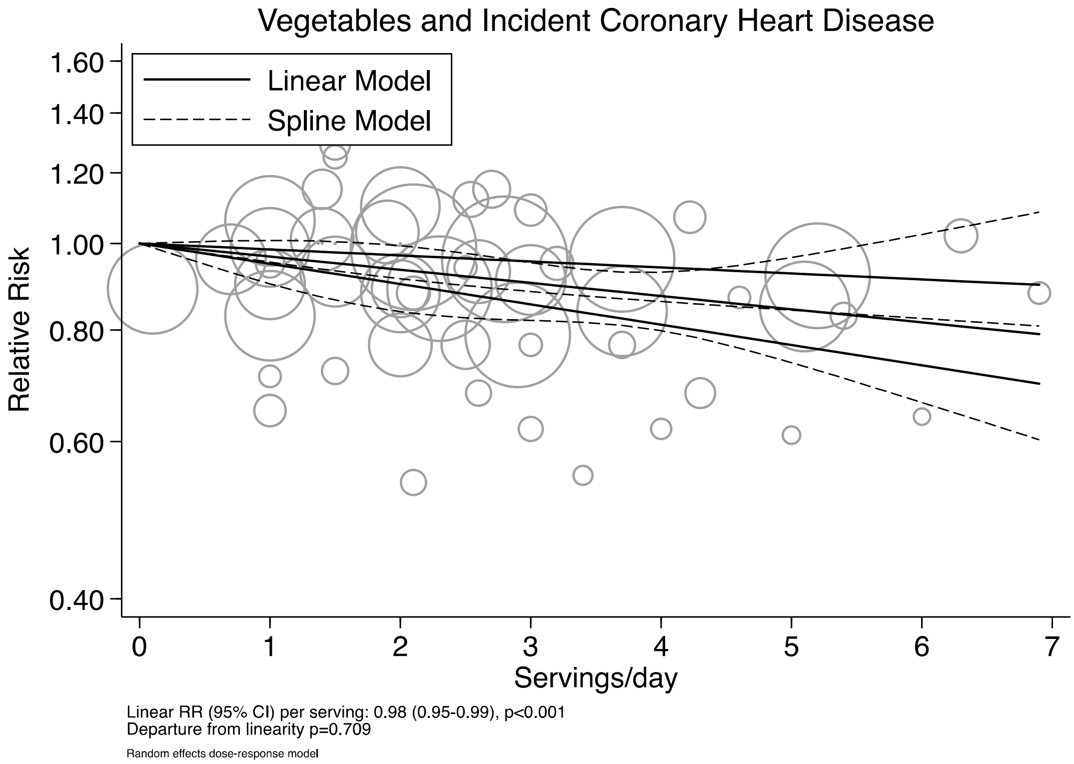


Figure S92. Linear and cubic-spline dose-response relation between increasing intake of vegetables and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

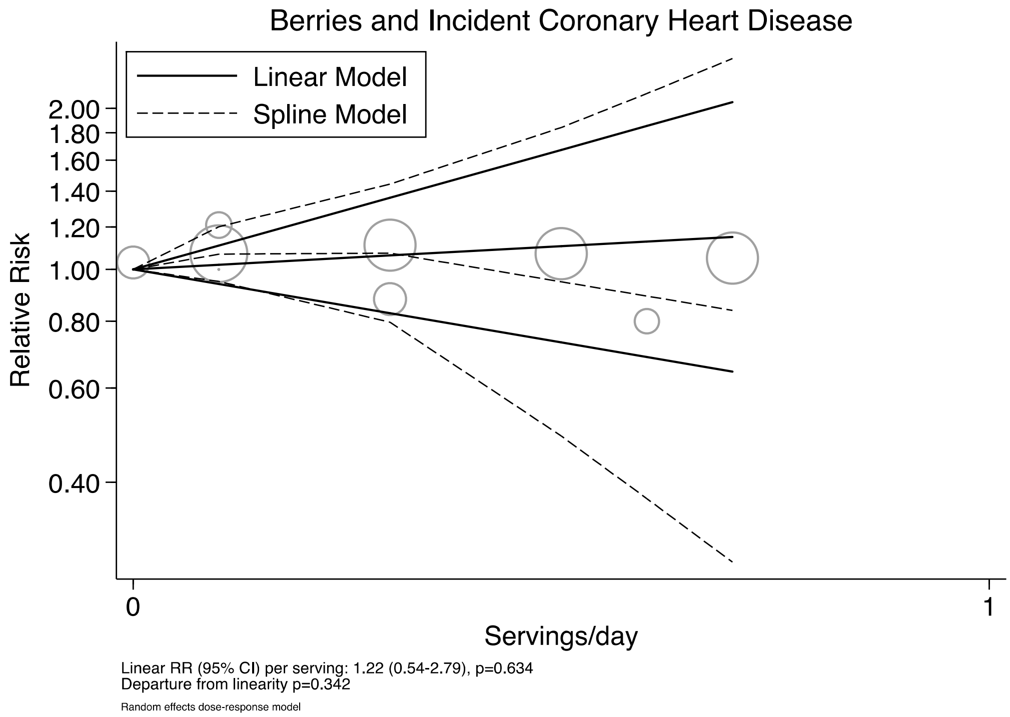


Figure S93. Linear and cubic-spline dose-response relation between increasing berries intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

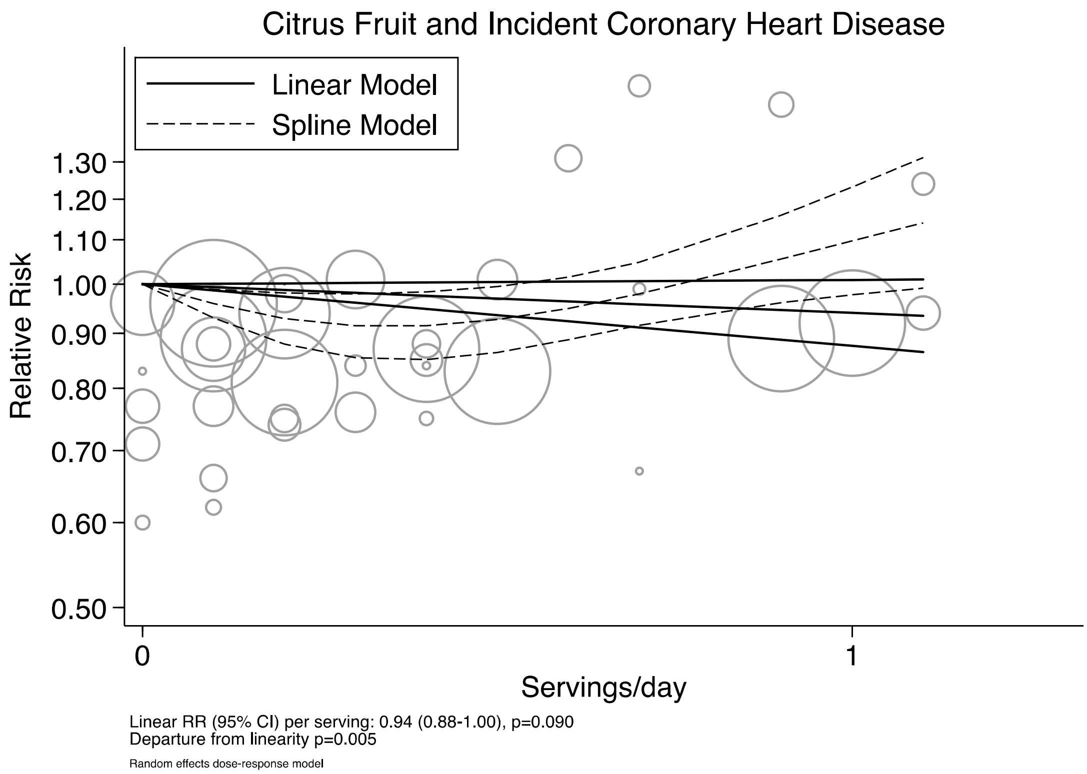


Figure S94. Linear and cubic-spline dose-response relation between increasing citrus fruit intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

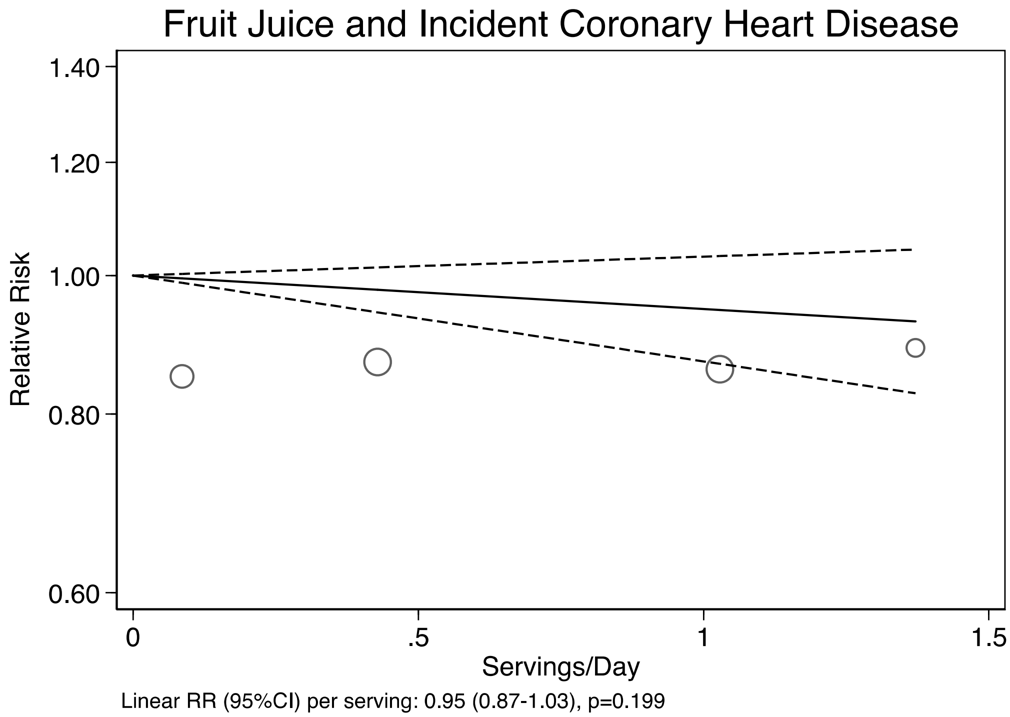


Figure S95. Linear and cubic-spline dose-response relation between increasing fruit juice intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

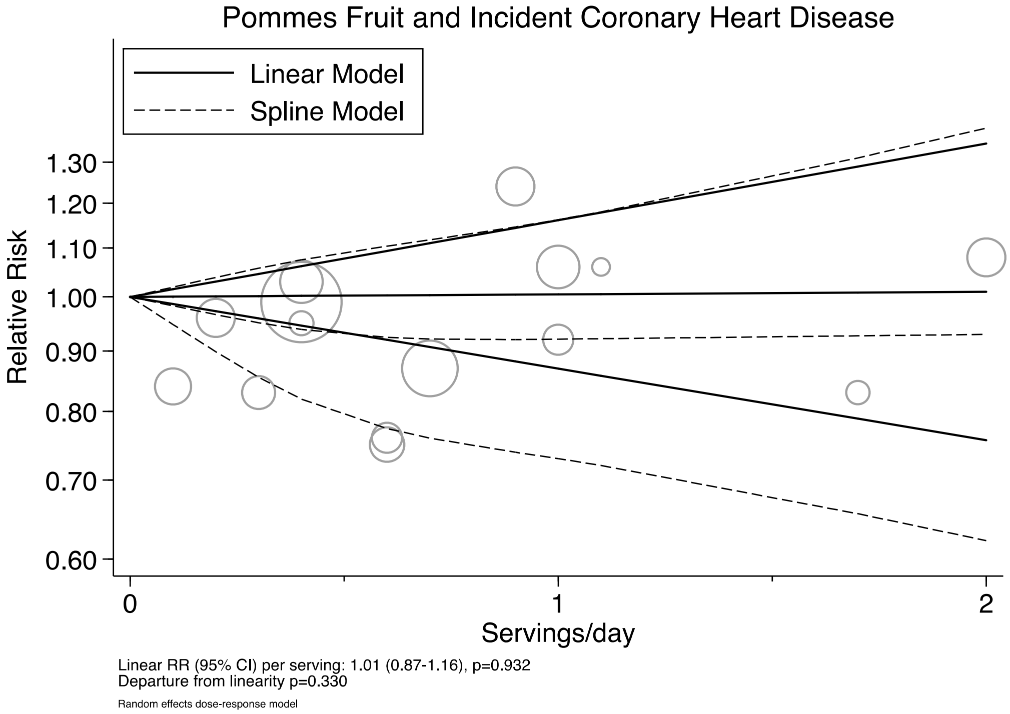


Figure S96. Linear and cubic-spline dose-response relation between increasing pommes intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

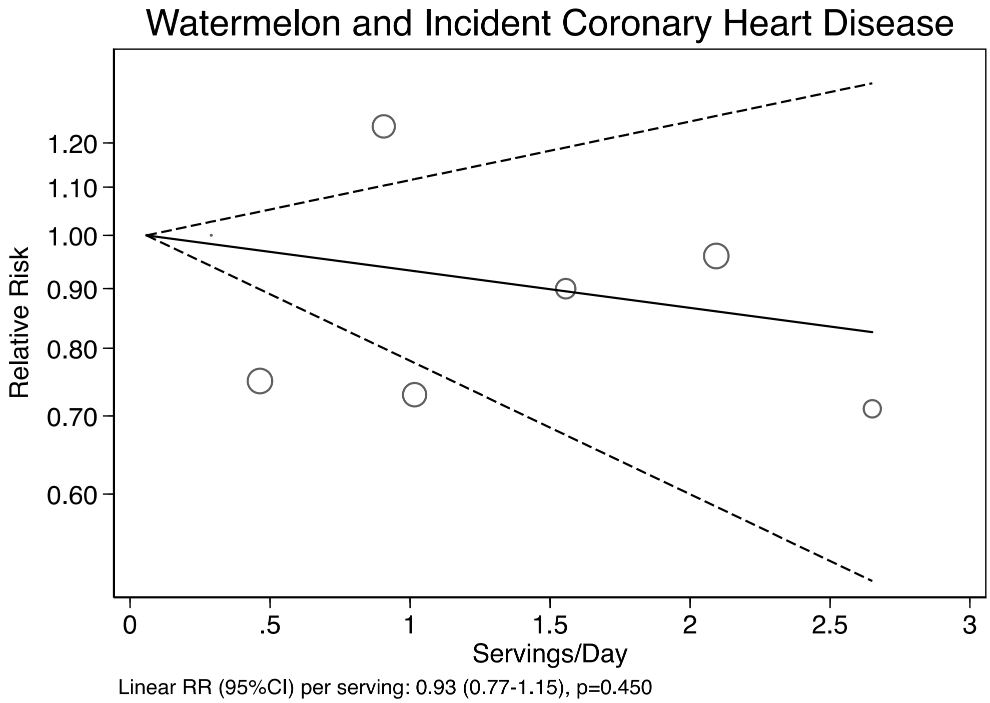


Figure S97. Linear dose-response relation between increasing watermelon intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

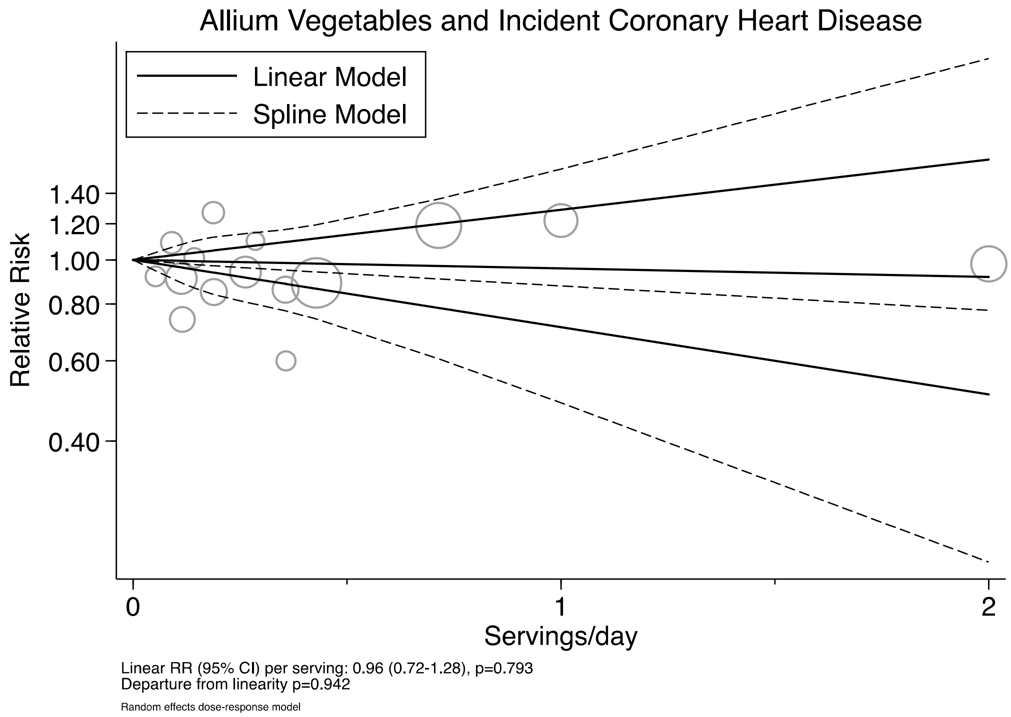


Figure S98. Linear and cubic-spline dose-response relation between increasing intake of allium vegetables and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

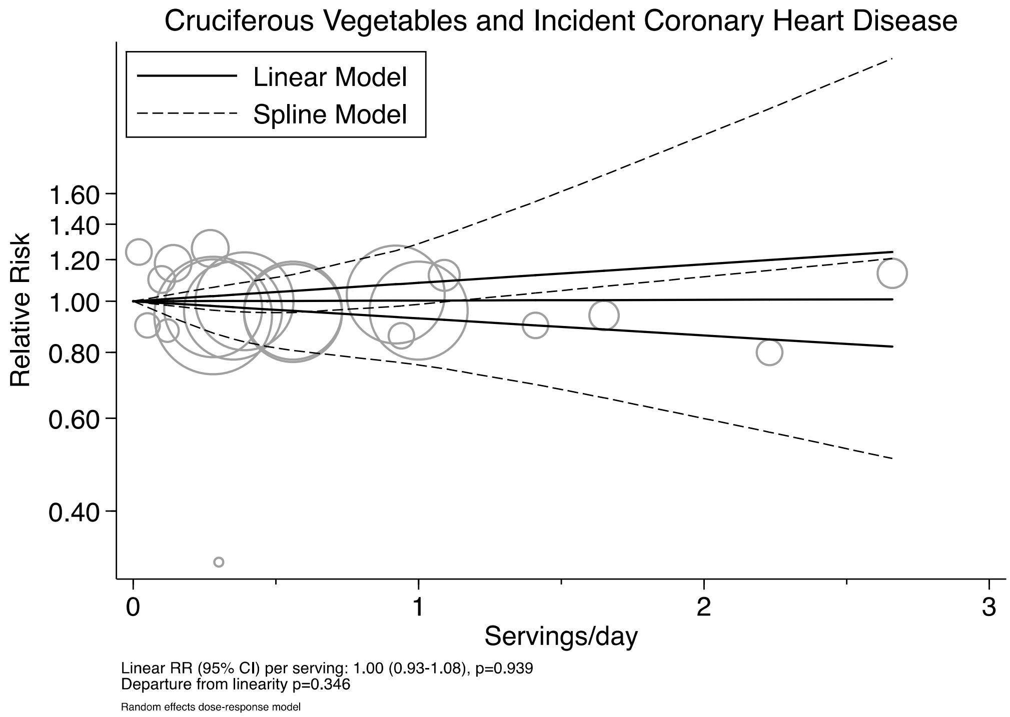


Figure S99. Linear and cubic-spline dose-response relation between increasing intake of cruciferous vegetables and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

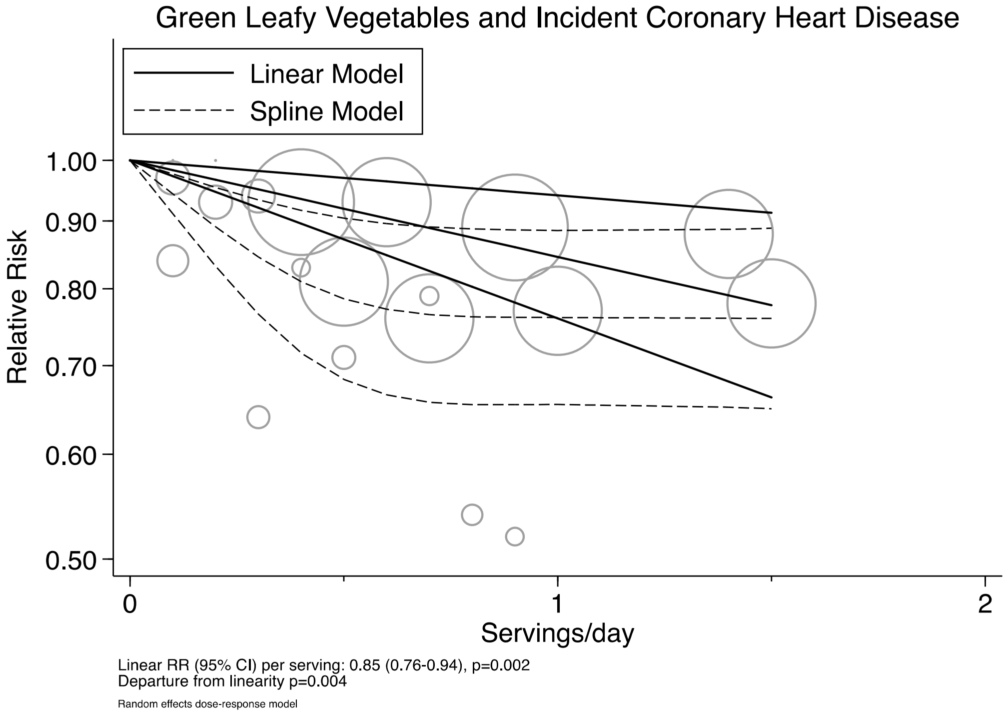


Figure S100. Linear and cubic-spline dose-response relation between increasing intake of green leafy vegetables and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

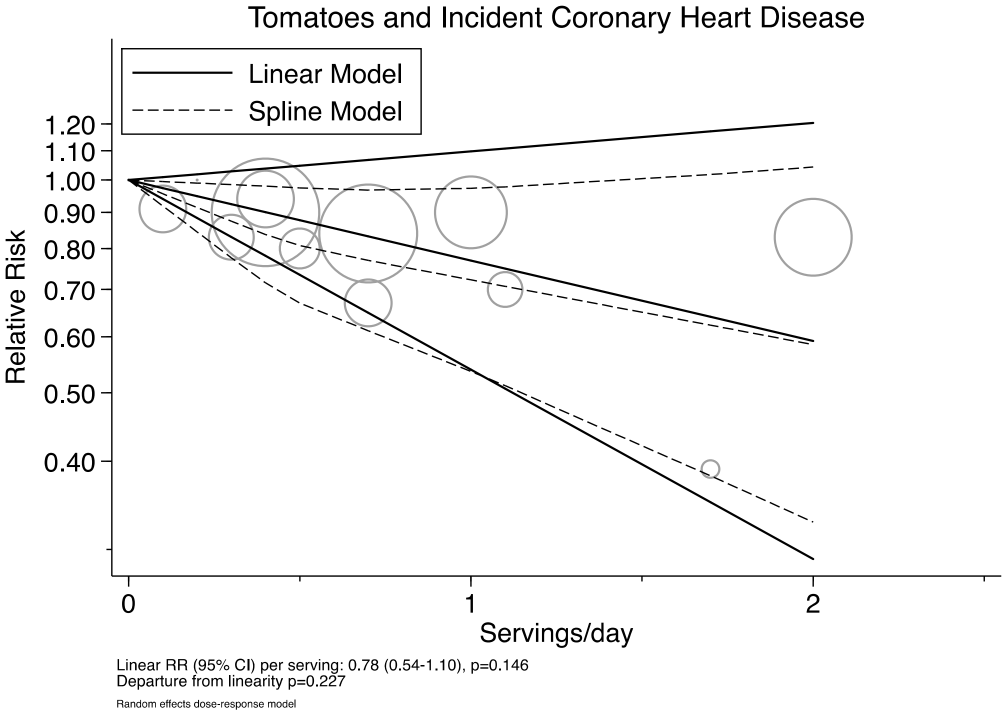


Figure S101. Linear and cubic-spline dose-response relation between increasing tomato intake and incidence of coronary heart disease. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

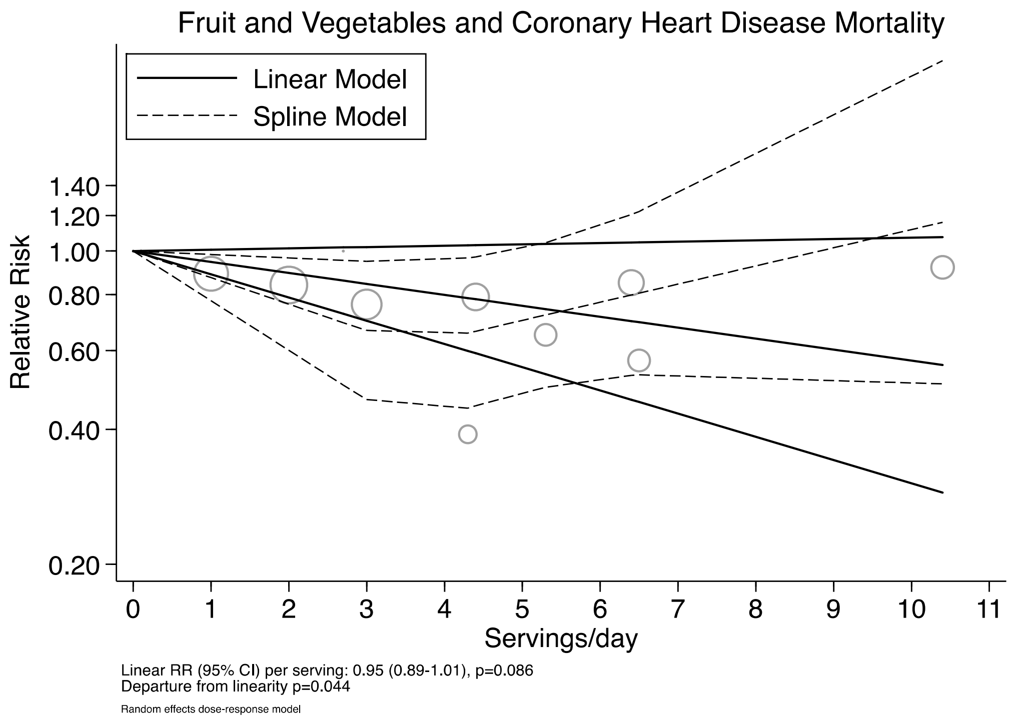


Figure S102. Linear and cubic-spline dose-response relation between increasing fruit and vegetable intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

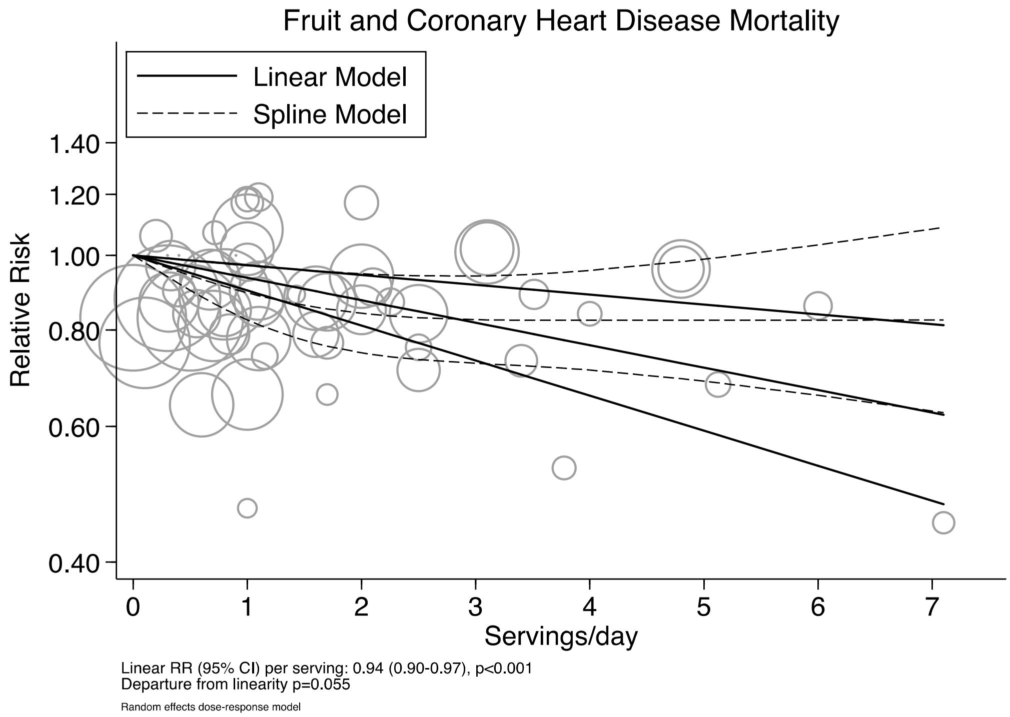


Figure S103. Linear and cubic-spline dose-response relation between increasing fruit intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

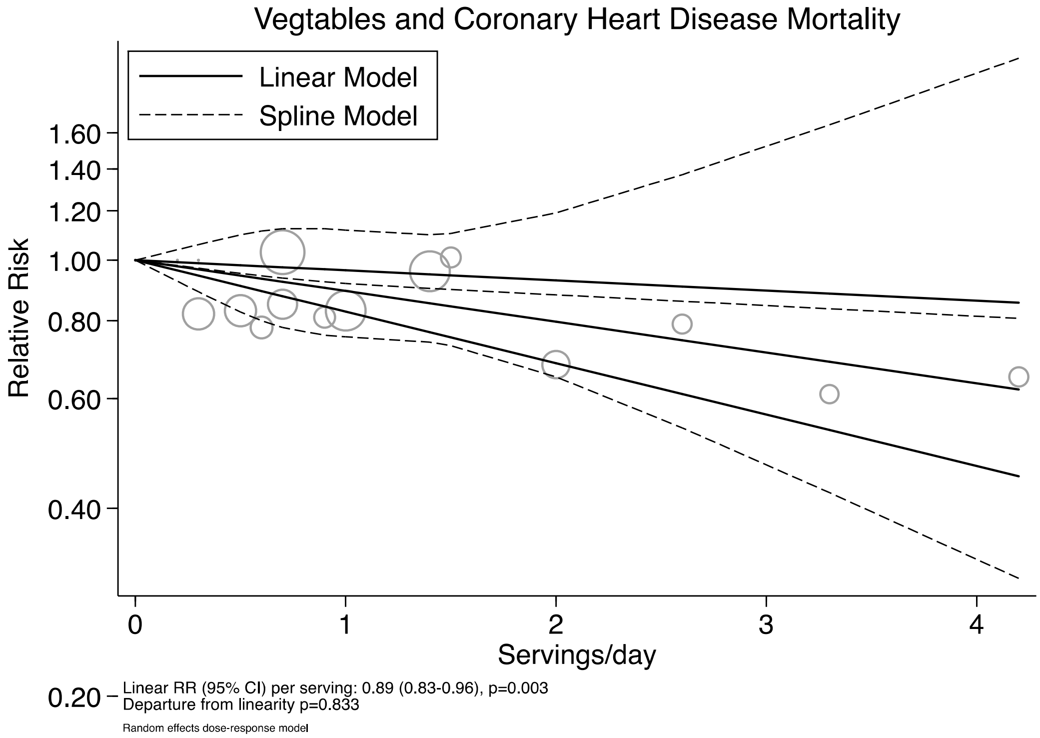


Figure S104. Linear and cubic-spline dose-response relation between increasing intake of vegetables and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

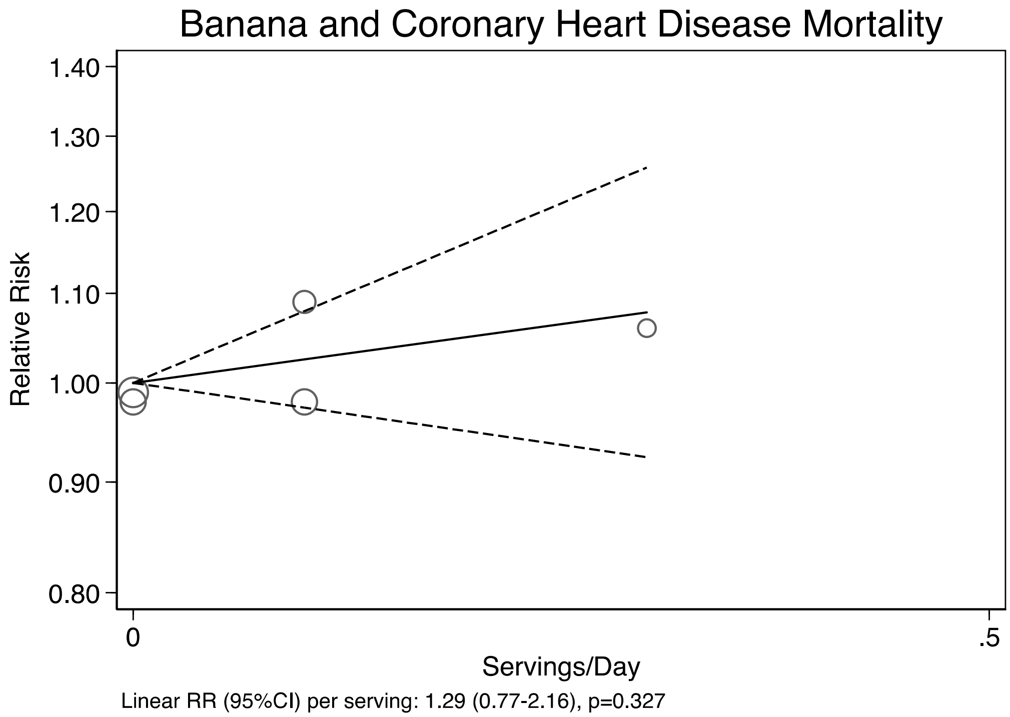


Figure S105. Linear dose-response relation between increasing banana intake and cardiovascular disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

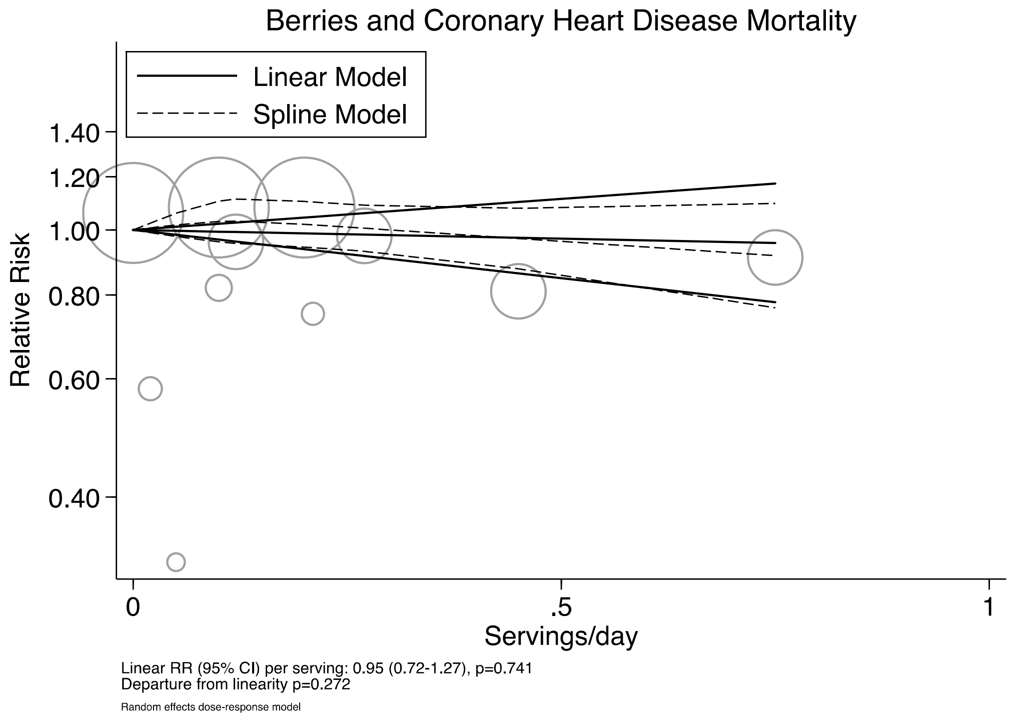


Figure S106. Linear dose-response relation between increasing berries intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

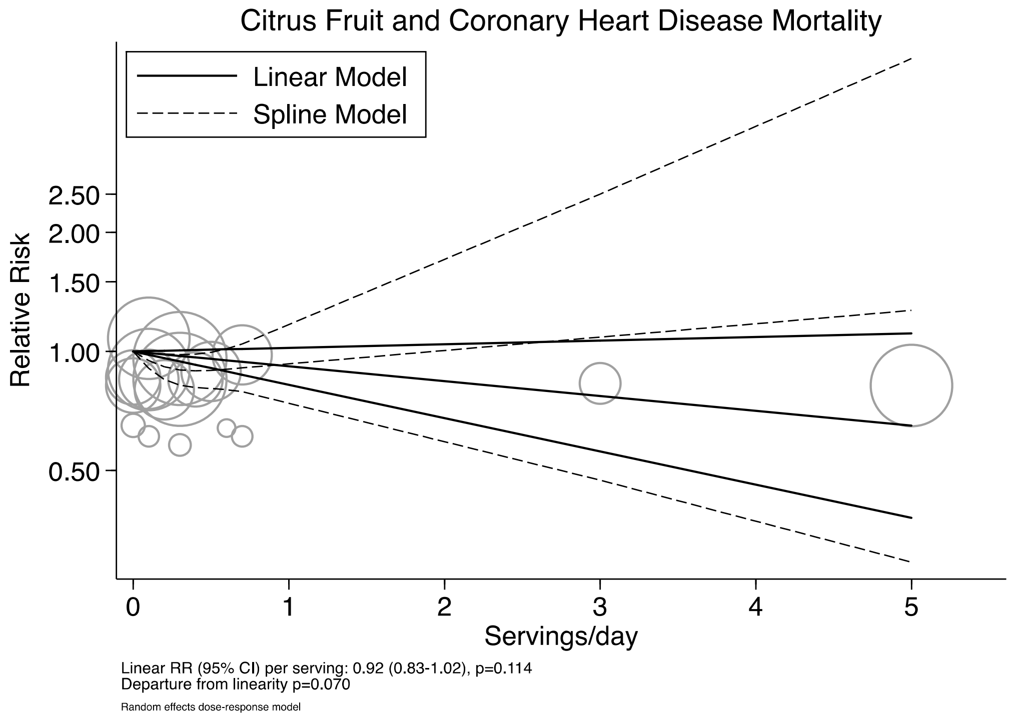


Figure S107. Linear and cubic-spline dose-response relation between increasing citrus fruit intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

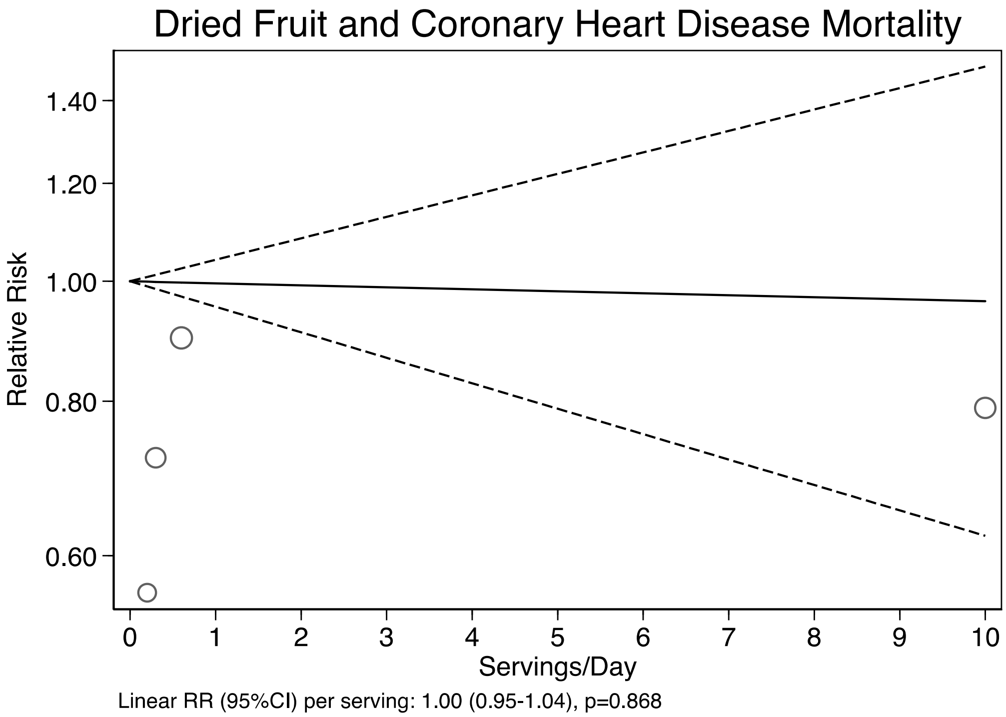


Figure S108. Linear and cubic-spline dose-response relation between increasing dried fruit intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

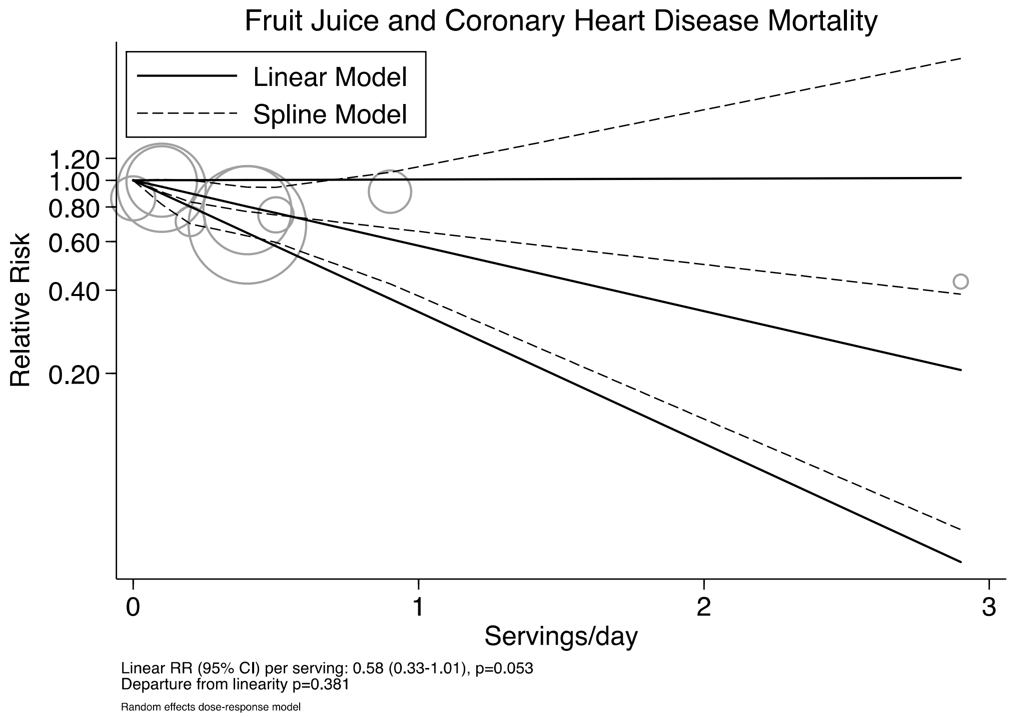


Figure S109. Linear and cubic-spline dose-response relation between increasing fruit juice intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

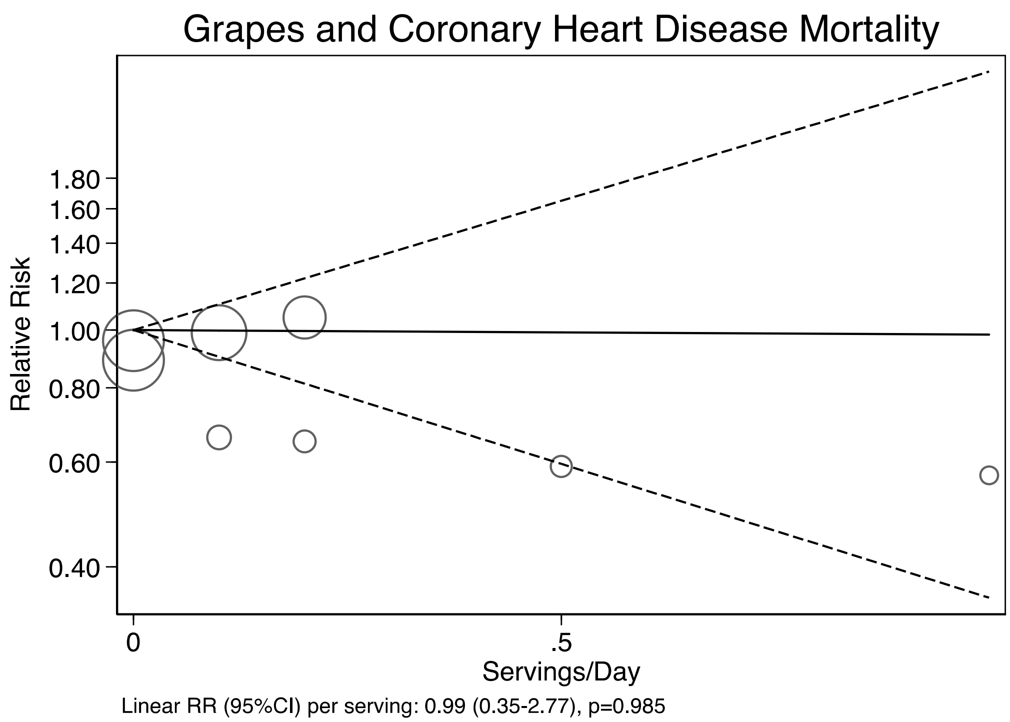


Figure S110. Linear dose-response relation between increasing grape intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

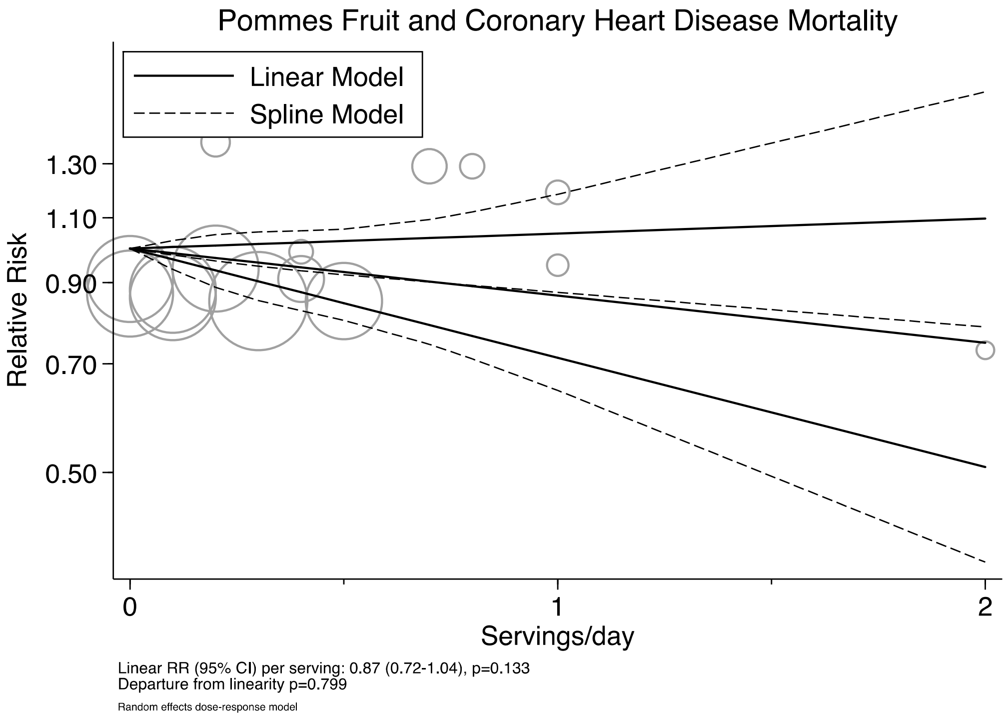


Figure S111. Linear and cubic-spline dose-response relation between increasing pommes intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

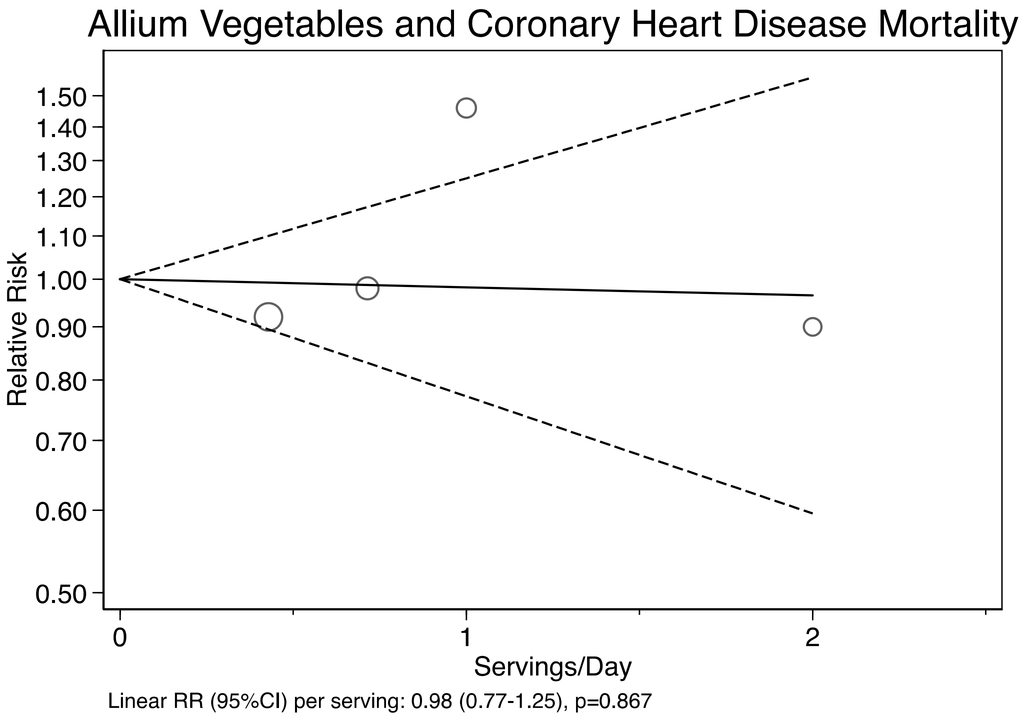


Figure S112. Linear dose-response relation between increasing intake of allium vegetables and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

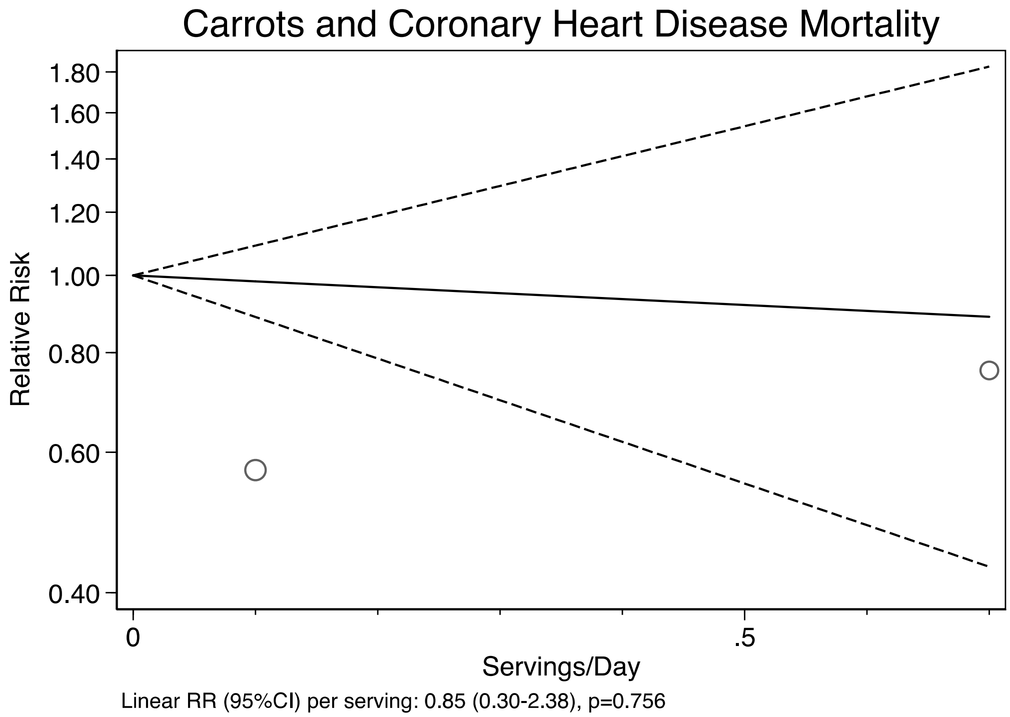


Figure S113. Linear dose-response relation between increasing intake of carrots and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

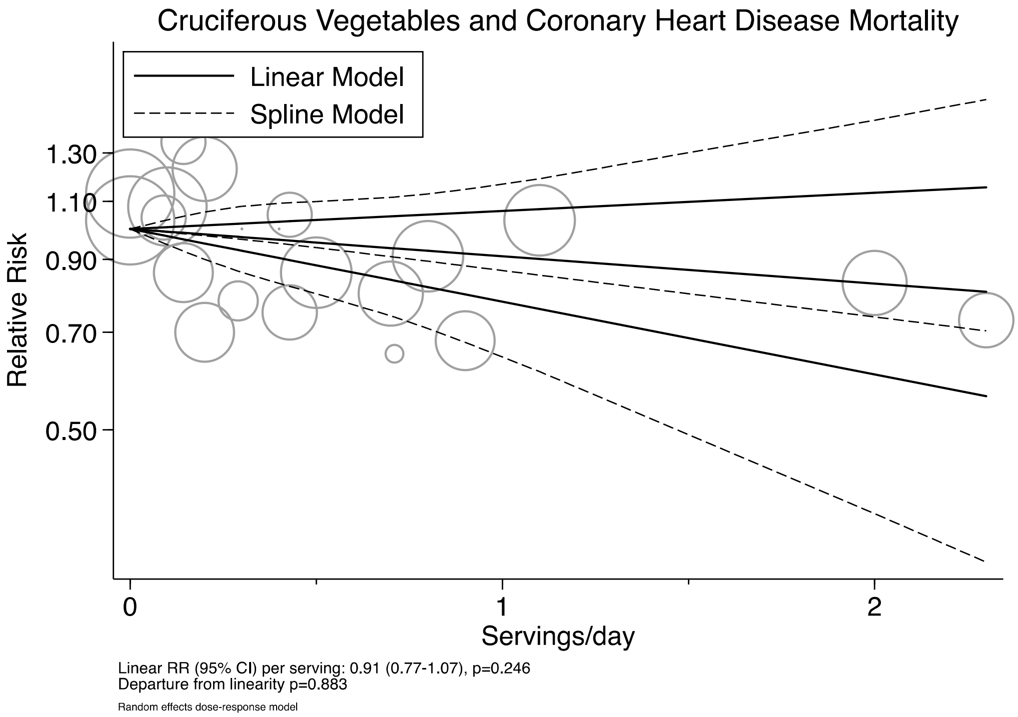


Figure S114. Linear and cubic-spline dose-response relation between increasing intake of cruciferous vegetables and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

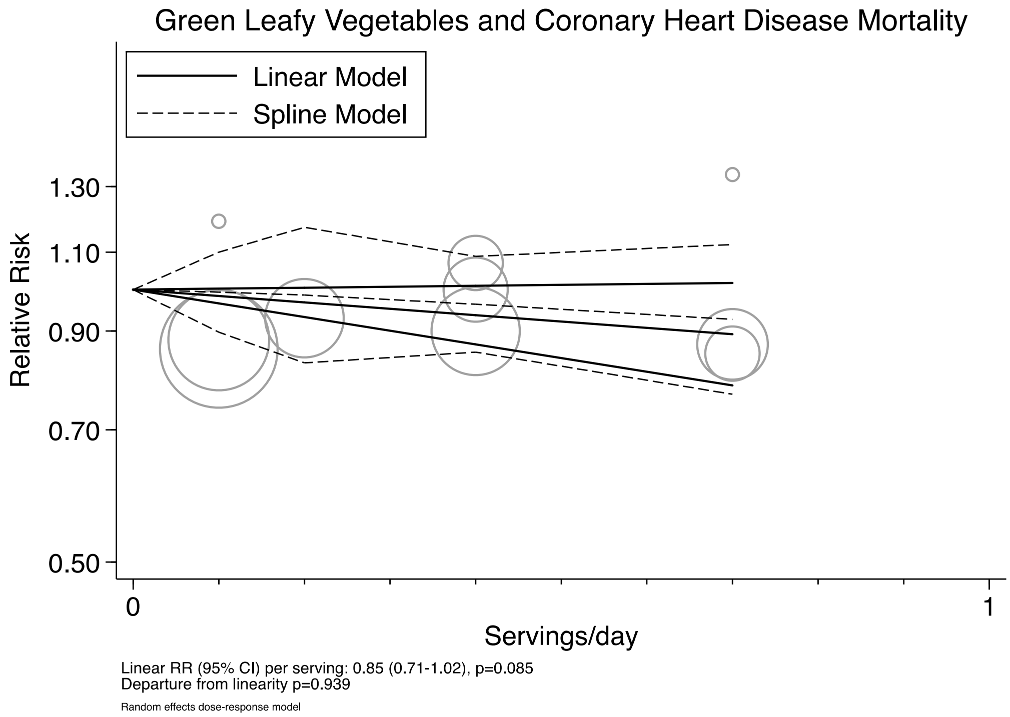


Figure S115. Linear dose-response relation between increasing intake of green leafy vegetables and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

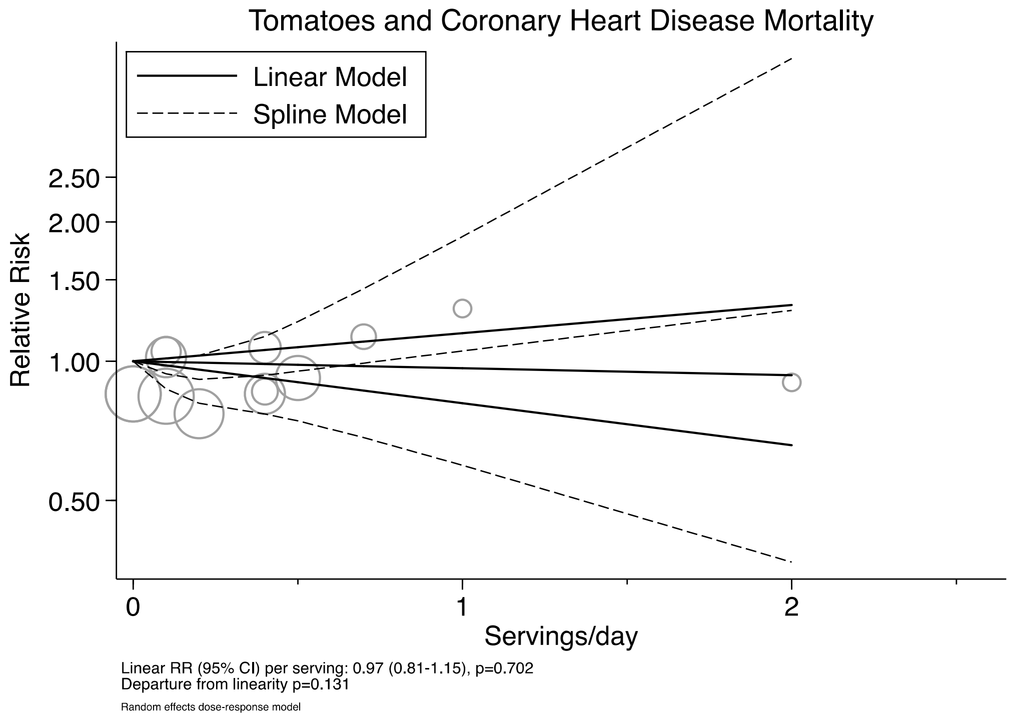


Figure S116. Linear dose-response relation between increasing tomato intake and coronary heart disease mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

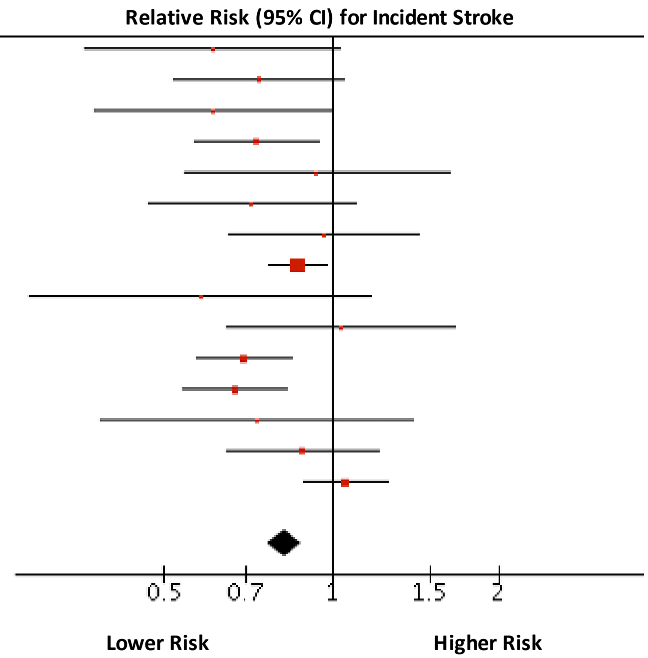
TOTAL FRUIT AND VEGETABLES AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	97	1.6%	0.61 [0.36, 1.04]
Nurses' Health Study - Joshipura 1999	75,596	204	3.7%	0.74 [0.52, 1.05]
HPFS - Joshipura 1999	38,683	336	1.9%	0.61 [0.38, 1.00]
National Health & Nutrition - Bazzano 2002	9,608	888	7.1%	0.73 [0.57, 0.95]
ARIC - Steffen 2003	11,940	214	1.5%	0.94 [0.54, 1.63]
Danish Diet Cancer Health - Johnsen 2003	54,506	266	2.5%	0.72 [0.47, 1.11]
MORGEN - Oude Griep 2011 (a)	20,069	233	3.0%	0.97 [0.66, 1.44]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	33.3%	0.87 [0.77, 0.98]
Japan Diabetes Complications Study - Tanaka 2013	1,414	68	0.9%	0.58 [0.29, 1.18]
Rotterdam - Bos 2014	3,750	545	2.1%	1.04 [0.65, 1.67]
CCHS - Manuel 2015 - F	44,776	842	12.0%	0.70 [0.57, 0.85]
CCHS - Manuel 2015 - M	37,483	709	9.9%	0.67 [0.54, 0.83]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.1%	0.73 [0.38, 1.40]
PURE - Miller 2017	135,335	2,234	4.7%	0.89 [0.65, 1.21]
Japan Public Health Centre - Yoshizaki 2019	16,498	197	14.8%	1.06 [0.89, 1.27]
Total (95% CI)	**532,667**	**11,091**	**100.0%**	**0.82 [0.77, 0.88]**

Heterogeneity: Chi² = 22.28, df = 14 (P = 0.07); I² = 37%

Test for overall effect: Z = 5.61 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	97	3.0%	0.61 [0.36, 1.04]
Nurses' Health Study - Joshipura 1999	75,596	204	5.8%	0.74 [0.52, 1.05]
HPFS - Joshipura 1999	38,683	336	3.5%	0.61 [0.38, 1.00]
National Health & Nutrition - Bazzano 2002	9,608	888	9.0%	0.73 [0.57, 0.95]
ARIC - Steffen 2003	11,940	214	2.9%	0.94 [0.54, 1.63]
Danish Diet Cancer Health - Johnsen 2003	54,506	266	4.3%	0.72 [0.47, 1.11]
MORGEN - Oude Griep 2011 (a)	20,069	233	5.0%	0.97 [0.66, 1.44]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	16.6%	0.87 [0.77, 0.98]
Japan Diabetes Complications Study - Tanaka 2013	1,414	68	1.8%	0.58 [0.29, 1.18]
Rotterdam - Bos 2014	3,750	545	3.7%	1.04 [0.65, 1.67]
CCHS - Manuel 2015 - F	44,776	842	11.8%	0.70 [0.57, 0.85]
CCHS - Manuel 2015 - M	37,483	709	10.7%	0.67 [0.54, 0.83]
PREDIMED- Buil-Cosiales 2016	7,216	169	2.1%	0.73 [0.38, 1.40]
PURE - Miller 2017	135,335	2,234	6.9%	0.89 [0.65, 1.21]
Japan Public Health Centre - Yoshizaki 2019	16,498	197	12.9%	1.06 [0.89, 1.27]
Total (95% CI) [Random Effects]	**532,667**	**11,091**	**100.0%**	**0.80 [0.73, 0.89]**

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 22.28$, df = 14 (P = 0.07); $I^2 = 37\%$

Test for overall effect: Z = 4.30 (P < 0.0001)

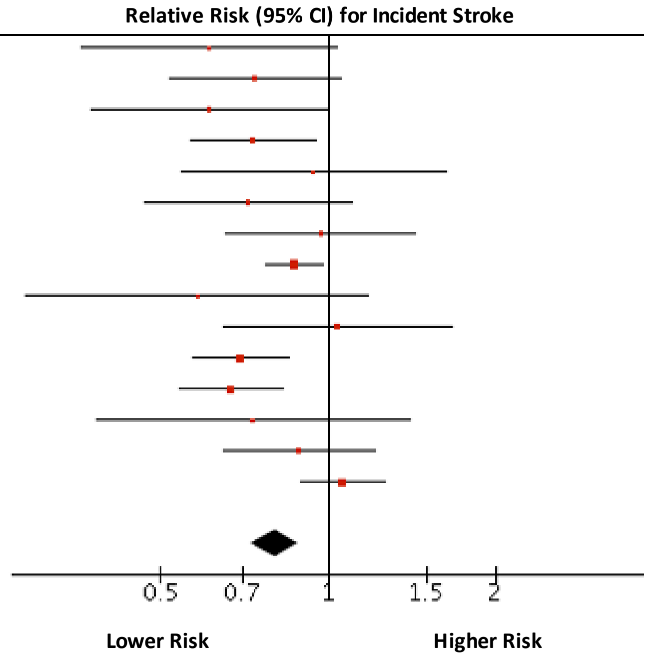


Figure S117. Relation between total fruit and vegetables intake and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

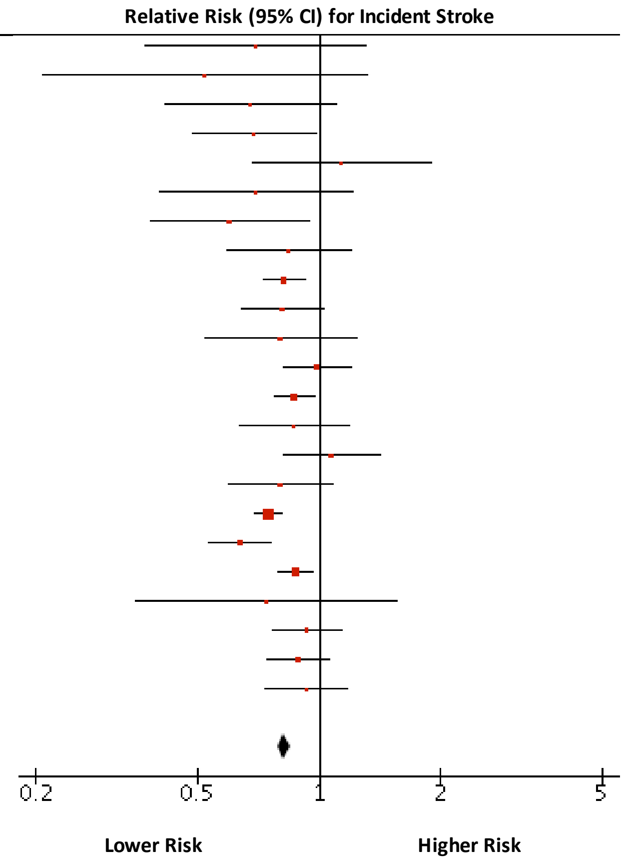
FRUIT AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	97	0.4%	0.70 [0.37, 1.31]
Zutphen Elderly Study - Keli 1996	552	42	0.2%	0.52 [0.21, 1.31]
HPFS - Joshipura 1999	38,683	366	0.6%	0.68 [0.41, 1.11]
Nurses' Health Study - Joshipura 1999	75,596	204	1.3%	0.69 [0.49, 0.98]
Shibata Study - Yokoyama 2000 - M	880	91	0.6%	1.14 [0.68, 1.90]
Shibata Study - Yokoyama 2000 - F	1,241	105	0.5%	0.70 [0.40, 1.21]
Danish Diet Cancer Health - Johnsen 2003	54,506	266	0.8%	0.60 [0.38, 0.94]
ATBC - Larsson 2009 - intracerebral hemorrhage	26,556	383	1.3%	0.84 [0.59, 1.20]
ATBC - Larsson 2009 - cerebral infraction	-	2,702	11.3%	0.82 [0.73, 0.92]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	2.8%	0.81 [0.64, 1.03]
ATBC - Larsson 2009 - subarachnoid hemorrhage	-	196	0.8%	0.80 [0.52, 1.24]
MONICA Finland - Zhang 2011 (b)	36,686	1,478	4.1%	0.99 [0.81, 1.20]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	11.3%	0.87 [0.77, 0.98]
MONICA Danish - Tognon 2014	1,849	167	1.6%	0.87 [0.64, 1.19]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	2.1%	1.07 [0.82, 1.41]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	1.8%	0.80 [0.60, 1.08]
China Kadoorie Biobank - Du 2016 - ischemic stroke	451,665	3,523	25.3%	0.75 [0.69, 0.81]
China Kadoorie Biobank-Du 2016 -hemorrhagic stroke	-	14,579	5.0%	0.64 [0.53, 0.76]
China Kadoorie Biobank - Du 2016 - other	-	11,054	16.2%	0.88 [0.80, 0.97]
PREDIMED- Buil-Cosiales 2016	7,216	169	0.3%	0.74 [0.35, 1.56]
PURE - Miller 2017	135,335	2,234	4.1%	0.93 [0.77, 1.13]
Japan Public Health Centre - Yoshizaki 2019	16,498	197	5.0%	0.89 [0.74, 1.06]
EPIC NL and MORGEN - Scheffers 2019	34,560	1,135	2.8%	0.93 [0.74, 1.18]
Total (95% CI)	**987,993**	**43,702**	**100.0%**	**0.82 [0.79, 0.85]**

Heterogeneity: Chi² = 33.36, df = 22 (P = 0.06); I² = 34%

Test for overall effect: Z = 9.77 (P < 0.00001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	97	0.8%	0.70 [0.37, 1.31]
Zutphen Elderly Study - Keli 1996	552	42	0.4%	0.52 [0.21, 1.31]
HPFS - Joshipura 1999	38,683	366	1.3%	0.68 [0.41, 1.11]
Nurses' Health Study - Joshipura 1999	75,596	204	2.3%	0.69 [0.49, 0.98]
Shibata Study - Yokoyama 2000 - M	880	91	1.2%	1.14 [0.68, 1.90]
Shibata Study - Yokoyama 2000 - F	1,241	105	1.0%	0.70 [0.40, 1.21]
Danish Diet Cancer Health - Johnsen 2003	54,506	266	1.5%	0.60 [0.38, 0.94]
ATBC - Larsson 2009 - intracerebral hemorrhage	26,556	383	2.3%	0.84 [0.59, 1.20]
ATBC - Larsson 2009 - cerebral infraction	-	2,702	9.9%	0.82 [0.73, 0.92]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	4.5%	0.81 [0.64, 1.03]
ATBC - Larsson 2009 - subarachnoid hemorrhage	-	196	1.6%	0.80 [0.52, 1.24]
MONICA Finland - Zhang 2011 (b)	36,686	1,478	5.7%	0.99 [0.81, 1.20]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	9.9%	0.87 [0.77, 0.98]
MONICA Danish - Tognon 2014	1,849	167	2.8%	0.87 [0.64, 1.19]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	3.5%	1.07 [0.82, 1.41]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	3.2%	0.80 [0.60, 1.08]
China Kadoorie Biobank - Du 2016 - ischemic stroke	451,665	3,523	12.8%	0.75 [0.69, 0.81]
China Kadoorie Biobank-Du 2016 -hemorrhagic stroke	-	14,579	6.6%	0.64 [0.53, 0.76]
China Kadoorie Biobank - Du 2016 - other	-	11,054	11.3%	0.88 [0.80, 0.97]
PREDIMED- Buil-Cosiales 2016	7,216	169	0.6%	0.74 [0.35, 1.56]
PURE - Miller 2017	135,335	2,234	5.7%	0.93 [0.77, 1.13]
Japan Public Health Centre - Yoshizaki 2019	16,498	197	6.6%	0.89 [0.74, 1.06]
EPIC NL and MORGEN - Scheffers 2019	34,560	1,135	4.5%	0.93 [0.74, 1.18]
Total (95% CI) [Random Effects]	**987,993**	**43,702**	**100.0%**	**0.83 [0.78, 0.88]**

Heterogeneity: Tau² = 0.01; Chi² = 33.36, df = 22 (P = 0.06); I² = 34%

Test for overall effect: Z = 6.30 (P < 0.00001)

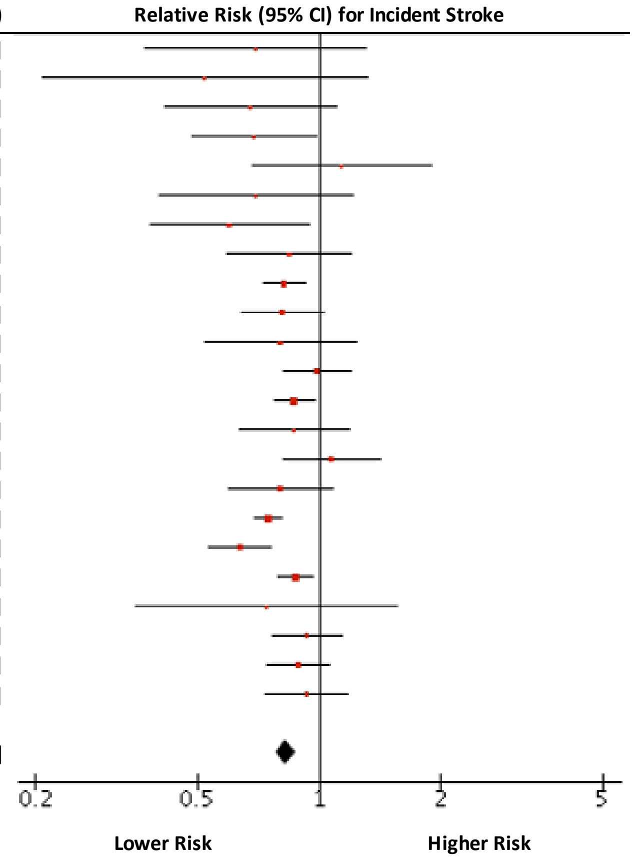


Figure S118. Relation between fruit intake and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

VEGETABLES AND STROKE INCIDENCE

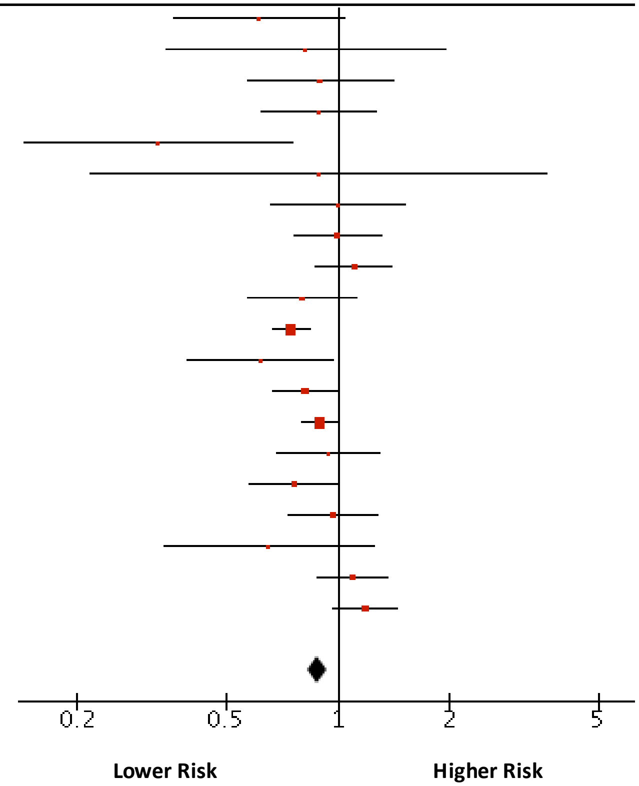
A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	97	1.1%	0.61 [0.36, 1.04]
Zutphen Elderly Study - Keli 1996	552	42	0.4%	0.82 [0.35, 1.94]
HPFS - Joshipura 1999	38,683	336	1.5%	0.90 [0.57, 1.41]
Nurses' Health Study - Joshipura 1999	75,596	204	2.4%	0.89 [0.62, 1.26]
Shibata Study - Yokoyama 2000 - M	880	91	0.4%	0.33 [0.14, 0.75]
Shibata Study - Yokoyama 2000 - F	1,241	105	0.2%	0.89 [0.22, 3.64]
Danish Diet Cancer Health - Johnsen 2003	54,506	266	1.8%	1.00 [0.66, 1.51]
Miyako Study - Pham 2007	9,651	226	4.0%	1.00 [0.76, 1.32]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	5.5%	1.11 [0.87, 1.40]
ATBC - Larsson 2009 - intracerebral hemorrhage	26,556	383	2.7%	0.80 [0.58, 1.12]
ATBC - Larsson 2009 - cerebral infraction	26,556	2,702	22.0%	0.75 [0.67, 0.84]
ATBC - Larsson 2009 - subarachnoid hemorrhage	26,556	196	1.5%	0.62 [0.39, 0.97]
MONICA Finland - Zhang 2011 (b)	36,686	1,478	7.9%	0.82 [0.67, 1.00]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	22.0%	0.90 [0.80, 1.01]
MONICA Danish - Tognon 2014	1,849	167	3.1%	0.94 [0.69, 1.29]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	4.0%	0.76 [0.58, 1.00]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	4.0%	0.97 [0.74, 1.28]
PREDIMED- Buil-Cosiales 2016	7,216	169	0.7%	0.65 [0.34, 1.24]
PURE - Miller 2017	135,335	2,234	6.6%	1.09 [0.88, 1.36]
Japan Public Health Centre - Yoshizaki 2019	16,498	197	7.9%	1.19 [0.97, 1.44]
Total (95% CI)	**564,531**	**13,607**	**100.0%**	**0.88 [0.83, 0.93]**

Heterogeneity: Chi² = 37.99, df = 19 (P = 0.006); I² = 50%

Test for overall effect: Z = 4.45 (P < 0.00001)

Relative Risk (95% CI) for Incident Stroke



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	97	2.4%	0.61 [0.36, 1.04]
Zutphen Elderly Study - Keli 1996	552	42	1.0%	0.82 [0.35, 1.94]
HPFS - Joshipura 1999	38,683	336	3.1%	0.90 [0.57, 1.41]
Nurses' Health Study - Joshipura 1999	75,596	204	4.4%	0.89 [0.62, 1.26]
Shibata Study - Yokoyama 2000 - M	880	91	1.1%	0.33 [0.14, 0.75]
Shibata Study - Yokoyama 2000 - F	1,241	105	0.4%	0.89 [0.22, 3.64]
Danish Diet Cancer Health - Johnsen 2003	54,506	266	3.6%	1.00 [0.66, 1.51]
Miyako Study - Pham 2007	9,651	226	5.9%	1.00 [0.76, 1.32]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	6.9%	1.11 [0.87, 1.40]
ATBC - Larsson 2009 - intracerebral hemorrhage	26,556	383	4.7%	0.80 [0.58, 1.12]
ATBC - Larsson 2009 - cerebral infraction	26,556	2,702	10.5%	0.75 [0.67, 0.84]
ATBC - Larsson 2009 - subarachnoid hemorrhage	26,556	196	3.1%	0.62 [0.39, 0.97]
MONICA Finland - Zhang 2011 (b)	36,686	1,478	8.0%	0.82 [0.67, 1.00]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	10.5%	0.90 [0.80, 1.01]
MONICA Danish - Tognon 2014	1,849	167	5.1%	0.94 [0.69, 1.29]
Malmo Diet Cancer Study- Sonestedt 2015 - F	16,397	-	5.9%	0.76 [0.58, 1.00]
Malmo Diet Cancer Study - Sonestedt 2015 - M	10,048	-	5.9%	0.97 [0.74, 1.28]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.7%	0.65 [0.34, 1.24]
PURE - Miller 2017	135,335	2,234	7.5%	1.09 [0.88, 1.36]
Japan Public Health Centre - Yoshizaki 2019	16,498	197	8.0%	1.19 [0.97, 1.44]
Total (95% CI) [Random Effects]	**564,531**	**13,607**	**100.0%**	**0.89 [0.81, 0.97]**

Heterogeneity: Tau² = 0.02; Chi² = 37.99, df = 19 (P = 0.006); I² = 50%

Test for overall effect: Z = 2.57 (P = 0.01)

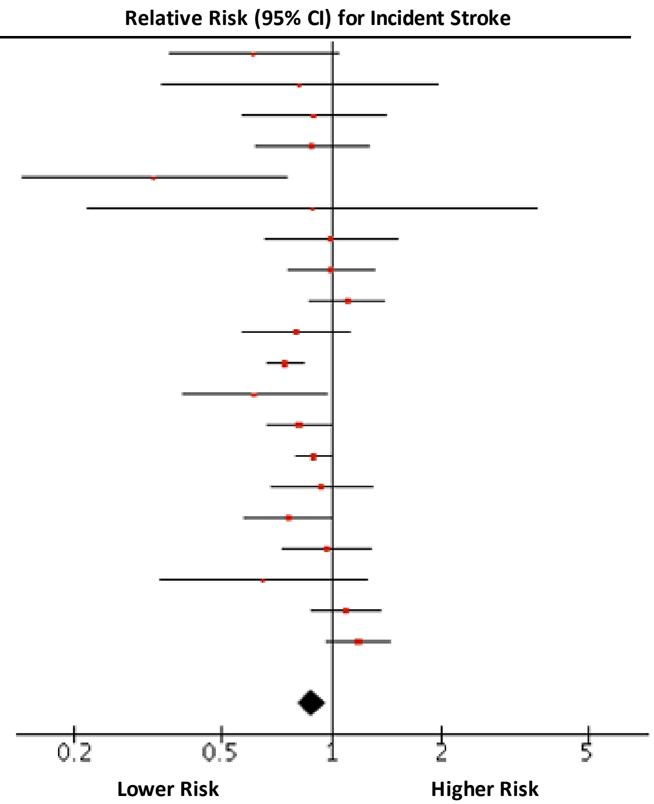


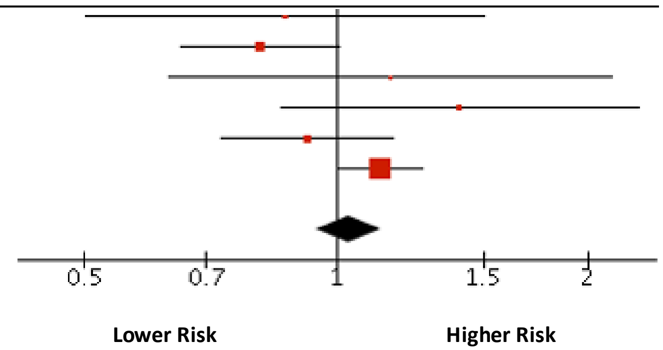
Figure S119. Relation between intake of vegetables and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BERRIES AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Incident Stroke
ATBC - Hirvonen 2000 - intracerebral hemorrage	26,593	95	2.7%	0.81 [0.65, 1.01]	
ATBC - Hirvonen 2000 - cerebral infarction	-	736	17.6%	1.16 [0.63, 2.13]	
ATBC - Hirvonen 2000 - subarachnoid hemorrage	-	83	2.2%	0.87 [0.50, 1.50]	
WHS - Sesso 2007	38,176	339	3.4%	1.40 [0.86, 2.29]	
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	14.8%	0.92 [0.73, 1.17]	
Swedish Mammography & Men - Larsson 2013	74,961	4,089	59.2%	1.13 [1.00, 1.27]	
Total (95% CI)	**143,662**	**5,967**	**100.0%**	**1.03 [0.94, 1.13]**	

Heterogeneity: Chi² = 9.90, df = 5 (P = 0.08); I² = 50%
Test for overall effect: Z = 0.72 (P = 0.47)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Incident Stroke
ATBC - Hirvonen 2000 - cerebral infarction	26,593	736	23.40%	0.81 [0.65, 1.01]	
ATBC - Hirvonen 2000 - subarachnoid hemorrage	-	83	6.10%	1.16 [0.63, 2.13]	
ATBC - Hirvonen 2000 - intracerebral hemorrage	-	95	7.20%	0.87 [0.50, 1.50]	
WHS - Sesso 2007	38,176	339	8.70%	1.40 [0.86, 2.29]	
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	21.70%	0.92 [0.73, 1.17]	
Swedish Mammography & Men - Larsson 2013	74,961	4,089	32.80%	1.13 [1.00, 1.27]	
Total (95% CI) [Random Effects]	**143,662**	**5,967**	**100.0%**	**1.00 [0.85, 1.18]**	

Heterogeneity: Tau² = 0.02; Chi² = 9.90, df = 5 (P = 0.08); I² = 50%
Test for overall effect: Z = 0.02 (P = 0.99)

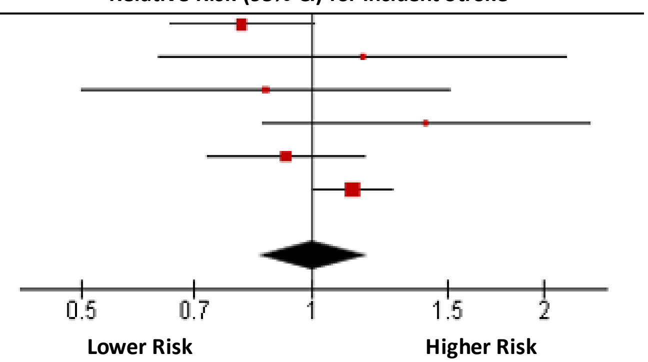


Figure S120. Relation between intake of berries and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

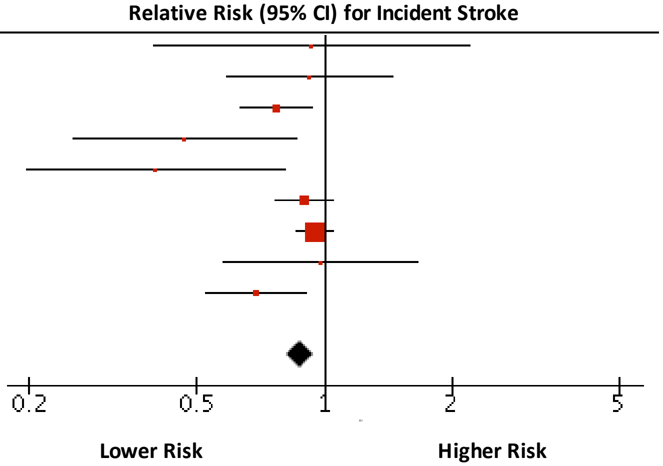
CITRUS FRUIT AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Zutphen Elderly Study - Keli 1996	552	42	0.7%	0.93 [0.39, 2.21]
HPFS - Joshipura 1999	38,683	366	2.5%	0.92 [0.59, 1.45]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	13.1%	0.77 [0.63, 0.94]
Jidni Medical School - Yamada 2011 - F	6,476	183	1.4%	0.47 [0.25, 0.86]
Jidni Medical School - Yamada 2011 - M	4,147	201	1.0%	0.40 [0.20, 0.81]
Nurses' Health Study - Cassidy 2012	69,622	943	20.5%	0.90 [0.77, 1.05]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	52.4%	0.95 [0.86, 1.05]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.8%	0.98 [0.58, 1.66]
REGARDS - Goetz 2016 (b)	20,024	524	6.7%	0.69 [0.52, 0.91]
Total (95% CI)	**225,613**	**7,142**	**100.0%**	**0.88 [0.82, 0.94]**

Heterogeneity: Chi² = 16.43, df = 8 (P = 0.04); I² = 51%

Test for overall effect: Z = 3.59 (P = 0.0003)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Zutphen Elderly Study - Keli 1996	552	42	2.3%	0.93 [0.39, 2.21]
HPFS - Joshipura 1999	38,683	366	7.0%	0.92 [0.59, 1.45]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	18.1%	0.77 [0.63, 0.94]
Jidni Medical School - Yamada 2011 - M	4,147	201	3.3%	0.40 [0.20, 0.81]
Jidni Medical School - Yamada 2011 - F	6,476	183	4.3%	0.47 [0.25, 0.86]
Nurses' Health Study - Cassidy 2012	69,622	943	21.0%	0.90 [0.77, 1.05]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	25.2%	0.95 [0.86, 1.05]
PREDIMED- Buil-Cosiales 2016	7,216	169	5.4%	0.98 [0.58, 1.66]
REGARDS - Goetz 2016 (b)	20,024	524	13.4%	0.69 [0.52, 0.91]
Total (95% CI) [Random Effects]	**225,613**	**7,142**	**100.0%**	**0.82 [0.71, 0.93]**

Heterogeneity: Tau² = 0.02; Chi² = 16.43, df = 8 (P = 0.04); I² = 51%

Test for overall effect: Z = 2.93 (P = 0.003)

Relative Risk (95% CI) for Incident Stroke

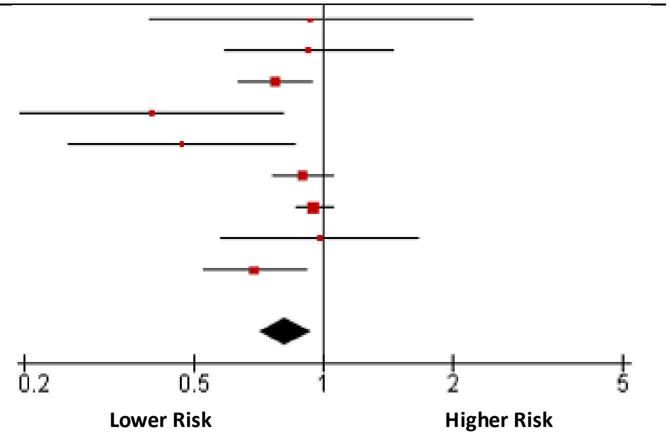


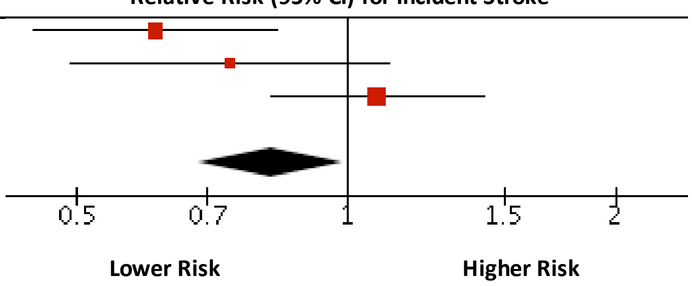
Figure S121. Relation between citrus fruit intake and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

FRUIT JUICE AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Joshipura 1999	75,596	204	34.6%	0.61 [0.45, 0.84]
HPFS - Joshipura 1999	38,683	366	20.1%	0.74 [0.49, 1.12]
EPIC NL and MORGEN - Scheffers 2019	34,560	1,135	45.2%	1.08 [0.82, 1.43]
Total (95% CI)	**148,839**	**1,705**	**100.0%**	**0.82 [0.68, 0.99]**

Heterogeneity: Chi² = 7.51, df = 2 (P = 0.02); I² = 73%
Test for overall effect: Z = 2.06 (P = 0.04)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Joshipura 1999	75,596	204	34.40%	0.61 [0.45, 0.84]
HPFS - Joshipura 1999	38,683	366	29.10%	0.74 [0.49, 1.12]
EPIC NL and MORGEN - Scheffers 2019	34,560	1,135	36.50%	1.08 [0.82, 1.43]
Total (95% CI) [Random Effects]	**148,839**	**1,705**	**100.0%**	**0.80 [0.55, 1.15]**

Heterogeneity: Tau² = 0.08; Chi² = 7.51, df = 2 (P = 0.02); I² = 73%
Test for overall effect: Z = 1.21 (P = 0.23)

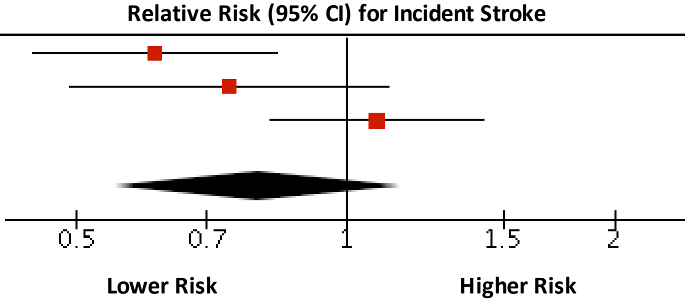


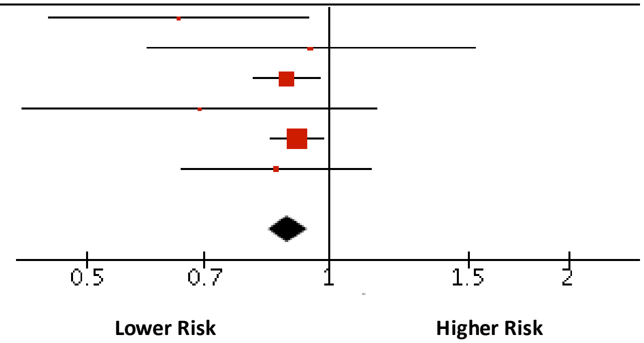
Figure S122. Relation between intake of fruit juice and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

POMMES AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health Exam - Knekt 2000 - M	9,208	445	2.4%	0.65 [0.45, 0.94]
Finish Mobile Clinic Health Exam - Knekt 2000 - F	-	378	1.5%	0.95 [0.59, 1.52]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	35.2%	0.89 [0.80, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.3%	0.69 [0.41, 1.15]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	55.0%	0.91 [0.85, 0.99]
NutriNet-Sante - Adriouch 2018	84,158	293	4.5%	0.86 [0.65, 1.13]
Total (95% CI)	**230,881**	**7,657**	**100.0%**	**0.89 [0.84, 0.95]**

Heterogeneity: Chi² = 4.25, df = 5 (P = 0.51); I² = 0%
Test for overall effect: Z = 3.86 (P = 0.0001)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health Exam - Knekt 2000 - M	9,208	445	2.4%	0.65 [0.45, 0.94]
Finish Mobile Clinic Health Exam - Knekt 2000 - F	-	378	1.5%	0.95 [0.59, 1.52]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	35.2%	0.89 [0.80, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.3%	0.69 [0.41, 1.15]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	55.0%	0.91 [0.85, 0.99]
NutriNet-Sante - Adriouch 2018	84,158	293	4.5%	0.86 [0.65, 1.13]
Total (95% CI) [Random Effects]	**230,881**	**7,657**	**100.0%**	**0.89 [0.84, 0.95]**

Heterogeneity: Tau² = 0.00; Chi² = 4.25, df = 5 (P = 0.51); I² = 0%
Test for overall effect: Z = 3.86 (P = 0.0001)

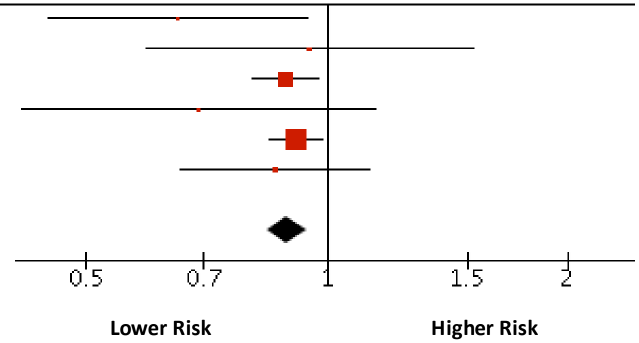


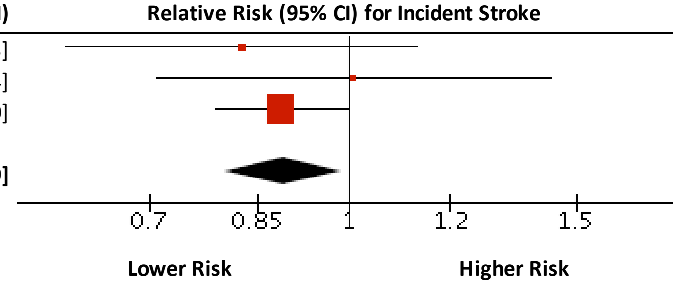
Figure S123. Relation between intake of pommes fruit and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi²) at a significance level of p<0.10, and quantified by I², with values ≥ 50% indicating substantial heterogeneity.

ALLIUM VEGETABLES AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health Exam - Knekt 2000 - M	9,208	445	11.2%	0.83 [0.60, 1.13]
Finish Mobile Clinic Health Exam - Knekt 2000 - F	-	378	8.9%	1.01 [0.71, 1.44]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	79.9%	0.89 [0.79, 1.00]
Total (95% CI)	**84,169**	**4,912**	**100.0%**	**0.89 [0.80, 0.99]**

Heterogeneity: Chi² = 0.71, df = 2 (P = 0.70); I² = 0%
Test for overall effect: Z = 2.17 (P = 0.03)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Finish Mobile Clinic Health Exam - Knekt 2000 - M	9,208	445	11.2%	0.83 [0.60, 1.13]
Finish Mobile Clinic Health Exam - Knekt 2000 - F	-	378	8.9%	1.01 [0.71, 1.44]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	79.9%	0.89 [0.79, 1.00]
Total (95% CI) [Random Effects]	**84,169**	**4,912**	**100.0%**	**0.89 [0.80, 0.99]**

Heterogeneity: Tau² = 0.00; Chi² = 0.71, df = 2 (P = 0.70); I² = 0%
Test for overall effect: Z = 2.17 (P = 0.03)

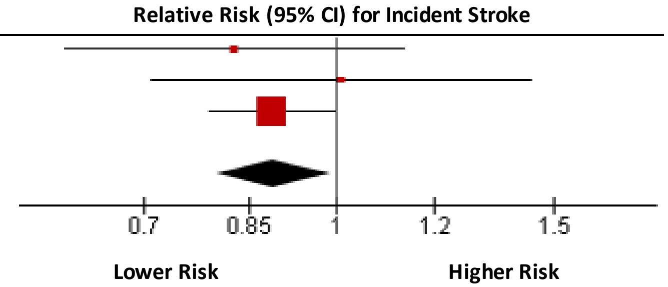


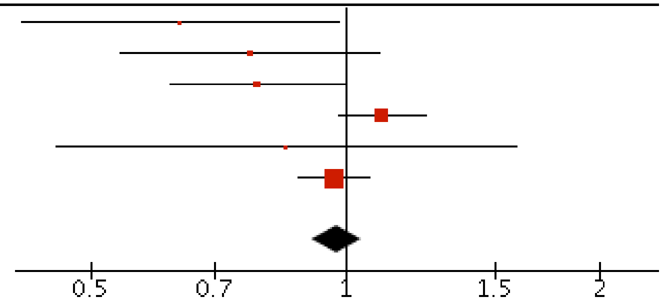
Figure S124. Relation between intake of allium vegetables and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CRUCIFEROUS VEGETABLES AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
HPFS - Joshipura 1999	38,683	336	2.6%	0.64 [0.41, 0.98]
Nurses' Health Study - Joshipura 1999	75,596	204	3.8%	0.77 [0.54, 1.10]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	8.6%	0.79 [0.62, 1.00]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	34.4%	1.11 [0.98, 1.24]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.2%	0.85 [0.46, 1.60]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	49.5%	0.97 [0.88, 1.07]
Total (95% CI)	**255,726**	**7,706**	**100.0%**	**0.98 [0.91, 1.05]**

Heterogeneity: Chi² = 13.17, df = 5 (P = 0.02); I² = 62%
Test for overall effect: Z = 0.70 (P = 0.49)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Joshipura 1999	75,596	204	11.3%	0.77 [0.54, 1.10]
HPFS - Joshipura 1999	38,683	336	8.5%	0.64 [0.41, 0.98]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	18.0%	0.79 [0.62, 1.00]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	27.9%	1.11 [0.98, 1.24]
PREDIMED- Buil-Cosiales 2016	7,216	169	4.6%	0.85 [0.46, 1.60]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	29.6%	0.97 [0.88, 1.07]
Total (95% CI) [Random Effects]	**255,726**	**7,706**	**100.0%**	**0.91 [0.78, 1.05]**

Heterogeneity: Tau² = 0.02; Chi² = 13.17, df = 5 (P = 0.02); I² = 62%
Test for overall effect: Z = 1.34 (P = 0.18)

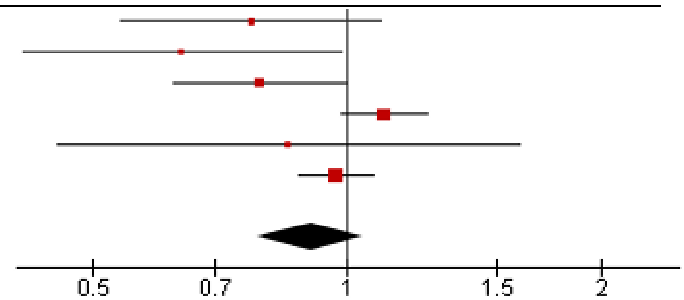


Figure S125. Relation between intake of cruciferous vegetables and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

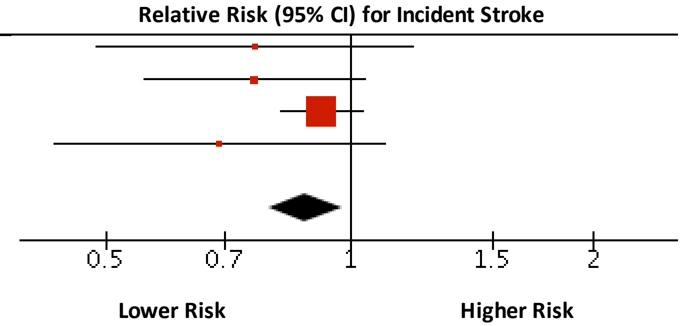
GREEN LEAFY VEGETABLES AND STROKE INCIDENCE

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
HPFS - Joshipura 1999	38,683	336	5.4%	0.76 [0.49, 1.20]
Nurses' Health Study - Joshipura 1999	75,596	204	11.1%	0.76 [0.56, 1.04]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	78.7%	0.92 [0.82, 1.04]
PREDIMED- Buil-Cosiales 2016	7,216	169	4.9%	0.69 [0.43, 1.11]
Total (95% CI)	**196,456**	**4,798**	**100.0%**	**0.88 [0.79, 0.98]**

Heterogeneity: $Chi^2 = 2.82$, df = 3 (P = 0.42); $I^2 = 0\%$

Test for overall effect: Z = 2.36 (P = 0.02)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Nurses' Health Study - Joshipura 1999	75,596	204	11.1%	0.76 [0.56, 1.04]
HPFS - Joshipura 1999	38,683	336	5.4%	0.76 [0.49, 1.20]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	78.7%	0.92 [0.82, 1.04]
PREDIMED- Buil-Cosiales 2016	7,216	169	4.9%	0.69 [0.43, 1.11]
Total (95% CI) [Random Effects]	**196,456**	**4,798**	**100.0%**	**0.88 [0.79, 0.98]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 2.82$, df = 3 (P = 0.42); $I^2 = 0\%$

Test for overall effect: Z = 2.36 (P = 0.02)

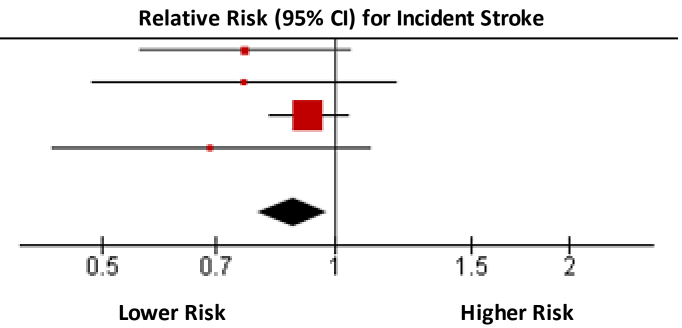


Figure S126. Relation between intake of green leafy vegetables and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

TOMATOES AND STROKE INCIDENCE

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
WHS - Sesso 2003 (b) - tomato based products	38,445	247	100.0%	0.20 [0.05, 0.82]
Total (95% CI)	**38,445**	**247**	**100.0%**	**0.20 [0.05, 0.82]**

Heterogeneity: Not applicable
Test for overall effect: Z = 2.24 (P = 0.03)

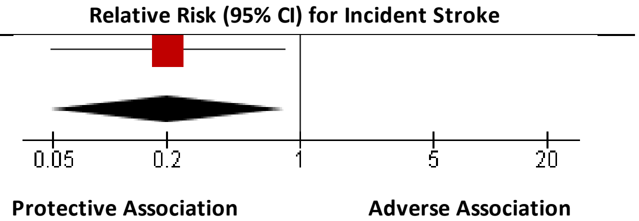
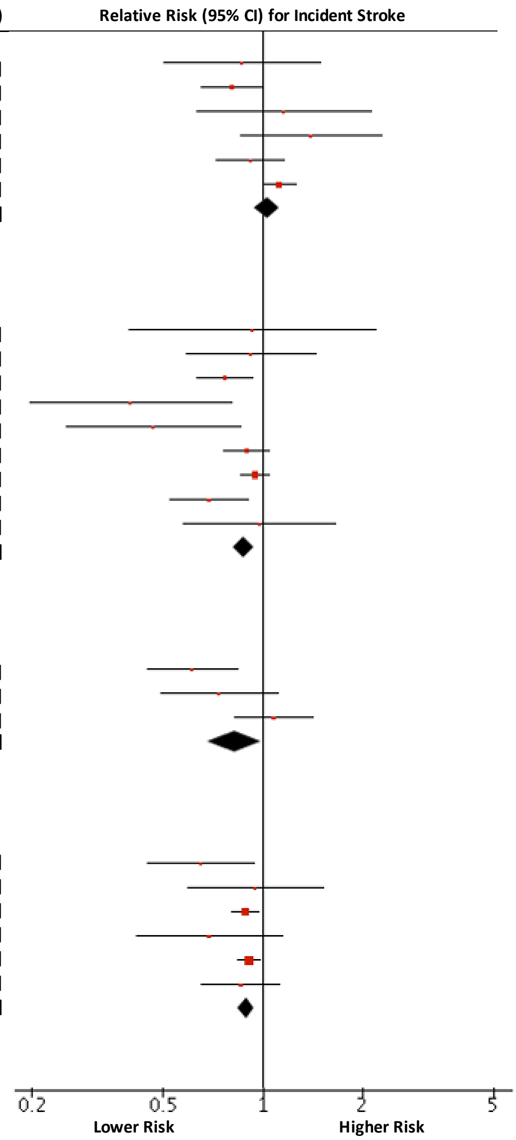


Figure S127. Relation between intake of tomatoes and stroke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Berries				
ATBC - Hirvonen 2000 - intracerebral hemorrag	26,593	95	0.5%	0.87 [0.50, 1.50]
ATBC - Hirvonen 2000 - cerebral infarction	-	736	3.3%	0.81 [0.65, 1.01]
ATBC - Hirvonen 2000 - subarachnoid hemorrag	-	83	0.4%	1.16 [0.63, 2.13]
WHS - Sesso 2007	38,176	339	0.6%	1.40 [0.86, 2.29]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	2.8%	0.92 [0.73, 1.17]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	11.2%	1.13 [1.00, 1.27]
Subtotal (95% CI)	**143,662**	**5,967**	**18.9%**	**1.03 [0.94, 1.13]**
Heterogeneity: Chi² = 9.90, df = 5 (P = 0.08); I² = 50%				
Test for overall effect: Z = 0.72 (P = 0.47)				
Citrus				
Zutphen Elderly Study - Keli 1996	552	42	0.2%	0.93 [0.39, 2.21]
HPFS - Joshipura 1999	38,683	366	0.8%	0.92 [0.59, 1.45]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	4.0%	0.77 [0.63, 0.94]
Jidni Medical School - Yamada 2011 - M	4,147	201	0.3%	0.40 [0.20, 0.81]
Jidni Medical School - Yamada 2011 - F	6,476	183	0.4%	0.47 [0.25, 0.86]
Nurses' Health Study - Cassidy 2012	69,622	943	6.3%	0.90 [0.77, 1.05]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	16.1%	0.95 [0.86, 1.05]
REGARDS - Goetz 2016 (b)	20,024	524	2.1%	0.69 [0.52, 0.91]
PREDIMED- Buil-Cosiales 2016	7,216	169	0.6%	0.98 [0.58, 1.66]
Subtotal (95% CI)	**225,613**	**7,142**	**30.8%**	**0.88 [0.82, 0.94]**
Heterogeneity: Chi² = 16.43, df = 8 (P = 0.04); I² = 51%				
Test for overall effect: Z = 3.59 (P = 0.0003)				
Fruit Juice				
Nurses' Health Study - Joshipura 1999	75,596	204	1.6%	0.61 [0.45, 0.84]
HPFS - Joshipura 1999	38,683	366	0.9%	0.74 [0.49, 1.12]
EPIC NL and MORGEN - Scheffers 2019	34,560	1,135	2.1%	1.08 [0.82, 1.43]
Subtotal (95% CI)	**148,839**	**1,705**	**4.5%**	**0.82 [0.68, 0.99]**
Heterogeneity: Chi² = 7.51, df = 2 (P = 0.02); I² = 73%				
Test for overall effect: Z = 2.06 (P = 0.04)				
Pommes				
Finish Mobile Clinic Health Exam - Knekt 2000 -	9,208	445	1.1%	0.65 [0.45, 0.94]
Finish Mobile Clinic Health Exam - Knekt 2000 -	-	378	0.7%	0.95 [0.59, 1.52]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	16.1%	0.89 [0.80, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	169	0.6%	0.69 [0.41, 1.15]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	25.2%	0.91 [0.85, 0.99]
NutriNet-Sante - Adriouch 2018	84,158	293	2.1%	0.86 [0.65, 1.13]
Subtotal (95% CI)	**230,881**	**7,657**	**45.8%**	**0.89 [0.84, 0.95]**
Heterogeneity: Chi² = 4.25, df = 5 (P = 0.51); I² = 0%				
Test for overall effect: Z = 3.86 (P = 0.0001)				
Test for subgroup differences: Chi² = 10.20, df = 3 (P = 0.02), I² = 70.6%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Berries				
ATBC - Hirvonen 2000 - subarachnoid hemorrag	26,593	83	1.4%	1.16 [0.63, 2.13]
ATBC - Hirvonen 2000 - intracerebral hemorrag	-	95	1.7%	0.87 [0.50, 1.50]
ATBC - Hirvonen 2000 - cerebral infarction	-	736	6.3%	0.81 [0.65, 1.01]
WHS - Sesso 2007	38,176	339	2.1%	1.40 [0.86, 2.29]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	5.8%	0.92 [0.73, 1.17]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	9.6%	1.13 [1.00, 1.27]
Subtotal (95% CI)	**143,662**	**5,967**	**26.9%**	**1.00 [0.85, 1.18]**
Heterogeneity: Tau² = 0.02; Chi² = 9.90, df = 5 (P = 0.08); I² = 50%				
Test for overall effect: Z = 0.02 (P = 0.99)				
Citrus				
Zutphen Elderly Study - Keli 1996	552	42	0.8%	0.93 [0.39, 2.21]
HPFS - Joshipura 1999	38,683	366	2.4%	0.92 [0.59, 1.45]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	6.9%	0.77 [0.63, 0.94]
Jidni Medical School - Yamada 2011 - F	6,476	183	1.4%	0.47 [0.25, 0.86]
Jidni Medical School - Yamada 2011 - M	4,147	201	1.1%	0.40 [0.20, 0.81]
Nurses' Health Study - Cassidy 2012	69,622	943	8.2%	0.90 [0.77, 1.05]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	10.3%	0.95 [0.86, 1.05]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.8%	0.98 [0.58, 1.66]
REGARDS - Goetz 2016 (b)	20,024	524	4.8%	0.69 [0.52, 0.91]
Subtotal (95% CI)	**225,613**	**7,142**	**37.7%**	**0.82 [0.71, 0.93]**
Heterogeneity: Tau² = 0.02; Chi² = 16.43, df = 8 (P = 0.04); I² = 51%				
Test for overall effect: Z = 2.93 (P = 0.003)				
Fruit Juice				
HPFS - Joshipura 1999	38,683	366	2.4%	0.74 [0.49, 1.12]
Nurses' Health Study - Joshipura 1999	75,596	204	3.7%	0.61 [0.45, 0.84]
EPIC NL and MORGEN - Scheffers 2019	34,560	1,135	4.4%	1.08 [0.82, 1.43]
Subtotal (95% CI)	**148,839**	**1,705**	**10.5%**	**0.80 [0.55, 1.15]**
Heterogeneity: Tau² = 0.08; Chi² = 7.51, df = 2 (P = 0.02); I² = 73%				
Test for overall effect: Z = 1.21 (P = 0.23)				
Pommes				
Finish Mobile Clinic Health Exam - Knekt 2000 -	9,208	378	2.0%	0.95 [0.59, 1.52]
Finish Mobile Clinic Health Exam - Knekt 2000 -	-	445	2.9%	0.65 [0.45, 0.94]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	9.6%	0.89 [0.80, 0.98]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.7%	0.69 [0.41, 1.15]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	10.2%	0.91 [0.85, 0.99]
NutriNet-Sante - Adriouch 2018	84,158	293	4.4%	0.86 [0.65, 1.13]
Subtotal (95% CI)	**230,881**	**7,657**	**30.7%**	**0.89 [0.84, 0.95]**
Heterogeneity: Tau² = 0.00; Chi² = 4.25, df = 5 (P = 0.51); I² = 0%				
Test for overall effect: Z = 3.86 (P = 0.0001)				
Test for subgroup differences: Chi² = 3.91, df = 3 (P = 0.27), I² = 23.3%				

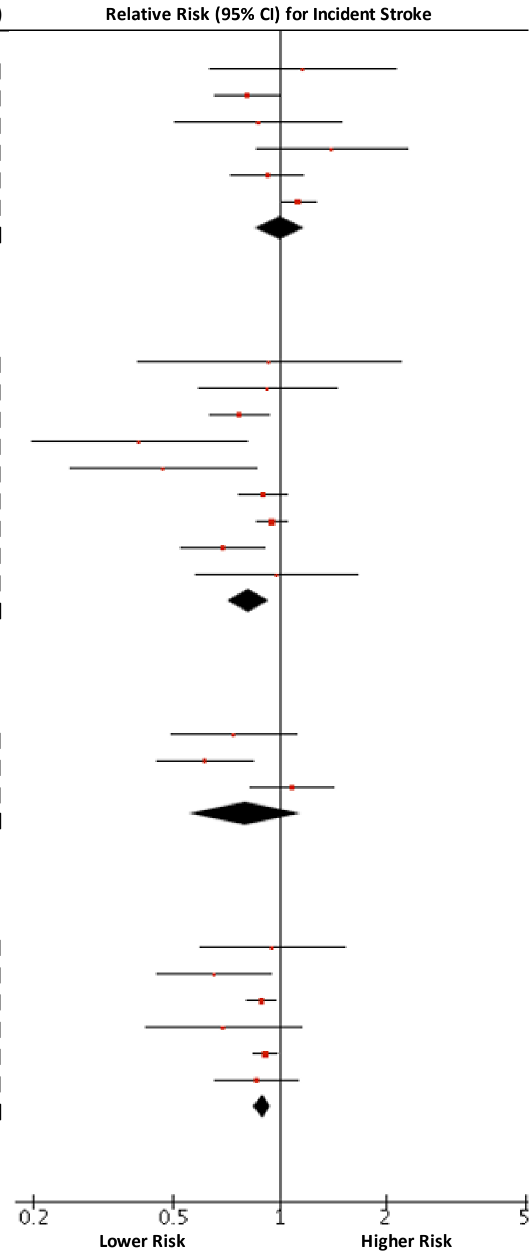
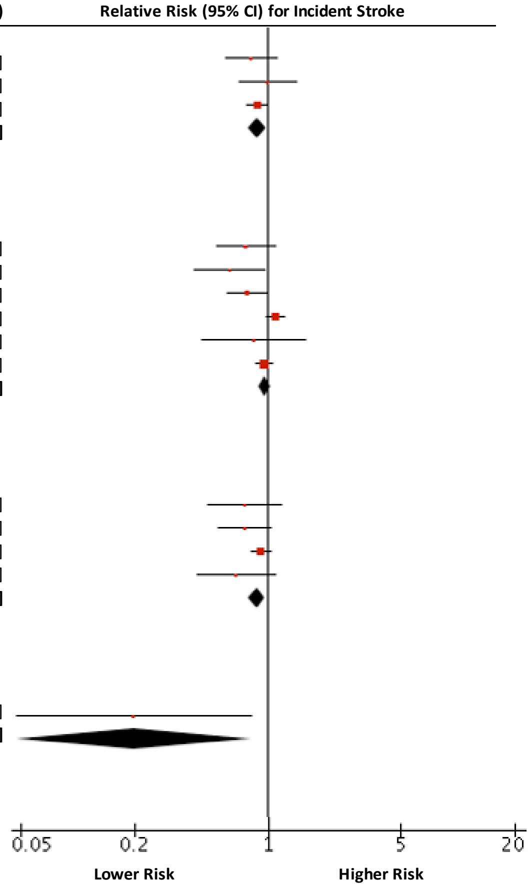


Figure S128. Relation between sources of fruit and stoke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Finish Mobile Clinic Health Exam - Knekt 2000 - M	9,208	445	2.6%	0.83 [0.60, 1.13]
Finish Mobile Clinic Health Exam - Knekt 2000 - F	-	378	2.0%	1.01 [0.71, 1.44]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	18.4%	0.89 [0.79, 1.00]
Subtotal (95% CI)	**84,169**	**4,912**	**23.0%**	**0.89 [0.80, 0.99]**
Heterogeneity: Chi² = 0.71, df = 2 (P = 0.70); I² = 0%				
Test for overall effect: Z = 2.17 (P = 0.03)				
Cruciferous				
Nurses' Health Study - Joshipura 1999	75,596	204	2.0%	0.77 [0.54, 1.10]
HPFS - Joshipura 1999	38,683	336	1.4%	0.64 [0.41, 0.98]
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	4.6%	0.79 [0.62, 1.00]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	18.4%	1.11 [0.98, 1.24]
PREDIMED- Buil-Cosiales 2016	7,216	169	0.6%	0.85 [0.46, 1.60]
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	26.5%	0.97 [0.88, 1.07]
Subtotal (95% CI)	**255,726**	**7,706**	**53.5%**	**0.98 [0.91, 1.05]**
Heterogeneity: Chi² = 13.17, df = 5 (P = 0.02); I² = 62%				
Test for overall effect: Z = 0.70 (P = 0.49)				
Green Leafy				
HPFS - Joshipura 1999	38,683	336	1.3%	0.76 [0.49, 1.20]
Nurses' Health Study - Joshipura 1999	75,596	204	2.6%	0.76 [0.56, 1.04]
Swedish Mammography & Men - Larsson 2013	74,961	4,089	18.4%	0.92 [0.82, 1.04]
PREDIMED- Buil-Cosiales 2016	7,216	169	1.1%	0.69 [0.43, 1.11]
Subtotal (95% CI)	**196,456**	**4,798**	**23.4%**	**0.88 [0.79, 0.98]**
Heterogeneity: Chi² = 2.82, df = 3 (P = 0.42); I² = 0%				
Test for overall effect: Z = 2.36 (P = 0.02)				
Tomatoes				
WHS - Sesso 2003 (b) - tomato based products	38,445	247	0.1%	0.20 [0.05, 0.82]
Subtotal (95% CI)	**38,445**	**247**	**0.1%**	**0.20 [0.05, 0.82]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 2.24 (P = 0.03)				
Test for subgroup differences: Chi² = 8.08, df = 3 (P = 0.04), I² = 62.9%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Incident Stroke
Allium					
Finish Mobile Clinic Health Exam - Knekt 2000 -	9,208	445	5.5%	0.83 [0.60, 1.13]	
Finish Mobile Clinic Health Exam - Knekt 2000 -	-	378	4.6%	1.01 [0.71, 1.44]	
Swedish Mammography & Men - Larsson 2013	74,961	4,089	14.7%	0.89 [0.79, 1.00]	
Subtotal (95% CI)	**84,169**	**4,912**	**24.8%**	**0.89 [0.80, 0.99]**	
Heterogeneity: Tau² = 0.00; Chi² = 0.71, df = 2 (P = 0.70); I² = 0%					
Test for overall effect: Z = 2.17 (P = 0.03)					
Cruciferous					
Danish Diet Cancer Health - Hansen 2017	55,338	2,283	16.1%	0.97 [0.88, 1.07]	
Finish Mobile Clinic Health Exam - Mizrahi 2009	3,932	625	8.1%	0.79 [0.62, 1.00]	
HPFS - Joshipura 1999	38,683	336	3.3%	0.64 [0.41, 0.98]	
Nurses' Health Study - Joshipura 1999	75,596	204	4.6%	0.77 [0.54, 1.10]	
PREDIMED- Buil-Cosiales 2016	7,216	169	1.7%	0.85 [0.46, 1.60]	
Swedish Mammography & Men - Larsson 2013	74,961	4,089	14.7%	1.11 [0.98, 1.24]	
Subtotal (95% CI)	**255,726**	**7,706**	**48.6%**	**0.91 [0.78, 1.05]**	
Heterogeneity: Tau² = 0.02; Chi² = 13.17, df = 5 (P = 0.02); I² = 62%					
Test for overall effect: Z = 1.34 (P = 0.18)					
Green Leafy					
HPFS - Joshipura 1999	38,683	336	3.1%	0.76 [0.49, 1.20]	
Nurses' Health Study - Joshipura 1999	75,596	204	5.5%	0.76 [0.56, 1.04]	
PREDIMED- Buil-Cosiales 2016	7,216	169	2.9%	0.69 [0.43, 1.11]	
Swedish Mammography & Men - Larsson 2013	74,961	4,089	14.7%	0.92 [0.82, 1.04]	
Subtotal (95% CI)	**196,456**	**4,798**	**26.2%**	**0.88 [0.79, 0.98]**	
Heterogeneity: Tau² = 0.00; Chi² = 2.82, df = 3 (P = 0.42); I² = 0%					
Test for overall effect: Z = 2.36 (P = 0.02)					
Tomatoes					
WHS - Sesso 2003 (b) - tomato based products	38,445	247	0.4%	0.20 [0.05, 0.82]	
Subtotal (95% CI)	**38,445**	**247**	**0.4%**	**0.20 [0.05, 0.82]**	
Heterogeneity: Not applicable					
Test for overall effect: Z = 2.24 (P = 0.03)					
Test for subgroup differences: Chi² = 4.37, df = 3 (P = 0.22), I² = 31.4%					

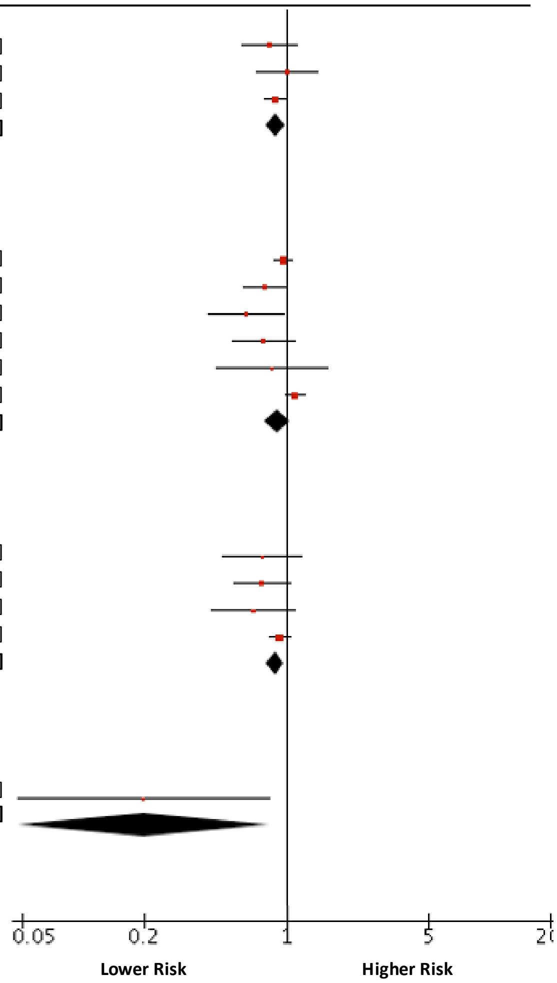


Figure S129. Relation between sources of vegetables and stoke incidence (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

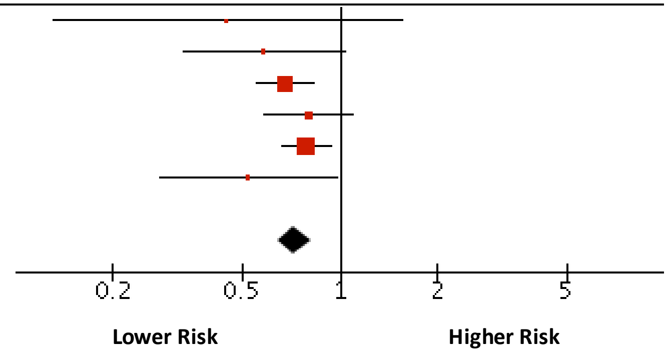
TOTAL FRUIT AND VEGETABLES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	14	0.90%	0.45 [0.13, 1.54]
National Health & Nutrition - Bazzano 2002	9,608	218	4.10%	0.58 [0.33, 1.03]
EPIC - Leenders 2014	451,151	1,291	34.90%	0.68 [0.56, 0.82]
NIPPON DATA80 - Okuda 2015	9,112	385	13.60%	0.80 [0.59, 1.10]
Migrant Study - Hjartaker 2015	9,766	1,034	43.10%	0.79 [0.66, 0.94]
HAPIEE - Stefler 2016	19,263	109	3.40%	0.52 [0.28, 0.98]
Total (95% CI)	**499,732**	**3,051**	**100.0%**	**0.73 [0.65, 0.81]**

Heterogeneity: Chi² = 3.89, df = 5 (P = 0.57); I² = 0%
Test for overall effect: Z = 5.43 (P < 0.00001)

Relative Risk (95% CI) for Stroke Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Framingham - Gillman 1995	832	14	0.9%	0.45 [0.13, 1.54]
National Health & Nutrition - Bazzano 2002	9,608	218	4.1%	0.58 [0.33, 1.03]
EPIC - Leenders 2014	451,151	1,291	34.9%	0.68 [0.56, 0.82]
NIPPON DATA80 - Okuda 2015	9,112	385	13.6%	0.80 [0.59, 1.10]
Migrant Study - Hjartaker 2015	9,766	1,034	43.1%	0.79 [0.66, 0.94]
HAPIEE - Stefler 2016	19,263	109	3.4%	0.52 [0.28, 0.98]
Total (95% CI) [Random Effects]	**499,732**	**3,051**	**100.0%**	**0.73 [0.65, 0.81]**

Heterogeneity: Tau² = 0.00; Chi² = 3.89, df = 5 (P = 0.57); I² = 0%
Test for overall effect: Z = 5.43 (P < 0.00001)

Relative Risk (95% CI) for Stroke Mortality

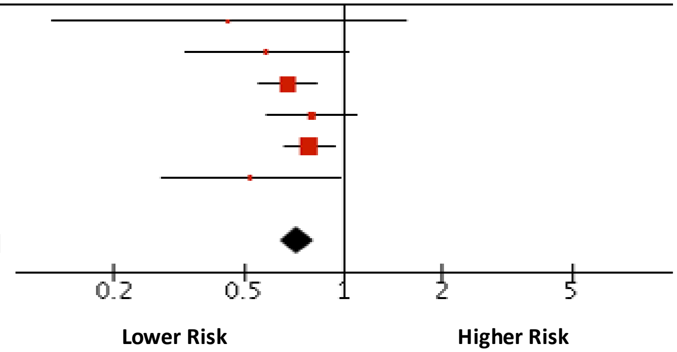


Figure S130. Relation between total fruit and vegetables intake and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

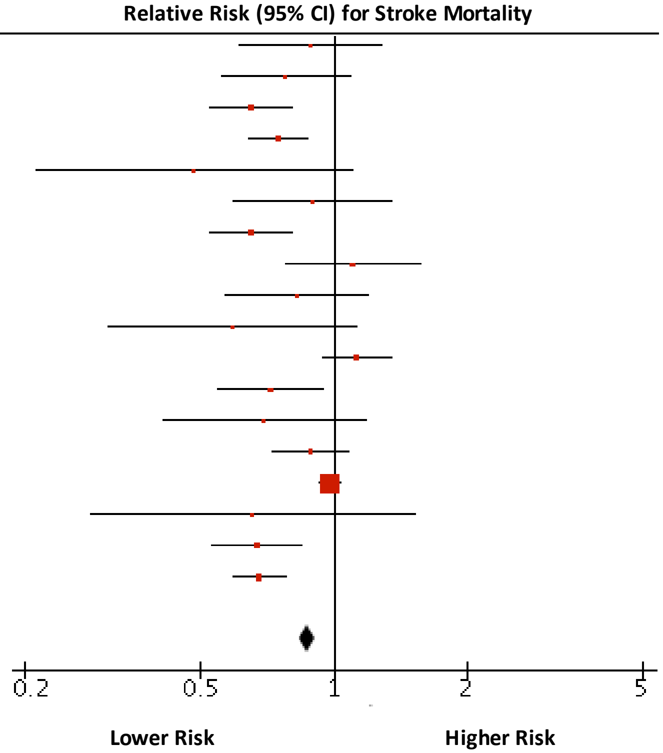
FRUIT AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Health Food Shoppers - Appleby 2002 - M	4,325	142	1.3%	0.89 [0.61, 1.29]
Health Food Shoppers - Appleby 2002 - F	6,416	214	1.6%	0.78 [0.56, 1.09]
Life Span Study - Sauvaget 2003 - M	14,966	692	3.8%	0.65 [0.52, 0.81]
Life Span Study - Sauvaget 2003 - F	23,471	1,234	7.2%	0.75 [0.64, 0.88]
Boyd Orr Cohort - Ness 2005	4,028	83	0.3%	0.48 [0.21, 1.10]
Miyako Study - Pham 2007	9,651	226	1.1%	0.90 [0.59, 1.35]
JACC - Nagura 2009	59,485	1,053	3.8%	0.65 [0.52, 0.81]
Multiethnic Cohort - Sharma 2013 - M	78,410	434	1.4%	1.11 [0.78, 1.57]
Multiethnic Cohort - Sharma 2013 - F	95,618	426	1.3%	0.83 [0.57, 1.20]
MONICA Danish - Tognon 2014	1,849	40	0.4%	0.59 [0.31, 1.12]
EPIC - Leenders 2014	451,151	1,291	5.7%	1.13 [0.95, 1.35]
NIPPON DATA80 - Okuda 2015	9,112	385	2.4%	0.72 [0.55, 0.95]
UK Women's Cohort - Lai 2015	30,458	148	0.6%	0.70 [0.41, 1.18]
Migrant Study - Hjartaker 2015	9,766	1,034	4.6%	0.89 [0.73, 1.08]
Linxian Nutrition - Wang 2016	2,445	452	51.5%	0.98 [0.92, 1.04]
HAPIEE - Stefler 2016	19,263	109	0.3%	0.66 [0.28, 1.53]
China Kadoorie Biobank - Du 2017 - ischemic	462,342	585	3.2%	0.67 [0.53, 0.85]
China Kadoorie Biobank- Du 2017-hemorrhagic	-	2,351	9.5%	0.68 [0.59, 0.78]
Total (95% CI)	**1,282,756**	**10,899**	**100.0%**	**0.87 [0.84, 0.91]**

Heterogeneity: $Chi^2 = 67.81$, $df = 17$ ($P < 0.00001$); $I^2 = 75\%$

Test for overall effect: $Z = 6.30$ ($P < 0.00001$)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Health Food Shoppers - Appleby 2002 - F	6,416	214	5.2%	0.78 [0.56, 1.09]
Health Food Shoppers - Appleby 2002 - M	4,325	142	4.6%	0.89 [0.61, 1.29]
Life Span Study - Sauvaget 2003 - F	23,471	1,234	8.1%	0.75 [0.64, 0.88]
Life Span Study - Sauvaget 2003 - M	14,966	692	7.1%	0.65 [0.52, 0.81]
Boyd Orr Cohort - Ness 2005	4,028	83	1.5%	0.48 [0.21, 1.10]
Miyako Study - Pham 2007	9,651	226	4.2%	0.90 [0.59, 1.35]
JACC - Nagura 2009	59,485	1,053	7.1%	0.65 [0.52, 0.81]
Multiethnic Cohort - Sharma 2013 - M	78,410	434	4.9%	1.11 [0.78, 1.57]
Multiethnic Cohort - Sharma 2013 - F	95,618	426	4.6%	0.83 [0.57, 1.20]
EPIC - Leenders 2014	451,151	1,291	7.8%	1.13 [0.95, 1.35]
MONICA Danish - Tognon 2014	1,849	40	2.3%	0.59 [0.31, 1.12]
Migrant Study - Hjartaker 2015	9,766	1,034	7.4%	0.89 [0.73, 1.08]
NIPPON DATA80 - Okuda 2015	9,112	385	6.1%	0.72 [0.55, 0.95]
UK Women's Cohort - Lai 2015	30,458	148	3.0%	0.70 [0.41, 1.18]
Linxian Nutrition - Wang 2016	2,445	452	9.4%	0.98 [0.92, 1.04]
HAPIEE - Stefler 2016	19,263	109	1.5%	0.66 [0.28, 1.53]
China Kadoorie Biobank- Du 2017-hemorrhagic	462,342	2,351	8.4%	0.68 [0.59, 0.78]
China Kadoorie Biobank - Du 2017 - ischemic	-	585	6.7%	0.67 [0.53, 0.85]
Total (95% CI) [Random Effects]	**1,282,756**	**10,899**	**100.0%**	**0.79 [0.71, 0.89]**

Heterogeneity: Tau² = 0.03; Chi² = 67.81, df = 17 (P < 0.00001); I² = 75%

Test for overall effect: Z = 4.12 (P < 0.0001)

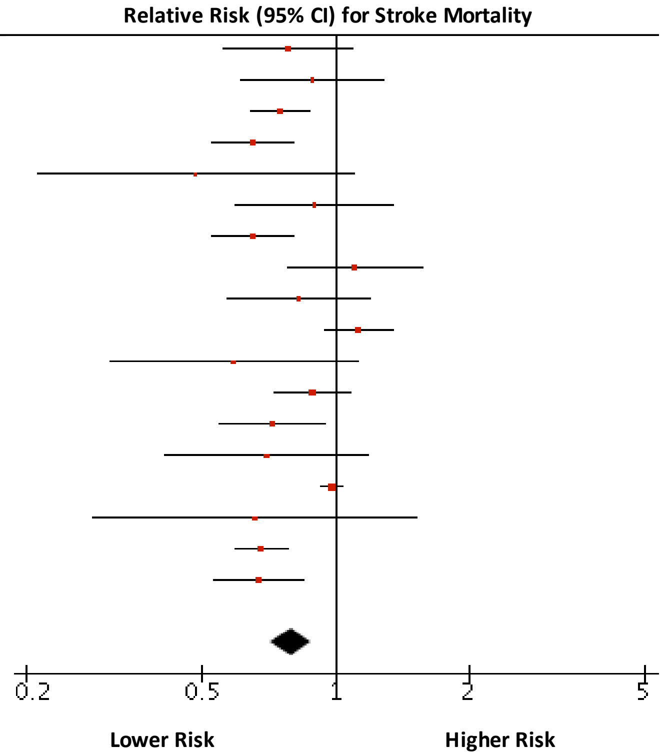


Figure S131. Relation between fruit intake and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

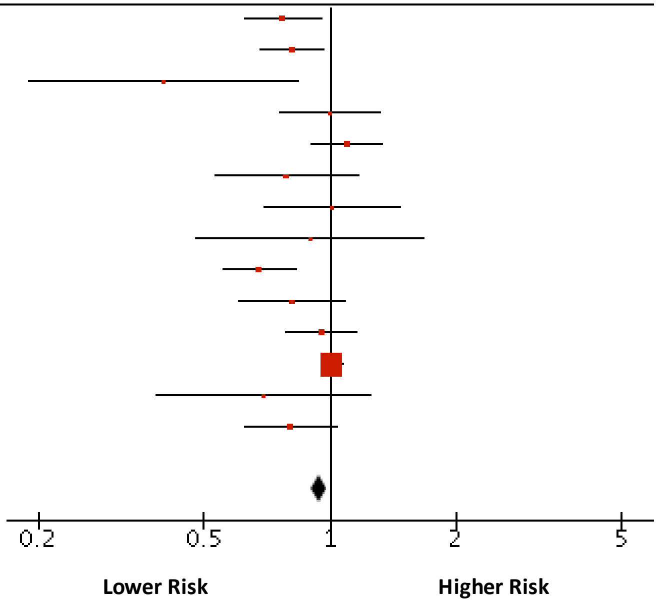
VEGETABLES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Life Span Study - Sauvaget 2003 - M	14,966	692	4.5%	0.77 [0.62, 0.96]
Life Span Study - Sauvaget 2003 - F	23,471	1,234	6.7%	0.81 [0.68, 0.97]
Boyd Orr Cohort - Ness 2005	4,028	83	0.4%	0.40 [0.19, 0.84]
Miyako Study - Pham 2007	9,651	226	2.8%	1.00 [0.76, 1.32]
JACC - Nagura 2009	59,485	1,053	5.4%	1.09 [0.90, 1.33]
Multiethnic Cohort - Sharma 2013 - F	95,618	426	1.3%	0.79 [0.53, 1.16]
Multiethnic Cohort - Sharma 2013 - M	78,410	434	1.5%	1.01 [0.70, 1.47]
MONICA Danish - Tognon 2014	1,849	40	0.5%	0.90 [0.48, 1.68]
EPIC - Leenders 2014	451,151	1,291	5.4%	0.68 [0.56, 0.82]
NIPPON DATA80 - Okuda 2015	9,112	385	2.4%	0.81 [0.60, 1.09]
Migrant Study - Hjartaker 2015	9,766	1,034	5.4%	0.95 [0.78, 1.16]
Linxian Nutrition - Wang 2016	2,445	452	60.0%	1.01 [0.95, 1.07]
HAPIEE - Stefler 2016	19,263	109	0.6%	0.69 [0.38, 1.24]
PLSAW - Blekkenhorst 2017	1,226	92	3.2%	0.80 [0.62, 1.04]
Total (95% CI)	**780,441**	**7,551**	**100.0%**	**0.94 [0.90, 0.99]**

Heterogeneity: Chi² = 34.54, df = 13 (P = 0.0010); I² = 62%
Test for overall effect: Z = 2.58 (P = 0.010)

Relative Risk (95% CI) for Stroke Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Life Span Study - Sauvaget 2003 - M	14,966	692	9.0%	0.77 [0.62, 0.96]
Life Span Study - Sauvaget 2003 - F	23,471	1,234	10.3%	0.81 [0.68, 0.97]
Boyd Orr Cohort - Ness 2005	4,028	83	1.7%	0.40 [0.19, 0.84]
Miyako Study - Pham 2007	9,651	226	7.2%	1.00 [0.76, 1.32]
JACC - Nagura 2009	59,485	1,053	9.6%	1.09 [0.90, 1.33]
Multiethnic Cohort - Sharma 2013 - M	78,410	434	5.0%	1.01 [0.70, 1.47]
Multiethnic Cohort - Sharma 2013 - F	95,618	426	4.7%	0.79 [0.53, 1.16]
EPIC - Leenders 2014	451,151	1,291	9.6%	0.68 [0.56, 0.82]
MONICA Danish - Tognon 2014	1,849	40	2.3%	0.90 [0.48, 1.68]
NIPPON DATA80 - Okuda 2015	9,112	385	6.7%	0.81 [0.60, 1.09]
Migrant Study - Hjartaker 2015	9,766	1,034	9.6%	0.95 [0.78, 1.16]
HAPIEE - Stefler 2016	19,263	109	2.5%	0.69 [0.38, 1.24]
Linxian Nutrition - Wang 2016	2,445	452	14.1%	1.01 [0.95, 1.07]
PLSAW - Blekkenhorst 2017	1,226	92	7.7%	0.80 [0.62, 1.04]
Total (95% CI) [Random Effects]	**780,441**	**7,551**	**100.0%**	**0.86 [0.78, 0.96]**

Heterogeneity: Tau² = 0.02; Chi² = 34.54, df = 13 (P = 0.0010); I² = 62%
Test for overall effect: Z = 2.79 (P = 0.005)

Relative Risk (95% CI) for Stroke Mortality

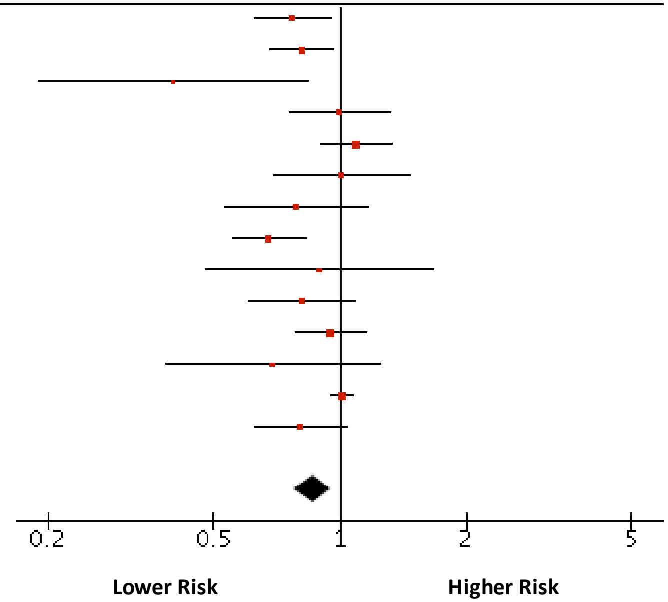


Figure S132. Relation between intake of vegetables and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BANANAS AND STROKE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Stroke Mortality
Migrant Study - Hjartaker 2015 - banana	9,766	1,034	100.0%	1.04 [0.70, 1.54]	
Total (95% CI)	**9,766**	**1,034**	**100.0%**	**1.04 [0.70, 1.54]**	
Heterogeneity: Not applicable					
Test for overall effect: Z = 0.20 (P = 0.84)					

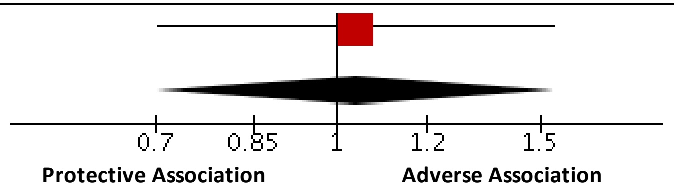


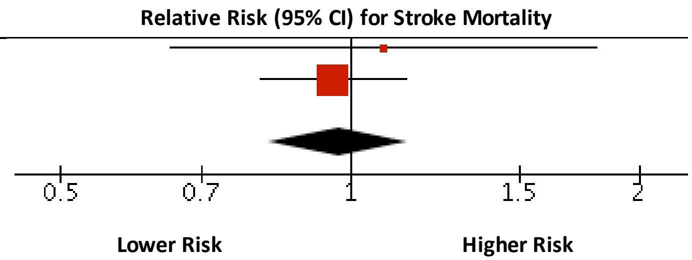
Figure S133. Relation between intake of bananas and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

BERRIES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015	30,458	148	10.7%	1.08 [0.65, 1.80]
Migrant Study - Hjartaker 2015	9,766	1,034	89.3%	0.96 [0.81, 1.15]
Total (95% CI)	**40,224**	**1,182**	**100.0%**	**0.97 [0.82, 1.15]**

Heterogeneity: Chi² = 0.19, df = 1 (P = 0.66); I² = 0%
Test for overall effect: Z = 0.32 (P = 0.75)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015	30,458	148	10.7%	1.08 [0.65, 1.80]
Migrant Study - Hjartaker 2015	9,766	1,034	89.3%	0.96 [0.81, 1.15]
Total (95% CI) [Random Effects]	**40,224**	**1,182**	**100.0%**	**0.97 [0.82, 1.15]**

Heterogeneity: Tau² = 0.00; Chi² = 0.19, df = 1 (P = 0.66); I² = 0%
Test for overall effect: Z = 0.32 (P = 0.75)

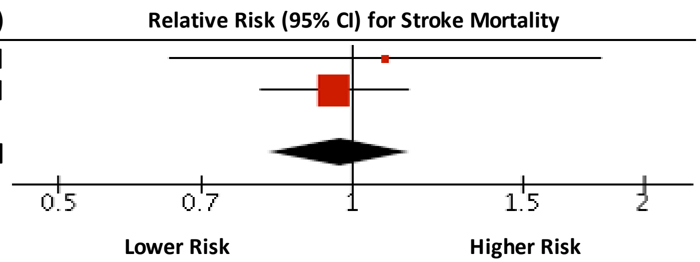


Figure S134. Relation between intake of berries and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

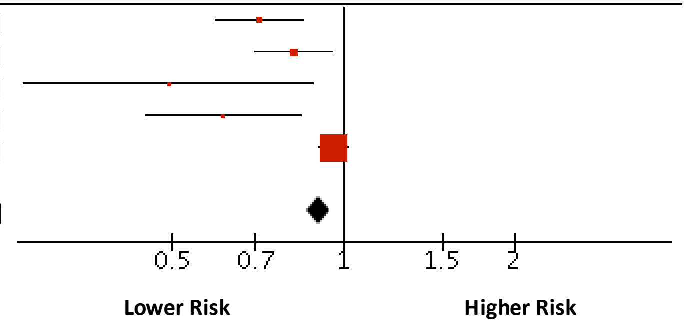
CITRUS FRUIT AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	59,504	1,028	8.6%	0.71 [0.60, 0.85]
JACC - Iso 2007 - M	43,031	1,207	10.8%	0.82 [0.70, 0.96]
UK Women's Cohort - Lai 2015	30,458	148	0.8%	0.49 [0.27, 0.89]
Migrant Study - Hjartaker 2015	9,766	1,034	2.7%	0.61 [0.45, 0.84]
Linxian Nutrition - Wang 2016	2,445	452	77.1%	0.96 [0.91, 1.02]
Total (95% CI)	**145,204**	**3,869**	**100.0%**	**0.90 [0.86, 0.95]**

Heterogeneity: Chi² = 22.75, df = 4 (P = 0.0001); I² = 82%
Test for overall effect: Z = 3.81 (P = 0.0001)

Relative Risk (95% CI) Stroke Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - M	43,031	1,207	24.3%	0.82 [0.70, 0.96]
JACC - Iso 2007 - F	59,504	1,028	23.3%	0.71 [0.60, 0.85]
UK Women's Cohort - Lai 2015	30,458	148	7.9%	0.49 [0.27, 0.89]
Migrant Study - Hjartaker 2015	9,766	1,034	16.4%	0.61 [0.45, 0.84]
Linxian Nutrition - Wang 2016	2,445	452	28.1%	0.96 [0.91, 1.02]
Total (95% CI) [Random Effects]	**145,204**	**3,869**	**100.0%**	**0.76 [0.63, 0.92]**

Heterogeneity: Tau² = 0.03; Chi² = 22.75, df = 4 (P = 0.0001); I² = 82%
Test for overall effect: Z = 2.79 (P = 0.005)

Relative Risk (95% CI) Stroke Mortality

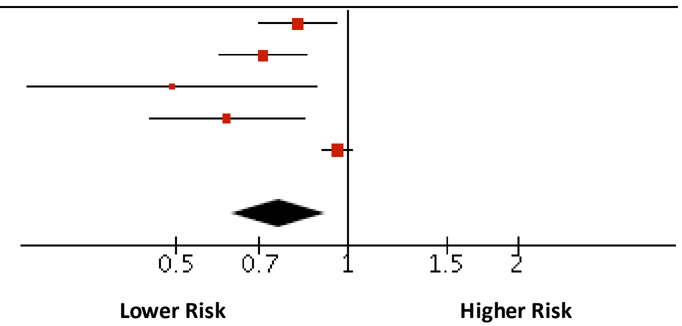


Figure S135. Relation between intake of citrus fruit and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

DRIED FRUIT AND STROKE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015	30,458	152	100.0%	0.95 [0.80, 1.13]
Total (95% CI)	**30,458**	**152**	**100.0%**	**0.95 [0.80, 1.13]**

Heterogeneity: Not applicable
Test for overall effect: Z = 0.56 (P = 0.58)

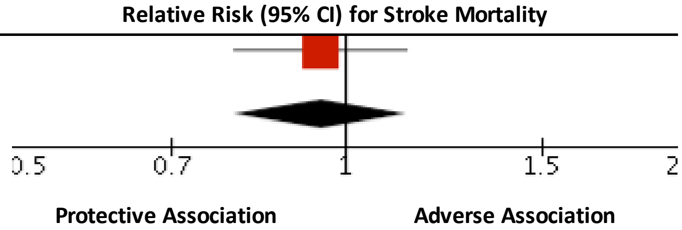


Figure S136. Relation between intake of dried fruit and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

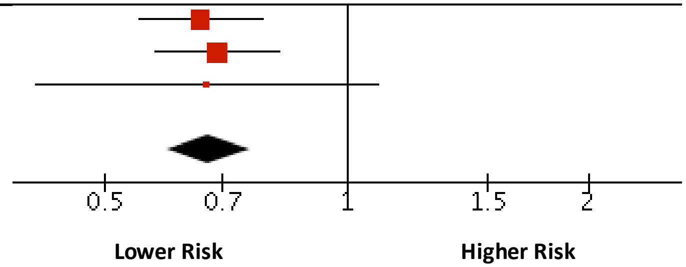
FRUIT JUICE AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	56,482	953	47.0%	0.66 [0.55, 0.78]
JACC - Iso 2007 - M	41,330	1,131	47.0%	0.69 [0.58, 0.82]
UK Women's Cohort - Lai 2015	30,458	148	6.1%	0.67 [0.41, 1.09]
Total (95% CI)	**128,270**	**2,232**	**100.0%**	**0.67 [0.60, 0.76]**

Heterogeneity: Chi² = 0.15, df = 2 (P = 0.93); I² = 0%
Test for overall effect: Z = 6.41 (P < 0.00001)

Relative Risk (95% CI) for Stroke Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	56,482	953	47.0%	0.66 [0.55, 0.78]
JACC - Iso 2007 - M	41,330	1,131	47.0%	0.69 [0.58, 0.82]
UK Women's Cohort - Lai 2015	30,458	148	6.1%	0.67 [0.41, 1.09]
Total (95% CI) [Random Effects]	**128,270**	**2,232**	**100.0%**	**0.67 [0.60, 0.76]**

Heterogeneity: Tau² = 0.00; Chi² = 0.15, df = 2 (P = 0.93); I² = 0%
Test for overall effect: Z = 6.41 (P < 0.00001)

Relative Risk (95% CI) for Stroke Mortality

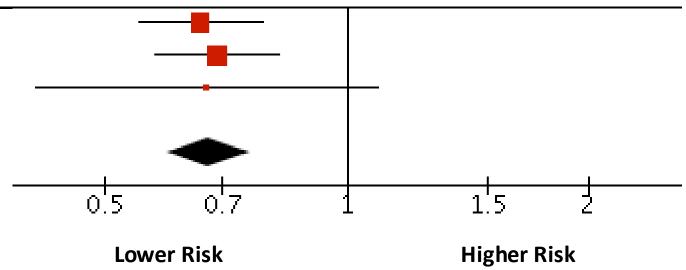


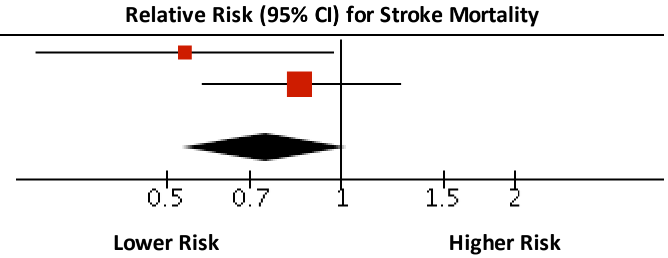
Figure S137. Relation between intake of fruit juice and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

GRAPES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015 - grapes	30,458	148	30.8%	0.54 [0.30, 0.97]
Migrant Study - Hjartaker 2015 - grapes	9,766	1,034	69.2%	0.85 [0.58, 1.26]
Total (95% CI)	**40,224**	**1,182**	**100.0%**	**0.74 [0.53, 1.02]**

Heterogeneity: Chi² = 1.63, df = 1 (P = 0.20); I² = 39%
Test for overall effect: Z = 1.81 (P = 0.07)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
UK Women's Cohort - Lai 2015 - grapes	30,458	148	38.2%	0.54 [0.30, 0.97]
Migrant Study - Hjartaker 2015 - grapes	9,766	1,034	61.8%	0.85 [0.58, 1.26]
Total (95% CI) [Random Effects]	**40,224**	**1,182**	**100.0%**	**0.71 [0.46, 1.11]**

Heterogeneity: Tau² = 0.04; Chi² = 1.63, df = 1 (P = 0.20); I² = 39%
Test for overall effect: Z = 1.50 (P = 0.13)

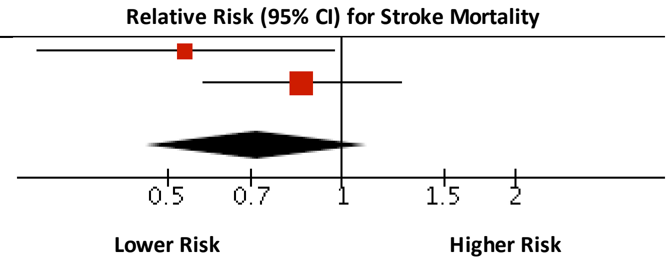


Figure S138. Relation between intake of grapes and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

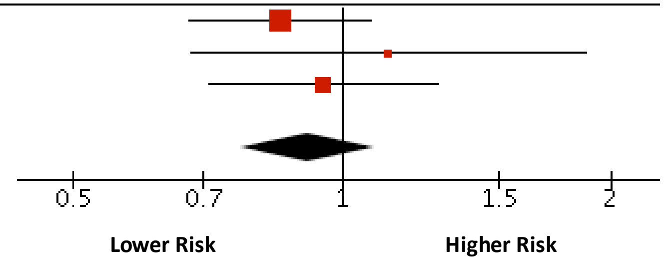
POMMES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007	34,492	469	54.0%	0.85 [0.67, 1.08]
UK Women's Cohort - Lai 2015	30,458	148	11.5%	1.13 [0.68, 1.88]
Migrant Study - Hjartaker 2015	9,766	1,034	34.5%	0.95 [0.71, 1.28]
Total (95% CI)	**74,716**	**1,651**	**100.0%**	**0.91 [0.77, 1.09]**

Heterogeneity: $Chi^2 = 1.06$, df = 2 (P = 0.59); $I^2 = 0\%$
Test for overall effect: Z = 1.02 (P = 0.31)

Relative Risk (95% CI) for Stroke Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Iowa WHS - Mink 2007	34,492	469	54.0%	0.85 [0.67, 1.08]
UK Women's Cohort - Lai 2015	30,458	148	11.5%	1.13 [0.68, 1.88]
Migrant Study - Hjartaker 2015	9,766	1,034	34.5%	0.95 [0.71, 1.28]
Total (95% CI) [Random Effects]	**74,716**	**1,651**	**100.0%**	**0.91 [0.77, 1.09]**

Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 1.06$, df = 2 (P = 0.59); $I^2 = 0\%$
Test for overall effect: Z = 1.02 (P = 0.31)

Relative Risk (95% CI) for Stroke Mortality

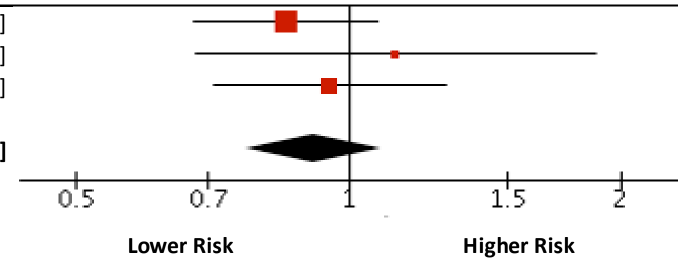


Figure S139. Relation between intake of pommes fruit and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

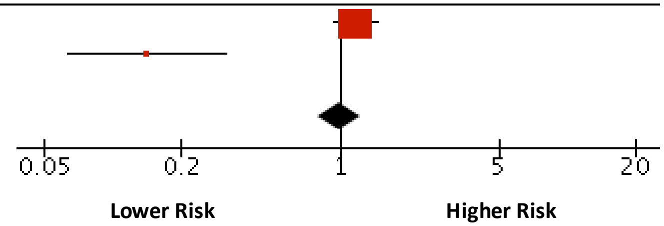
ALLIUM AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Linxian Nutrition - Wang 2016	2,445	452	51.7%	1.17 [0.93, 1.48]
PLSAW - Blekkenhorst 2017	1,226	92	48.3%	0.14 [0.06, 0.31]
Total (95% CI)	**3,671**	**544**	**100.0%**	**0.99 [0.79, 1.24]**

Heterogeneity: Chi² = 24.86, df = 1 (P < 0.00001); I² = 96%
Test for overall effect: Z = 0.07 (P = 0.94)

Relative Risk (95% CI) for Stroke Mortality



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Linxian Nutrition - Wang 2016	2,445	452	51.7%	1.17 [0.93, 1.48]
PLSAW - Blekkenhorst 2017	1,226	92	48.3%	0.14 [0.06, 0.31]
Total (95% CI) [Random Effects]	**3,671**	**544**	**100.0%**	**0.42 [0.05, 3.38]**

Heterogeneity: Tau² = 2.18; Chi² = 24.86, df = 1 (P < 0.00001); I² = 96%
Test for overall effect: Z = 0.82 (P = 0.41)

Relative Risk (95% CI) for Stroke Mortality

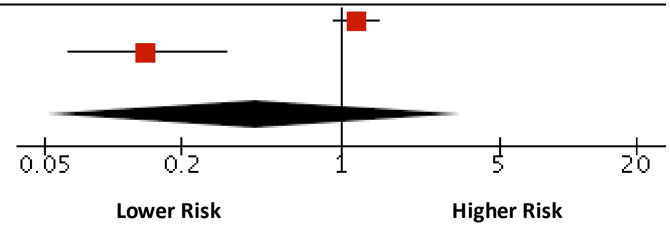


Figure S140. Relation between intake of allium vegetables and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CARROTS AND STROKE MORTALITY

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Miigrant Study - Hjartaker 2015 - carrots	9,766	1,034	100.0%	0.54 [0.48, 0.61]
Total (95% CI)	**9,766**	**1,034**	**100.0%**	**0.54 [0.48, 0.61]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 10.33 (P < 0.00001)				

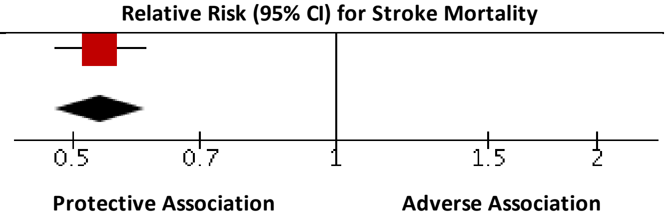


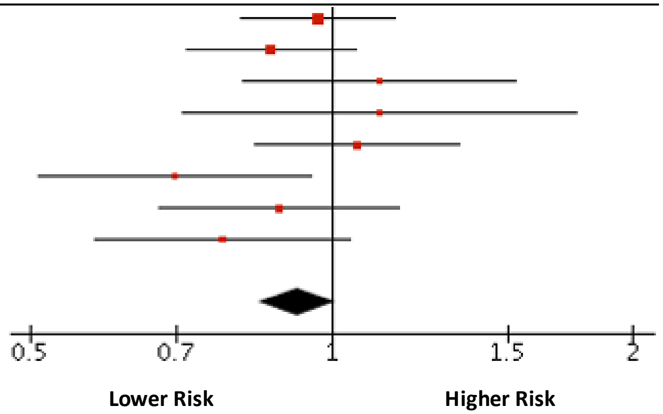
Figure S141. Relation between intake of carrots and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

CRUCIFEROUS VEGETABLES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Stroke Mortality
JACC - Iso 2007 - M	39,486	1,098	25.4%	0.97 [0.81, 1.16]	
JACC - Iso 2007 - F	54,325	919	20.6%	0.87 [0.71, 1.06]	
Migrant Study - Hjartaker 2015 - cauliflower	9,766	1,034	8.0%	1.12 [0.82, 1.53]	
Migrant Study - Hjartaker 2015 - cabbage	-	-	3.9%	1.12 [0.71, 1.75]	
Linxian Nutrition - Wang 2016	2,445	452	14.3%	1.06 [0.84, 1.34]	
PLSAW - Blekkenhorst 2017	1,226	92	8.0%	0.70 [0.51, 0.95]	
Japan Public Health Center - Mori 2018 - M	40,642	856	10.5%	0.89 [0.67, 1.17]	
Japan Public Health Center - Mori 2018 - F	47,562	614	9.2%	0.78 [0.58, 1.04]	
Total (95% CI)	**195,452**	**5,065**	**100.0%**	**0.92 [0.85, 1.01]**	

Heterogeneity: Chi² = 8.55, df = 7 (P = 0.29); I² = 18%
Test for overall effect: Z = 1.75 (P = 0.08)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)	Relative Risk (95% CI) for Stroke Mortality
JACC - Iso 2007 - M	39,486	1,098	22.2%	0.97 [0.81, 1.16]	
JACC - Iso 2007 - F	54,325	919	19.2%	0.87 [0.71, 1.06]	
Migrant Study - Hjartaker 2015 - cabbage	9,766	1,034	4.7%	1.12 [0.71, 1.75]	
Migrant Study - Hjartaker 2015 - cauliflower	-	-	9.0%	1.12 [0.82, 1.53]	
Linxian Nutrition - Wang 2016	2,445	452	14.5%	1.06 [0.84, 1.34]	
PLSAW - Blekkenhorst 2017	1,226	92	9.0%	0.70 [0.51, 0.95]	
Japan Public Health Center - Mori 2018 - F	47,562	614	10.1%	0.78 [0.58, 1.04]	
Japan Public Health Center - Mori 2018 - M	40,642	856	11.3%	0.89 [0.67, 1.17]	
Total (95% CI) [Random Effects]	**195,452**	**5,065**	**100.0%**	**0.92 [0.83, 1.02]**	

Heterogeneity: Tau² = 0.00; Chi² = 8.55, df = 7 (P = 0.29); I² = 18%
Test for overall effect: Z = 1.57 (P = 0.12)

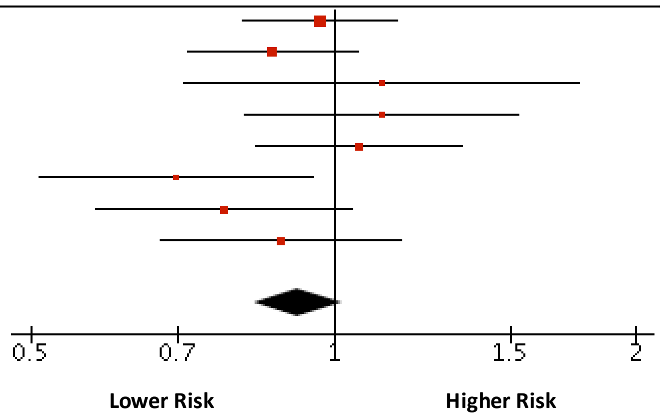


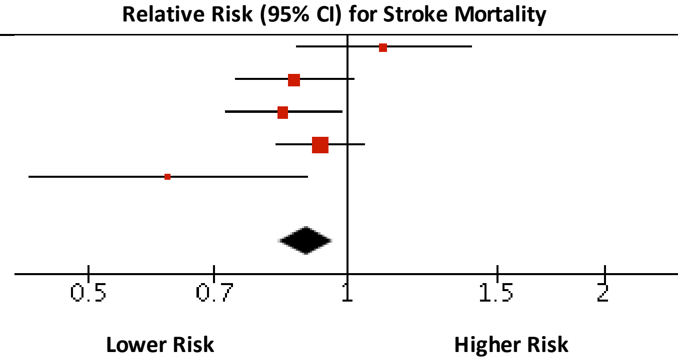
Figure S142. Relation between intake of cruciferous vegetables and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

GREEN LEAFY VEGETABLES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Health Food Shoppers - Appleby 2002	10,741	356	10.1%	1.11 [0.87, 1.40]
JACC - Iso 2007 - M	43,850	1,229	22.7%	0.87 [0.74, 1.02]
JACC - Iso 2007 - F	60,169	1,032	22.7%	0.84 [0.72, 0.99]
Migrant Study - Hjartaker 2015	9,766	1,034	40.4%	0.93 [0.83, 1.05]
Linxian Nutrition - Wang 2016	2,445	452	4.0%	0.62 [0.43, 0.90]
Total (95% CI)	**126,971**	**4,103**	**100.0%**	**0.90 [0.83, 0.97]**

Heterogeneity: Chi² = 8.00, df = 4 (P = 0.09); I² = 50%
Test for overall effect: Z = 2.83 (P = 0.005)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Health Food Shoppers - Appleby 2002	10,741	356	15.3%	1.11 [0.87, 1.40]
JACC - Iso 2007 - M	43,850	1,229	23.7%	0.87 [0.74, 1.02]
JACC - Iso 2007 - F	60,169	1,032	23.7%	0.84 [0.72, 0.99]
Migrant Study - Hjartaker 2015	9,766	1,034	29.4%	0.93 [0.83, 1.05]
Linxian Nutrition - Wang 2016	2,445	452	7.8%	0.62 [0.43, 0.90]
Total (95% CI) [Random Effects]	**126,971**	**4,103**	**100.0%**	**0.89 [0.79, 1.00]**

Heterogeneity: Tau² = 0.01; Chi² = 8.00, df = 4 (P = 0.09); I² = 50%
Test for overall effect: Z = 1.98 (P = 0.05)

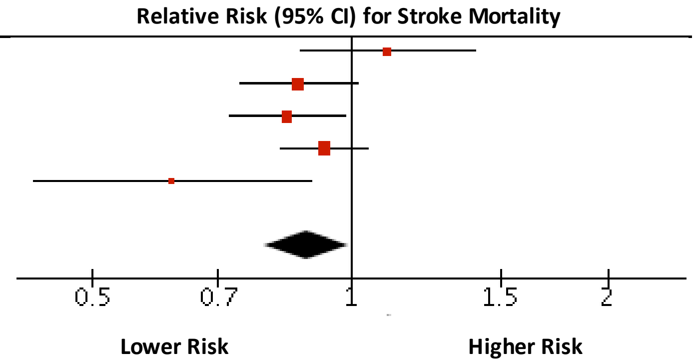


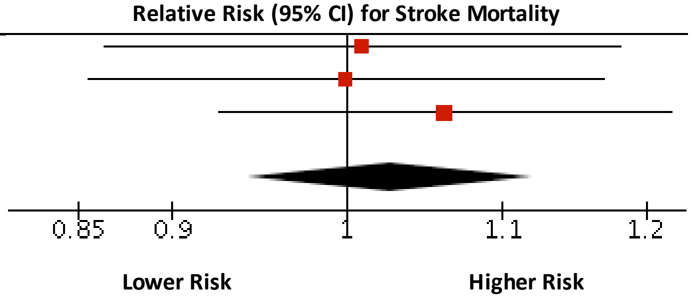
Figure S143. Relation between intake of green leafy vegetables and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

TOMATOES AND STROKE MORTALITY

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	56,947	947	30.20%	1.01 [0.86, 1.18]
JACC - Iso 2007 - M	41,547	1,126	30.20%	1.00 [0.85, 1.17]
Migrant Study - Hjartaker 2015	9,766	1,034	39.50%	1.06 [0.93, 1.22]
Total (95% CI)	**108,260**	**3,107**	**100.00%**	**1.03 [0.94, 1.12]**

Heterogeneity: Chi² = 0.38, df = 2 (P = 0.83); I² = 0%
Test for overall effect: Z = 0.61 (P = 0.54)



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
JACC - Iso 2007 - F	56,947	947	30.20%	1.01 [0.86, 1.18]
JACC - Iso 2007 - M	41,547	1,126	30.20%	1.00 [0.85, 1.17]
Migrant Study - Hjartaker 2015	9,766	1,034	39.50%	1.06 [0.93, 1.22]
Total (95% CI) [Random Effects]	**108,260**	**3,107**	**100.00%**	**1.03 [0.94, 1.12]**

Heterogeneity: Tau² = 0.00; Chi² = 0.38, df = 2 (P = 0.83); I² = 0%
Test for overall effect: Z = 0.61 (P = 0.54)

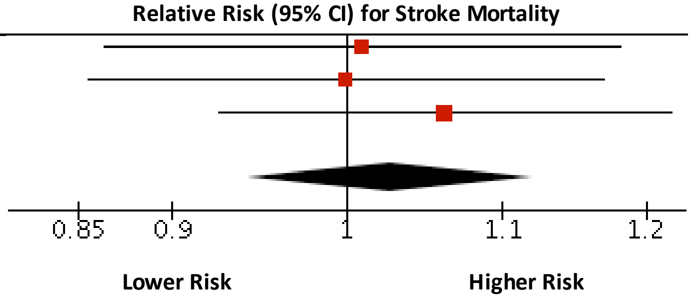
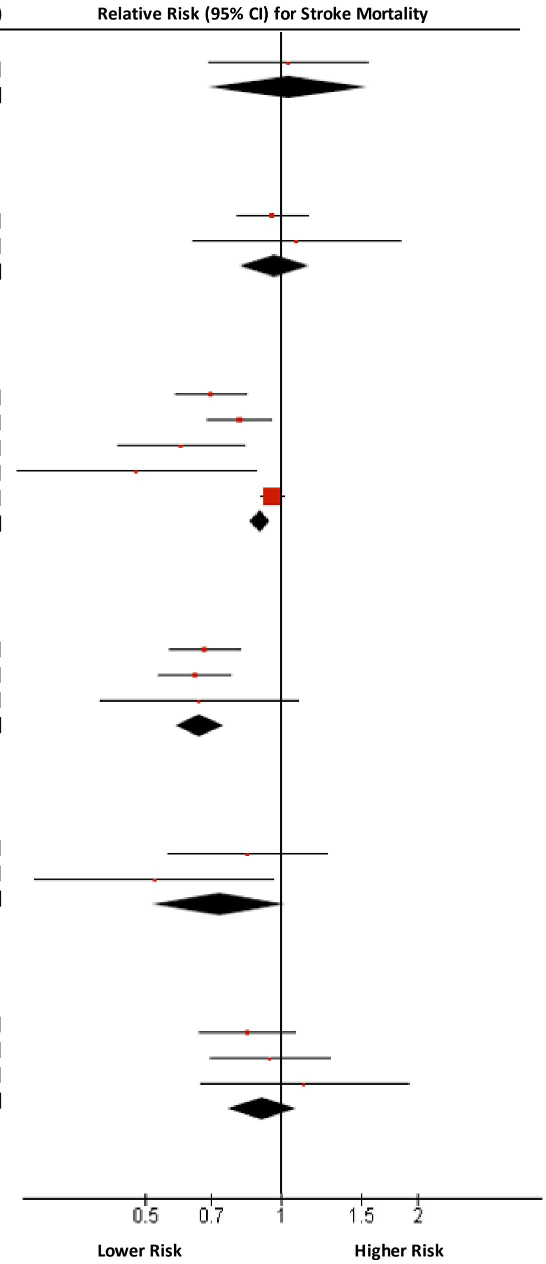


Figure S144. Relation between intake of tomatoes and stroke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of $p<0.10$, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Bananas				
Migrant Study - Hjartaker 2015 - banana	9,766	1,034	1.2%	1.04 [0.70, 1.54]
Subtotal (95% CI)	**9,766**	**1,034**	**1.2%**	**1.04 [0.70, 1.54]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.20 (P = 0.84)				
Berries				
Migrant Study - Hjartaker 2015	9,766	1,034	6.1%	0.96 [0.81, 1.15]
UK Women's Cohort - Lai 2015	30,458	148	0.7%	1.08 [0.65, 1.80]
Subtotal (95% CI)	**40,224**	**1,182**	**6.8%**	**0.97 [0.82, 1.15]**
Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.19$, df = 1 (P = 0.66); $I^2 = 0\%$				
Test for overall effect: Z = 0.32 (P = 0.75)				
Citrus				
JACC - Iso 2007 - F	59,504	1,028	6.1%	0.71 [0.60, 0.85]
JACC - Iso 2007 - M	43,031	1,207	7.7%	0.82 [0.70, 0.96]
Migrant Study - Hjartaker 2015	9,766	1,034	1.9%	0.61 [0.45, 0.84]
UK Women's Cohort - Lai 2015	30,458	148	0.5%	0.49 [0.27, 0.89]
Linxian Nutrition - Wang 2016	2,445	452	54.7%	0.96 [0.91, 1.02]
Subtotal (95% CI)	**145,204**	**3,869**	**70.9%**	**0.90 [0.86, 0.95]**
Heterogeneity: $Tau^2 = 0.03$; $Chi^2 = 22.75$, df = 4 (P = 0.0001); $I^2 = 82\%$				
Test for overall effect: Z = 2.79 (P = 0.005)				
Fruit Juice				
JACC - Iso 2007 - M	41,330	1,131	6.1%	0.69 [0.58, 0.82]
JACC - Iso 2007 - F	56,482	953	6.1%	0.66 [0.55, 0.78]
UK Women's Cohort - Lai 2015	30,458	148	0.8%	0.67 [0.41, 1.09]
Subtotal (95% CI)	**128,270**	**2,232**	**12.9%**	**0.67 [0.60, 0.76]**
Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 0.15$, df = 2 (P = 0.93); $I^2 = 0\%$				
Test for overall effect: Z = 6.41 (P < 0.00001)				
Grapes				
Migrant Study - Hjartaker 2015 - grapes	9,766	1,034	1.2%	0.85 [0.58, 1.26]
UK Women's Cohort - Lai 2015 - grapes	30,458	148	0.5%	0.54 [0.30, 0.97]
Subtotal (95% CI)	**40,224**	**1,182**	**1.8%**	**0.74 [0.53, 1.02]**
Heterogeneity: $Tau^2 = 0.04$; $Chi^2 = 1.63$, df = 1 (P = 0.20); $I^2 = 39\%$				
Test for overall effect: Z = 1.50 (P = 0.13)				
Pommes				
Iowa WHS - Mink 2007	34,492	469	3.4%	0.85 [0.67, 1.08]
Migrant Study - Hjartaker 2015	9,766	1,034	2.2%	0.95 [0.71, 1.28]
UK Women's Cohort - Lai 2015	30,458	148	0.7%	1.13 [0.68, 1.88]
Subtotal (95% CI)	**74,716**	**1,651**	**6.3%**	**0.91 [0.77, 1.09]**
Heterogeneity: $Tau^2 = 0.00$; $Chi^2 = 1.06$, df = 2 (P = 0.59); $I^2 = 0\%$				
Test for overall effect: Z = 1.02 (P = 0.31)				
Test for subgroup differences: $Chi^2 = 23.18$, df = 5 (P = 0.0003), $I^2 = 78.4\%$				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Bananas				
Migrant Study - Hjartaker 2015 - banana	9,766	1,034	4.5%	1.04 [0.70, 1.54]
Subtotal (95% CI)	**9,766**	**1,034**	**4.5%**	**1.04 [0.70, 1.54]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 0.20 (P = 0.84)				
Berries				
UK Women's Cohort - Lai 2015	30,458	148	3.2%	1.08 [0.65, 1.80]
Migrant Study - Hjartaker 2015	9,766	1,034	8.9%	0.96 [0.81, 1.15]
Subtotal (95% CI)	**40,224**	**1,182**	**12.1%**	**0.97 [0.82, 1.15]**
Heterogeneity: Tau² = 0.00; Chi² = 0.19, df = 1 (P = 0.66); I² = 0%				
Test for overall effect: Z = 0.32 (P = 0.75)				
Citrus				
JACC - Iso 2007 - F	59,504	1,028	8.9%	0.71 [0.60, 0.85]
JACC - Iso 2007 - M	43,031	1,207	9.4%	0.82 [0.70, 0.96]
UK Women's Cohort - Lai 2015	30,458	148	2.6%	0.49 [0.27, 0.89]
Migrant Study - Hjartaker 2015	9,766	1,034	5.8%	0.61 [0.45, 0.84]
Linxian Nutrition - Wang 2016	2,445	452	11.5%	0.96 [0.91, 1.02]
Subtotal (95% CI)	**145,204**	**3,869**	**38.2%**	**0.76 [0.63, 0.92]**
Heterogeneity: Tau² = 0.03; Chi² = 22.75, df = 4 (P = 0.0001); I² = 82%				
Test for overall effect: Z = 2.79 (P = 0.005)				
Fruit Juice				
JACC - Iso 2007 - F	56,482	953	8.9%	0.66 [0.55, 0.78]
JACC - Iso 2007 - M	41,330	1,131	8.9%	0.69 [0.58, 0.82]
UK Women's Cohort - Lai 2015	30,458	148	3.4%	0.67 [0.41, 1.09]
Subtotal (95% CI)	**128,270**	**2,232**	**21.2%**	**0.67 [0.60, 0.76]**
Heterogeneity: Tau² = 0.00; Chi² = 0.15, df = 2 (P = 0.93); I² = 0%				
Test for overall effect: Z = 6.41 (P < 0.00001)				
Grapes				
UK Women's Cohort - Lai 2015 - grapes	30,458	148	2.6%	0.54 [0.30, 0.97]
Migrant Study - Hjartaker 2015 - grapes	9,766	1,034	4.5%	0.85 [0.58, 1.26]
Subtotal (95% CI)	**40,224**	**1,182**	**7.1%**	**0.71 [0.46, 1.11]**
Heterogeneity: Tau² = 0.04; Chi² = 1.63, df = 1 (P = 0.20); I² = 39%				
Test for overall effect: Z = 1.50 (P = 0.13)				
Pommes				
Iowa WHS - Mink 2007	34,492	469	7.5%	0.85 [0.67, 1.08]
Migrant Study - Hjartaker 2015	9,766	1,034	6.2%	0.95 [0.71, 1.28]
UK Women's Cohort - Lai 2015	30,458	148	3.2%	1.13 [0.68, 1.88]
Subtotal (95% CI)	**74,716**	**1,651**	**16.9%**	**0.91 [0.77, 1.09]**
Heterogeneity: Tau² = 0.00; Chi² = 1.06, df = 2 (P = 0.59); I² = 0%				
Test for overall effect: Z = 1.02 (P = 0.31)				
Test for subgroup differences: Chi² = 17.65, df = 5 (P = 0.003), I² = 71.7%				

Relative Risk (95% CI) for Stroke Mortality

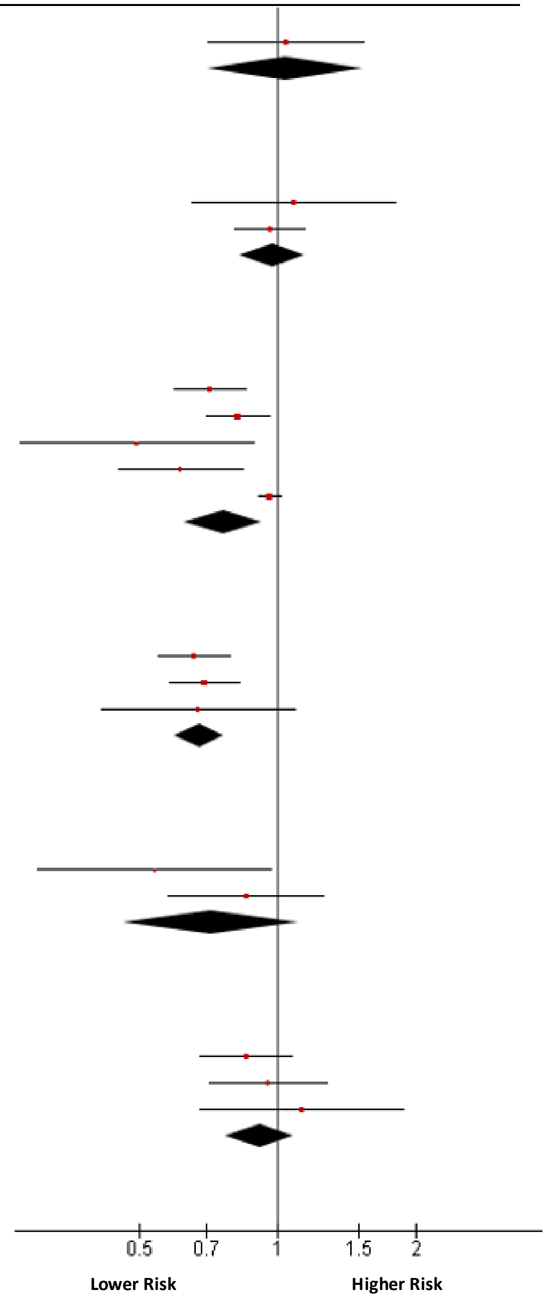
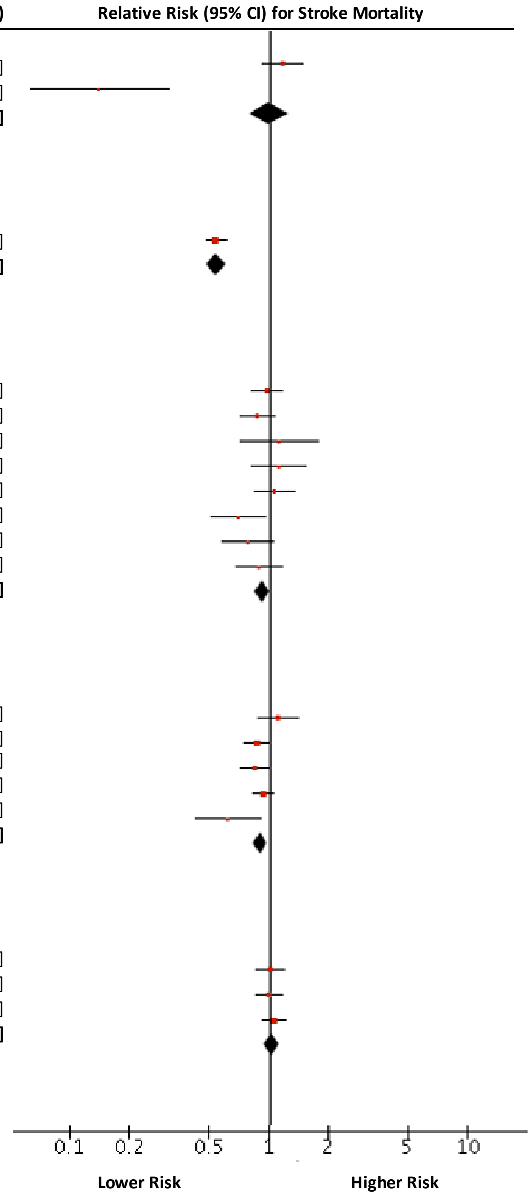


Figure S145. Relation between sources of fruit and stoke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

A. Fixed Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Linxian Nutrition - Wang 2016	2,445	452	3.4%	1.17 [0.93, 1.48]
PLSAW - Blekkenhorst 2017	1,226	92	0.3%	0.14 [0.06, 0.31]
Subtotal (95% CI)	**3,671**	**544**	**3.7%**	**0.99 [0.79, 1.24]**
Heterogeneity: Chi² = 24.86, df = 1 (P < 0.00001); I² = 96%				
Test for overall effect: Z = 0.07 (P = 0.94)				
Carrots				
Miigrant Study - Hjartaker 2015 - carrots	9,766	1,034	13.6%	0.54 [0.48, 0.61]
Subtotal (95% CI)	**9,766**	**1,034**	**13.6%**	**0.54 [0.48, 0.61]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 10.33 (P < 0.00001)				
Cruciferous				
JACC - Iso 2007 - M	39,486	1,098	6.0%	0.97 [0.81, 1.16]
JACC - Iso 2007 - F	54,325	919	4.9%	0.87 [0.71, 1.06]
Migrant Study - Hjartaker 2015 - cabbage	9,766	1,034	0.9%	1.12 [0.71, 1.75]
Migrant Study - Hjartaker 2015 - cauliflower	-	-	1.9%	1.12 [0.82, 1.53]
Linxian Nutrition - Wang 2016	2,445	452	3.4%	1.06 [0.84, 1.34]
PLSAW - Blekkenhorst 2017	1,226	92	1.9%	0.70 [0.51, 0.95]
Japan Public Health Center - Mori 2018 - F	47,562	614	2.2%	0.78 [0.58, 1.04]
Japan Public Health Center - Mori 2018 - M	40,642	856	2.5%	0.89 [0.67, 1.17]
Subtotal (95% CI)	**195,452**	**5,065**	**23.8%**	**0.92 [0.85, 1.01]**
Heterogeneity: Chi² = 8.55, df = 7 (P = 0.29); I² = 18%				
Test for overall effect: Z = 1.75 (P = 0.08)				
Green Leafy				
Health Food Shoppers - Appleby 2002	10,741	356	3.4%	1.11 [0.87, 1.40]
JACC - Iso 2007 - M	43,850	1,229	7.6%	0.87 [0.74, 1.02]
JACC - Iso 2007 - F	60,169	1,032	7.6%	0.84 [0.72, 0.99]
Migrant Study - Hjartaker 2015	9,766	1,034	13.6%	0.93 [0.83, 1.05]
Linxian Nutrition - Wang 2016	2,445	452	1.4%	0.62 [0.43, 0.90]
Subtotal (95% CI)	**126,971**	**4,103**	**33.7%**	**0.90 [0.83, 0.97]**
Heterogeneity: Chi² = 8.00, df = 4 (P = 0.09); I² = 50%				
Test for overall effect: Z = 2.83 (P = 0.005)				
Tomatoes				
JACC - Iso 2007 - F	56,947	947	7.6%	1.01 [0.86, 1.18]
JACC - Iso 2007 - M	41,547	1,126	7.6%	1.00 [0.85, 1.17]
Migrant Study - Hjartaker 2015	9,766	1,034	10.0%	1.06 [0.93, 1.22]
Subtotal (95% CI)	**108,260**	**3,107**	**25.3%**	**1.03 [0.94, 1.12]**
Heterogeneity: Chi² = 0.38, df = 2 (P = 0.83); I² = 0%				
Test for overall effect: Z = 0.61 (P = 0.54)				
Test for subgroup differences: Chi² = 82.07, df = 4 (P < 0.00001), I² = 95.1%				



B. Random Effects

Cohort and Study	Participants, N	Cases, N	Weight	RR (95% CI)
Allium				
Linxian Nutrition - Wang 2016	2,445	452	5.4%	1.17 [0.93, 1.48]
PLSAW - Blekkenhorst 2017	1,226	92	1.7%	0.14 [0.06, 0.31]
Subtotal (95% CI)	**3,671**	**544**	**7.0%**	**0.42 [0.05, 3.38]**
Heterogeneity: Tau² = 2.18; Chi² = 24.86, df = 1 (P < 0.00001); I² = 96%				
Test for overall effect: Z = 0.82 (P = 0.41)				
Carrots				
Miigrant Study - Hjartaker 2015 - carrots	9,766	1,034	6.4%	0.54 [0.48, 0.61]
Subtotal (95% CI)	**9,766**	**1,034**	**6.4%**	**0.54 [0.48, 0.61]**
Heterogeneity: Not applicable				
Test for overall effect: Z = 10.33 (P < 0.00001)				
Cruciferous				
JACC - Iso 2007 - M	39,486	1,098	5.9%	0.97 [0.81, 1.16]
JACC - Iso 2007 - F	54,325	919	5.7%	0.87 [0.71, 1.06]
Migrant Study - Hjartaker 2015 - cabbage	9,766	1,034	3.5%	1.12 [0.71, 1.75]
Migrant Study - Hjartaker 2015 - cauliflower	-	-	4.6%	1.12 [0.82, 1.53]
Linxian Nutrition - Wang 2016	2,445	452	5.4%	1.06 [0.84, 1.34]
PLSAW - Blekkenhorst 2017	1,226	92	4.6%	0.70 [0.51, 0.95]
Japan Public Health Center - Mori 2018 - M	40,642	856	5.0%	0.89 [0.67, 1.17]
Japan Public Health Center - Mori 2018 - F	47,562	614	4.9%	0.78 [0.58, 1.04]
Subtotal (95% CI)	**195,452**	**5,065**	**39.9%**	**0.92 [0.83, 1.02]**
Heterogeneity: Tau² = 0.00; Chi² = 8.55, df = 7 (P = 0.29); I² = 18%				
Test for overall effect: Z = 1.57 (P = 0.12)				
Green Leafy				
Health Food Shoppers - Appleby 2002	10,741	356	5.4%	1.11 [0.87, 1.40]
JACC - Iso 2007 - M	43,850	1,229	6.1%	0.87 [0.74, 1.02]
JACC - Iso 2007 - F	60,169	1,032	6.1%	0.84 [0.72, 0.99]
Migrant Study - Hjartaker 2015	9,766	1,034	6.4%	0.93 [0.83, 1.05]
Linxian Nutrition - Wang 2016	2,445	452	4.1%	0.62 [0.43, 0.90]
Subtotal (95% CI)	**126,971**	**4,103**	**28.0%**	**0.89 [0.79, 1.00]**
Heterogeneity: Tau² = 0.01; Chi² = 8.00, df = 4 (P = 0.09); I² = 50%				
Test for overall effect: Z = 1.98 (P = 0.05)				
Tomatoes				
JACC - Iso 2007 - F	56,947	947	6.1%	1.01 [0.86, 1.18]
JACC - Iso 2007 - M	41,547	1,126	6.1%	1.00 [0.85, 1.17]
Migrant Study - Hjartaker 2015	9,766	1,034	6.2%	1.06 [0.93, 1.22]
Subtotal (95% CI)	**108,260**	**3,107**	**18.4%**	**1.03 [0.94, 1.12]**
Heterogeneity: Tau² = 0.00; Chi² = 0.38, df = 2 (P = 0.83); I² = 0%				
Test for overall effect: Z = 0.61 (P = 0.54)				
Test for subgroup differences: Chi² = 80.08, df = 4 (P < 0.00001), I² = 95.0%				
				0.88 [0.78, 0.99]

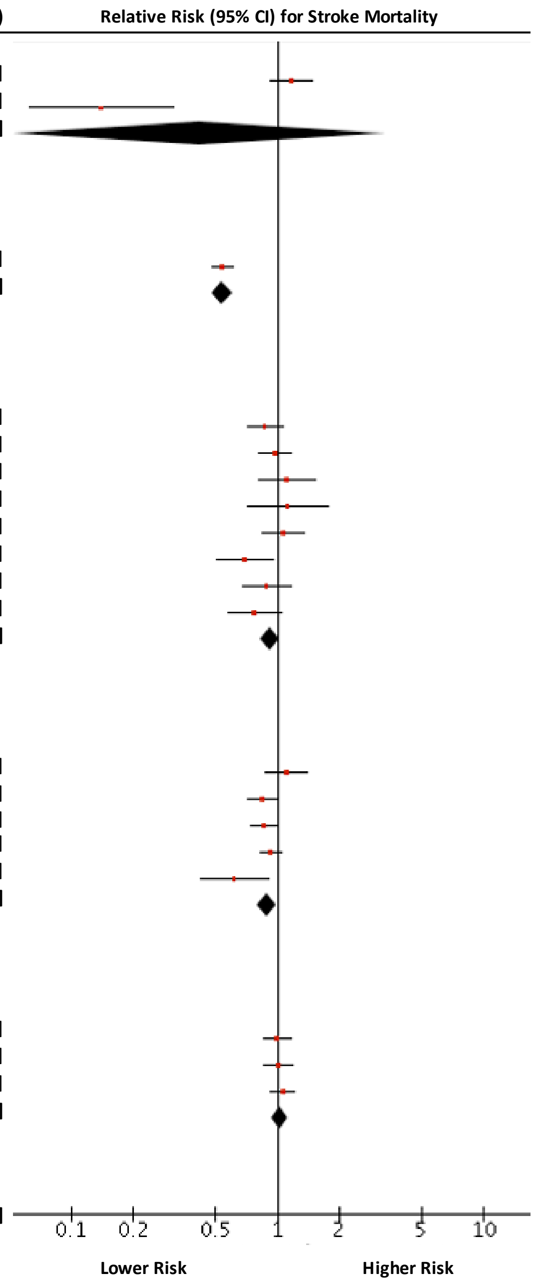


Figure S146. Relation between sources of vegetables and stoke mortality (highest vs. lowest level of intake). All results are presented as relative risk (RR) with 95% confidence intervals (95% CI). Pooled risk estimate is represented by the black diamond using (A) fixed effects and (B) random effects models. Inter-study heterogeneity was assessed using the Cochran Q statistic (Chi^2) at a significance level of p<0.10, and quantified by I^2, with values ≥ 50% indicating substantial heterogeneity.

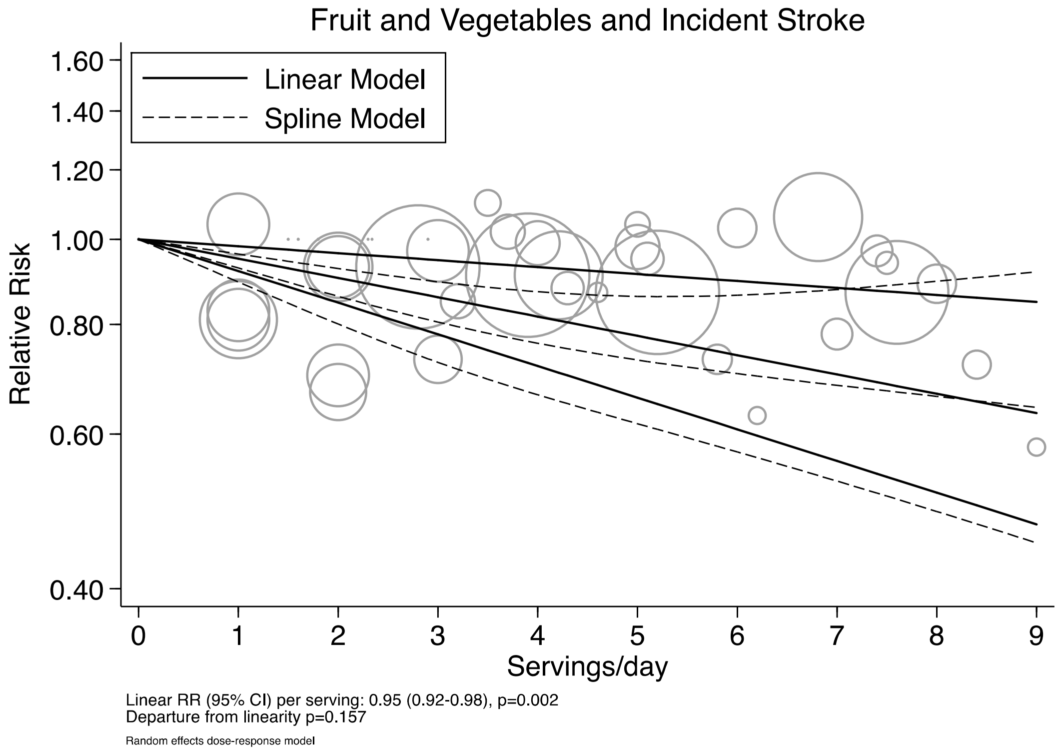


Figure S147. Linear and cubic-spline dose-response relation between increasing fruit and vegetable intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

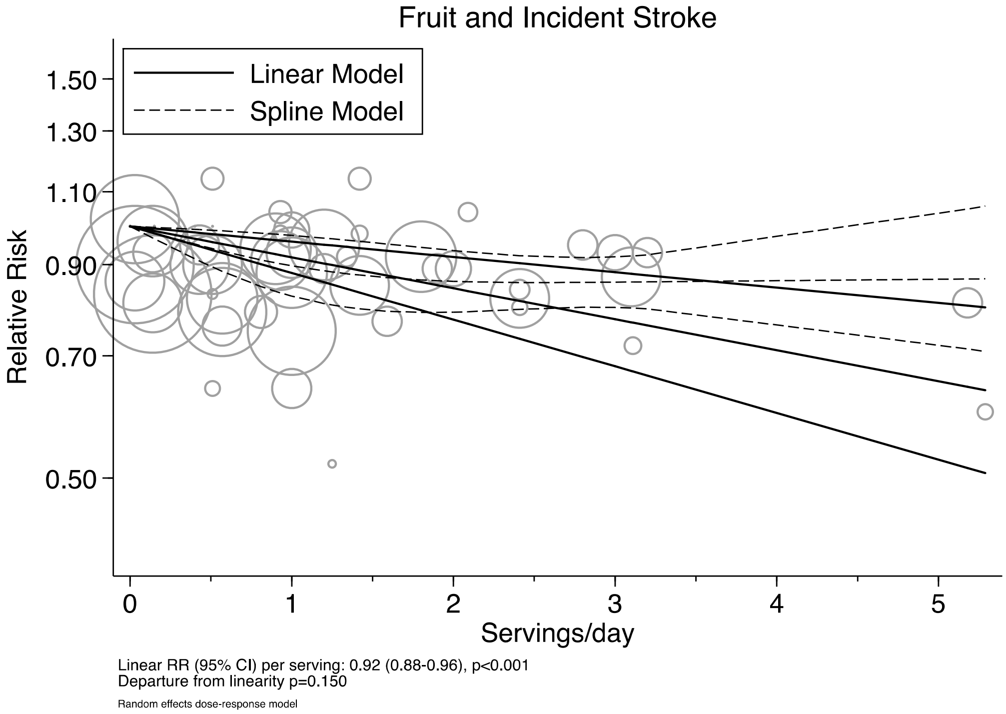


Figure S148. Linear and cubic-spline dose-response relation between increasing fruit intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

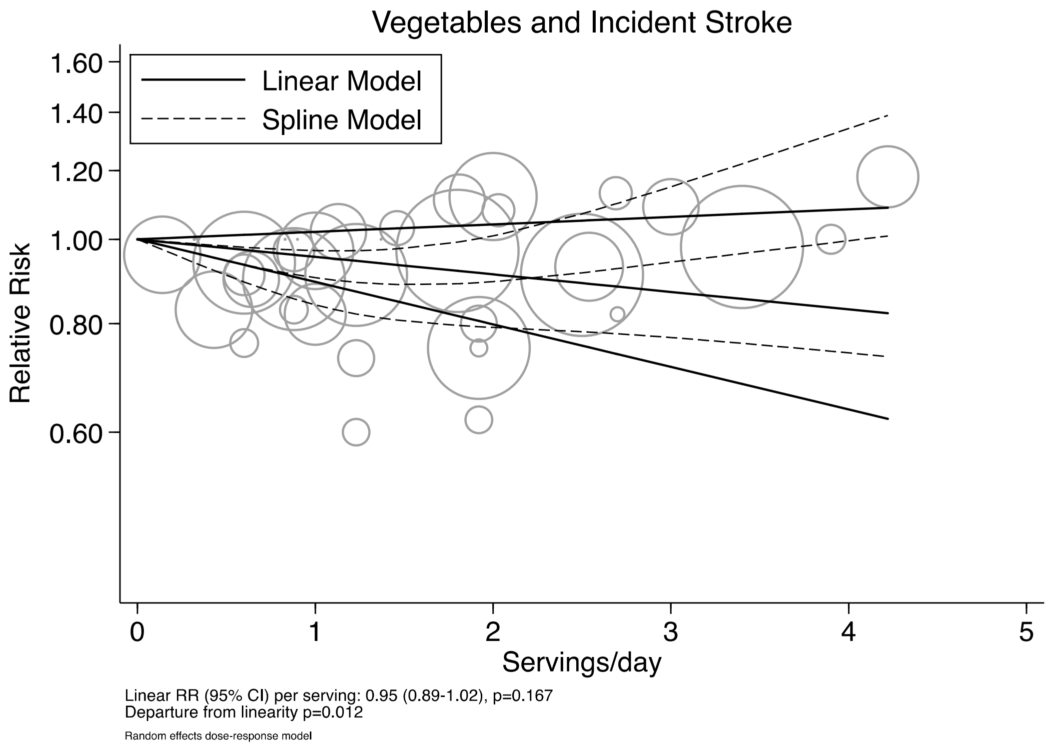


Figure S149. Linear and cubic-spline dose-response relation between increasing intake of vegetables and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

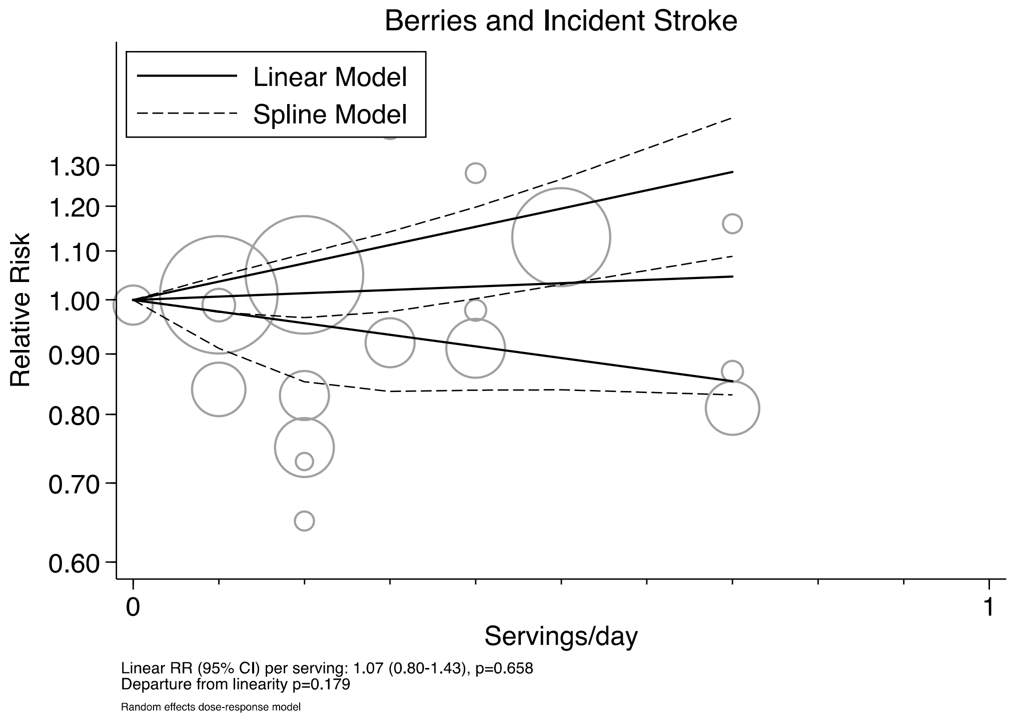


Figure S150. Linear and cubic-spline dose-response relation between increasing berries intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

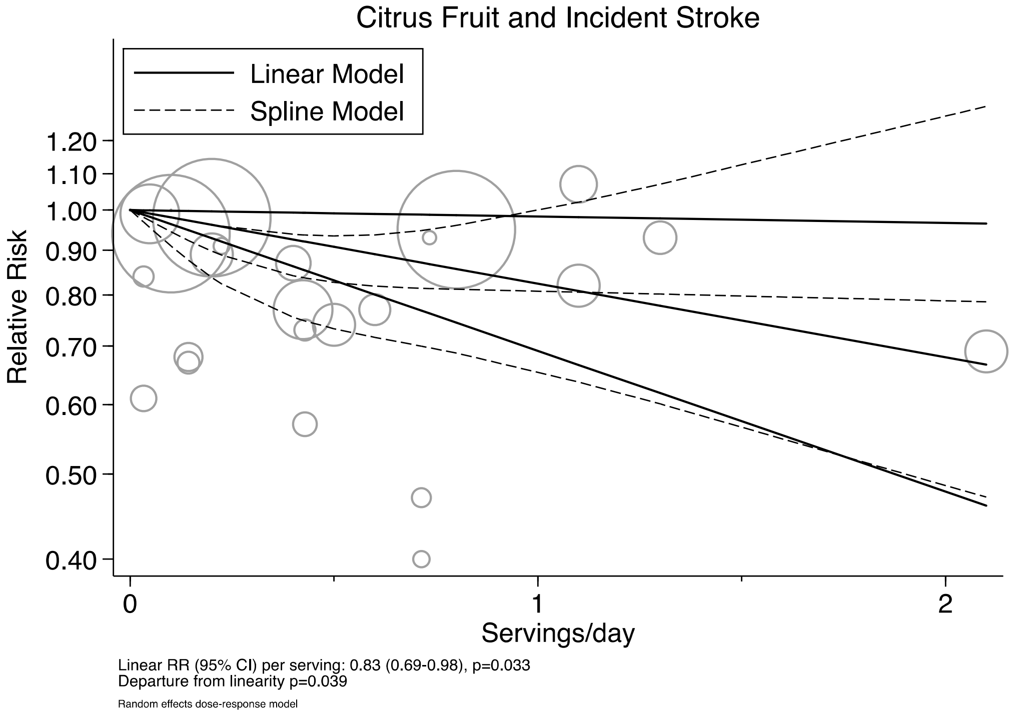


Figure S151. Linear and cubic-spline dose-response relation between increasing citrus fruit intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

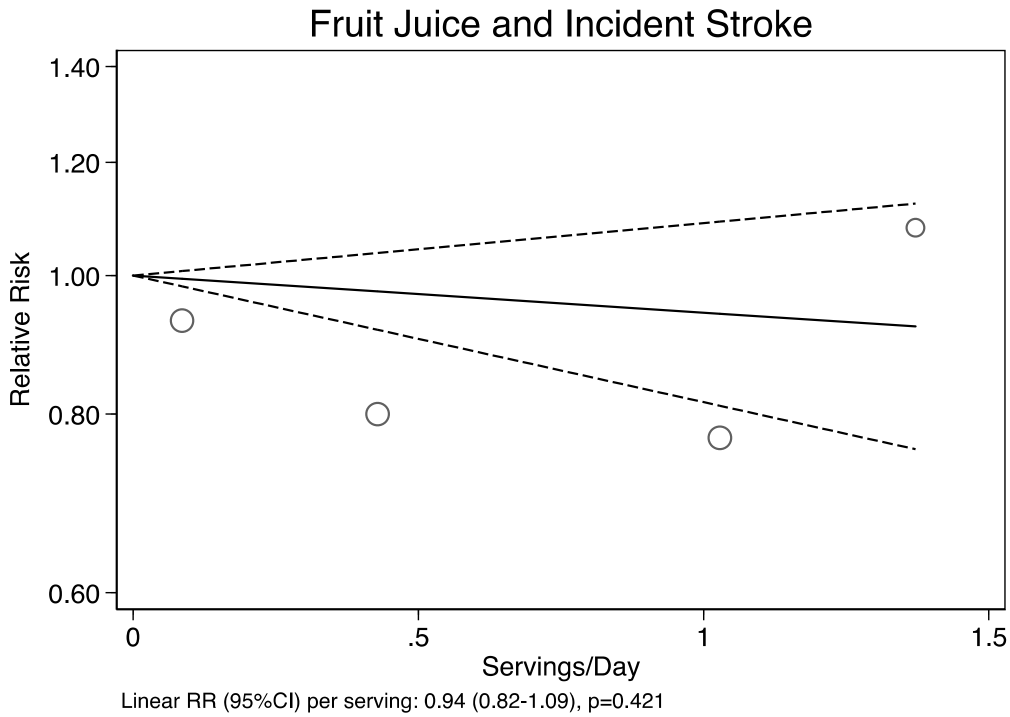


Figure S152. Linear and cubic-spline dose-response relation between increasing fruit juice intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

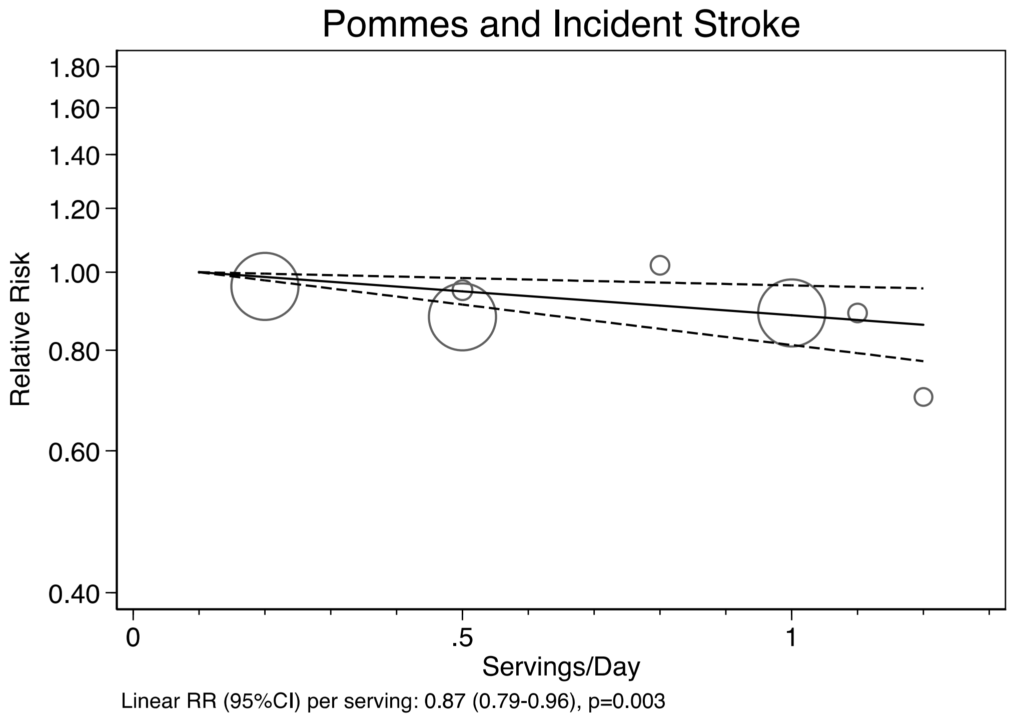


Figure S153. Linear dose-response relation between increasing pommes intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

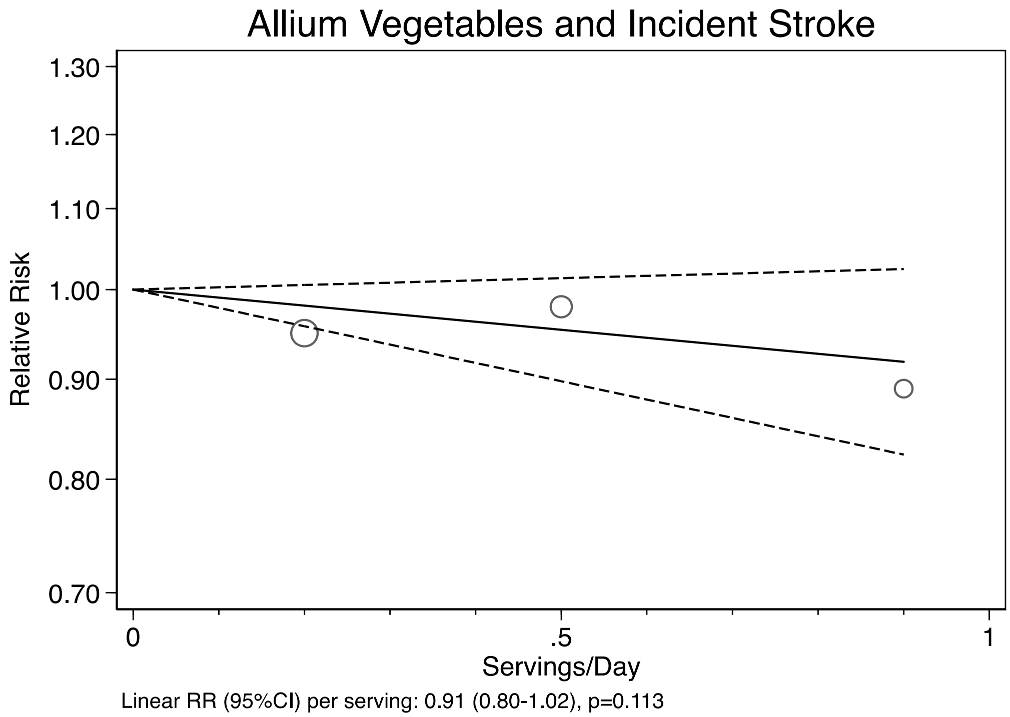


Figure S154 Linear dose-response relation between increasing intake of allium vegetables and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

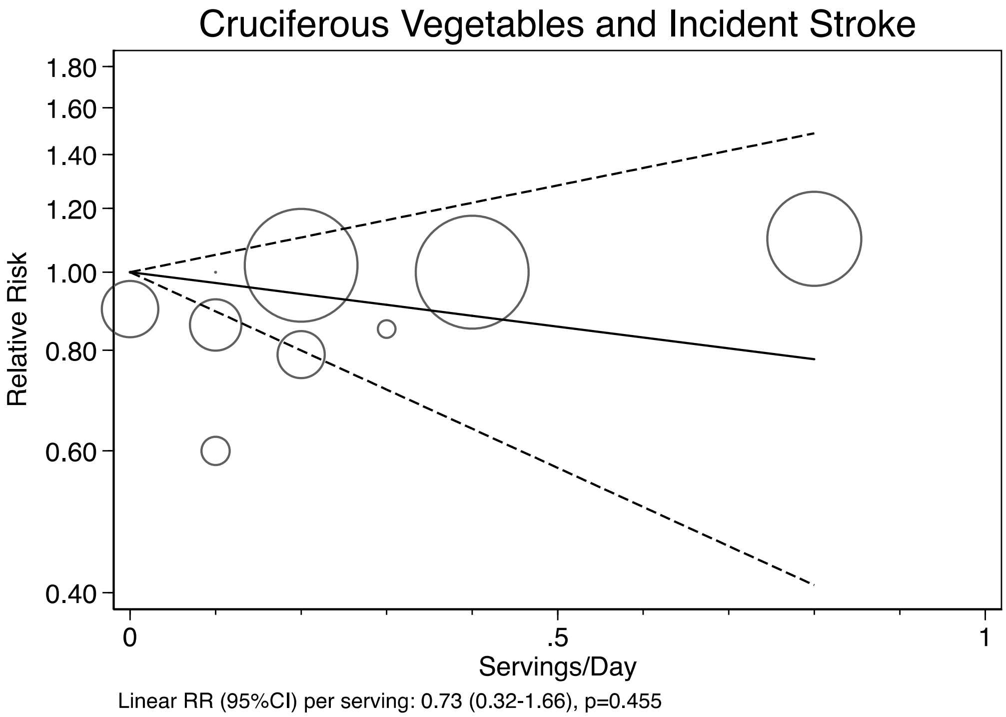


Figure S155. Linear dose-response relation between increasing intake of cruciferous vegetables and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

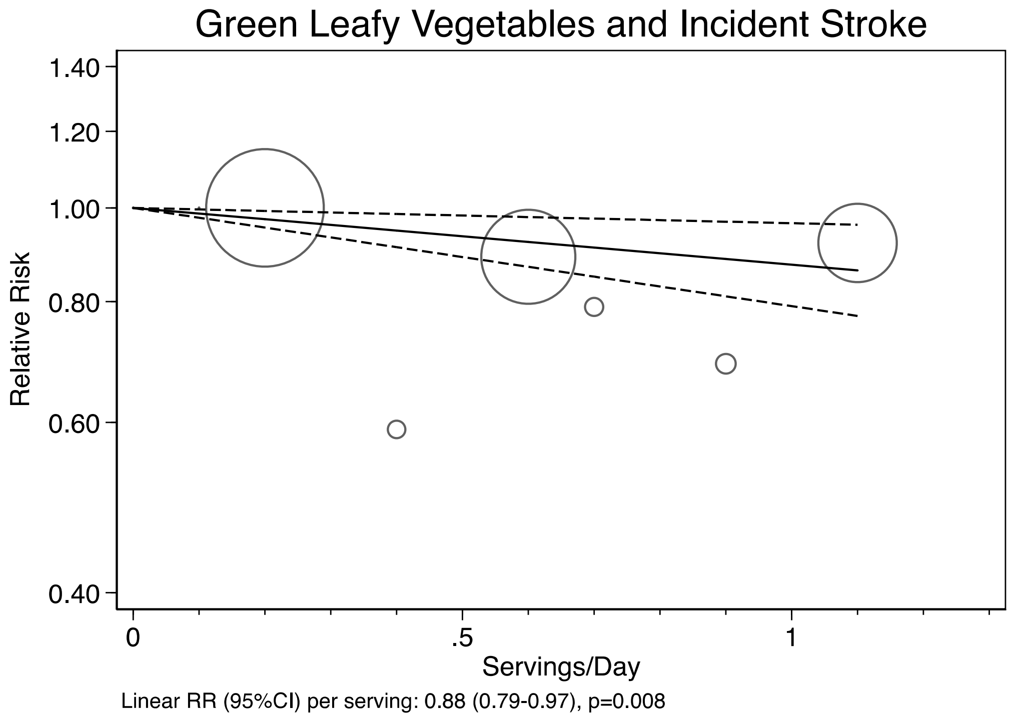


Figure S156. Linear dose-response relation between increasing intake of green leafy vegetables and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

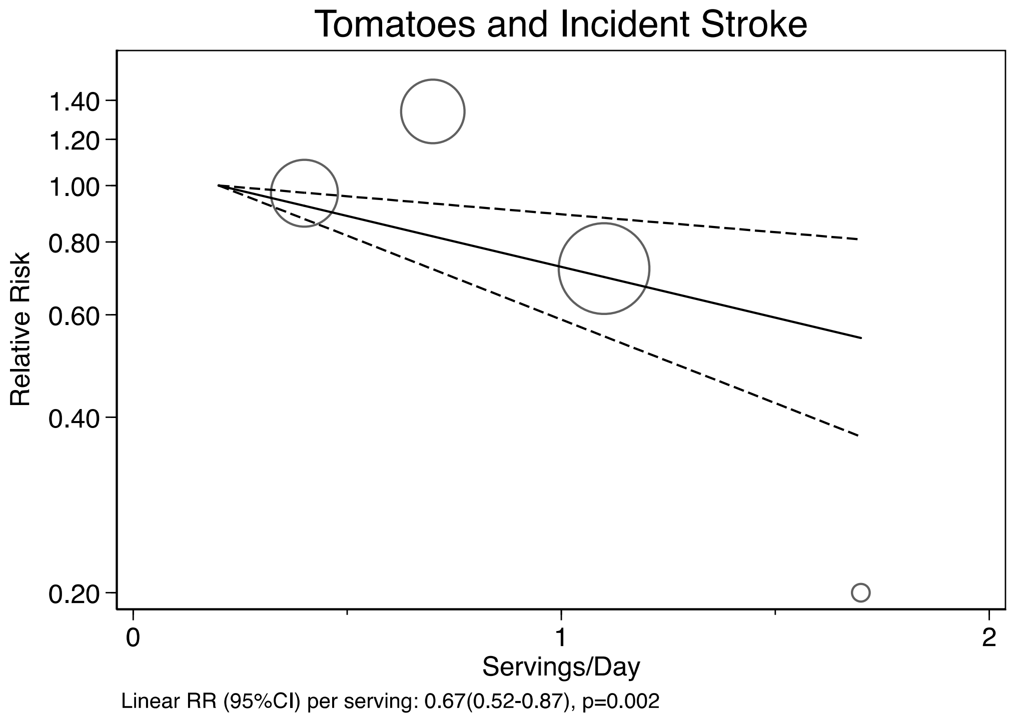


Figure S157. Linear dose-response relation between increasing tomato intake and incidence of stroke. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

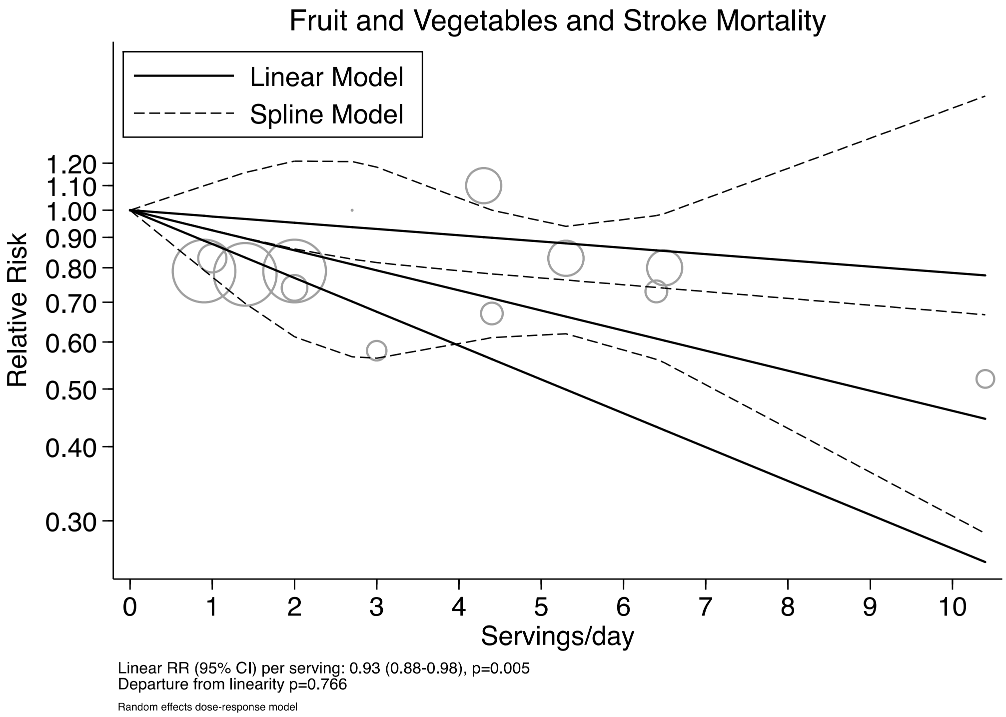


Figure S158. Linear dose-response relation between increasing fruit and vegetable intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

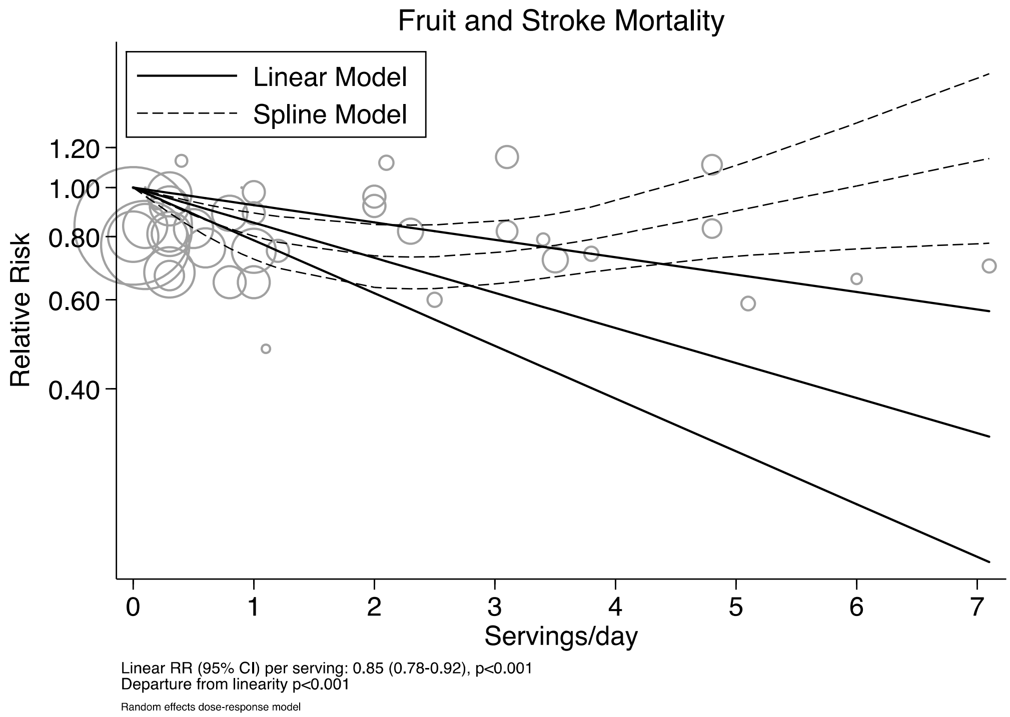


Figure S159. Linear and cubic-spline dose-response relation between increasing fruit intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

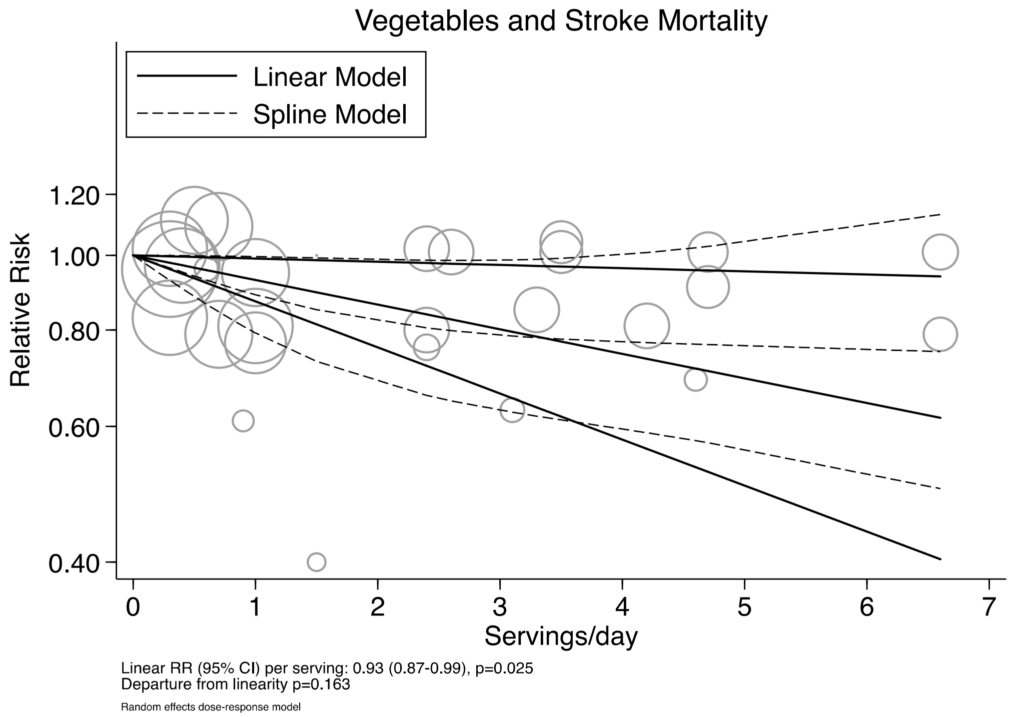


Figure S160. Linear and cubic-spline dose-response relation between increasing intake of vegetables and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

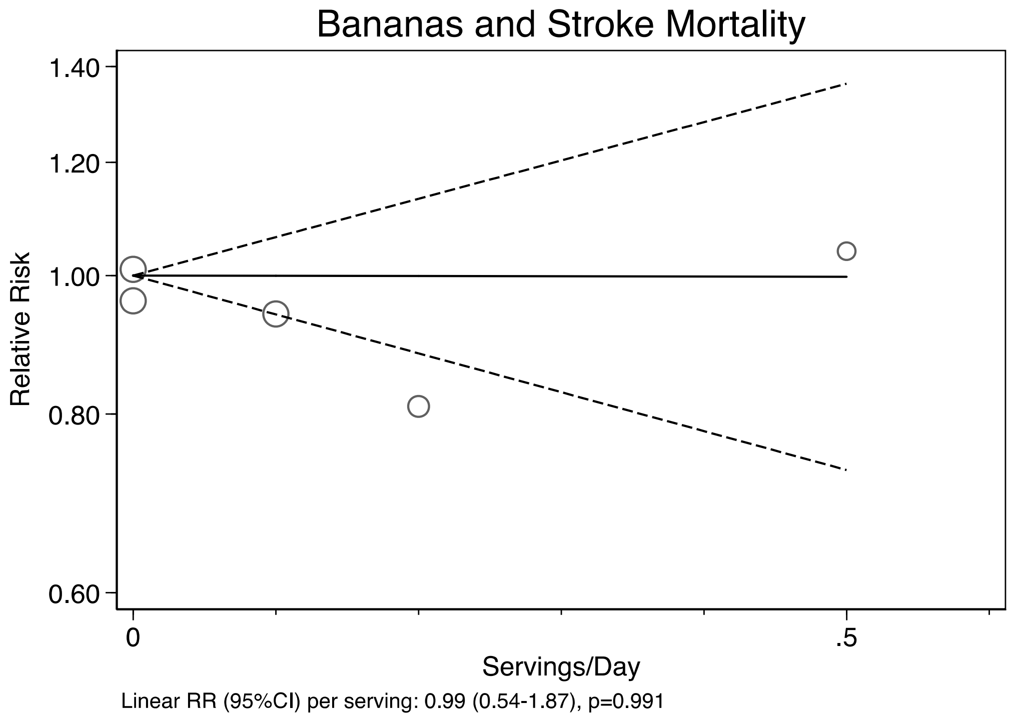


Figure S161 Linear dose-response relation between increasing banana intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

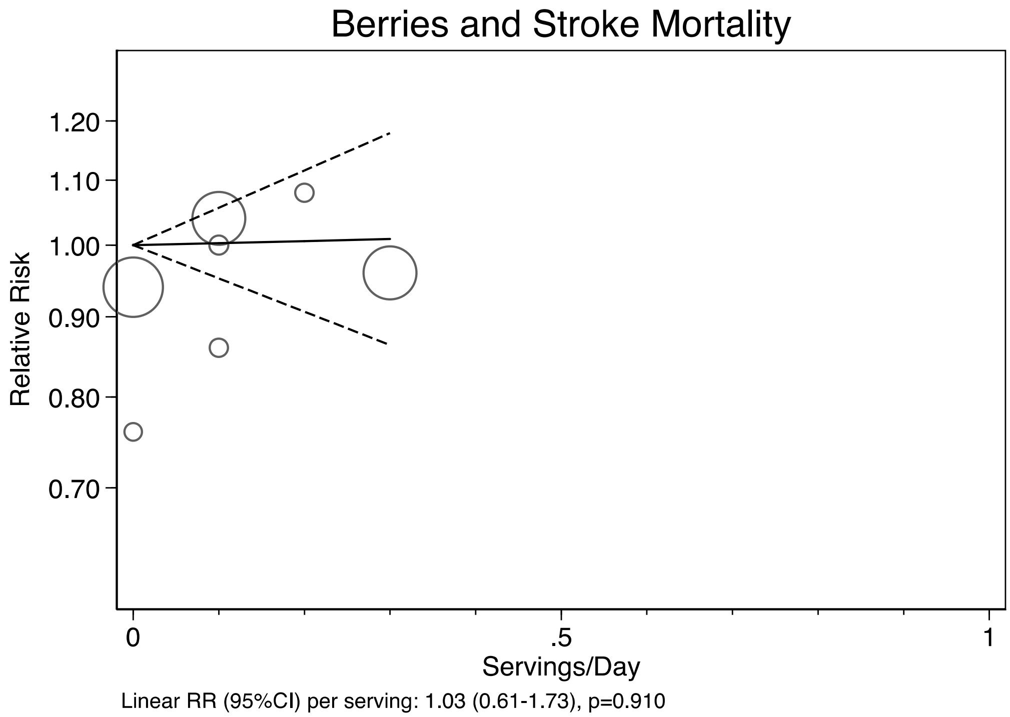


Figure S162. Linear dose-response relation between increasing berries intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

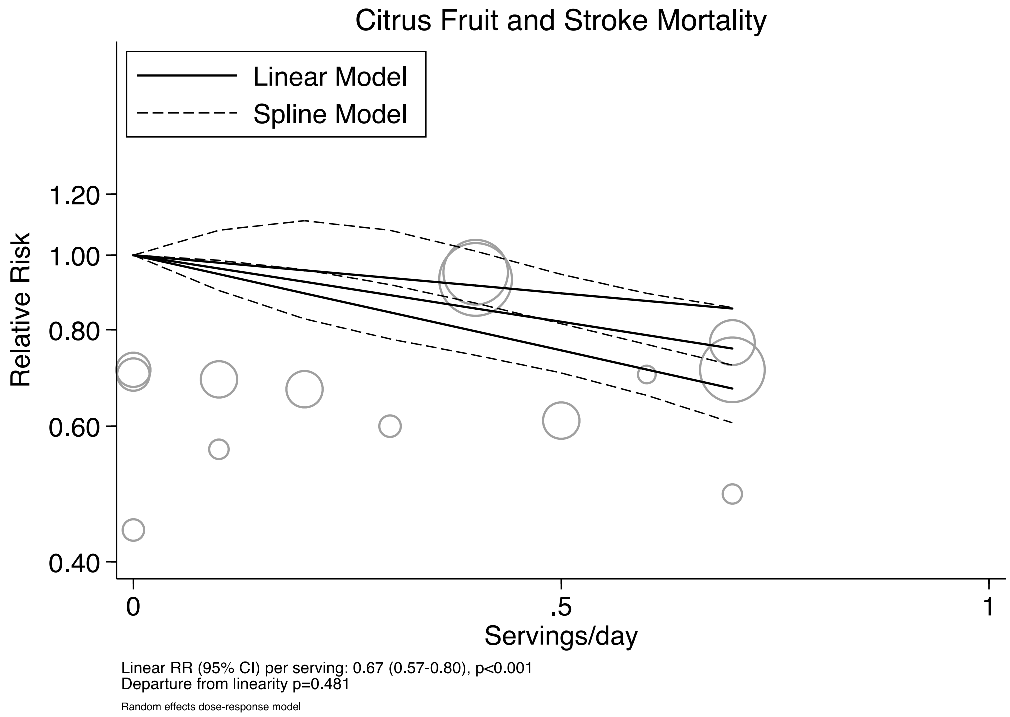


Figure S163. Linear and cubic-spline dose-response relation between increasing citrus fruit intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

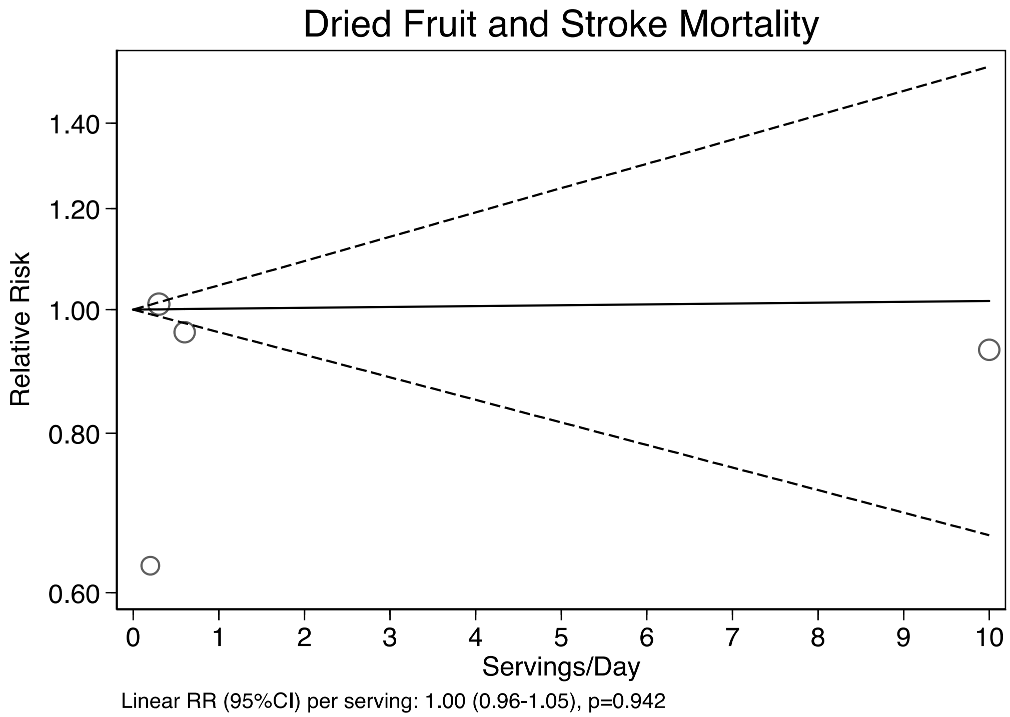


Figure S164. Linear and cubic-spline dose-response relation between increasing dried fruit intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

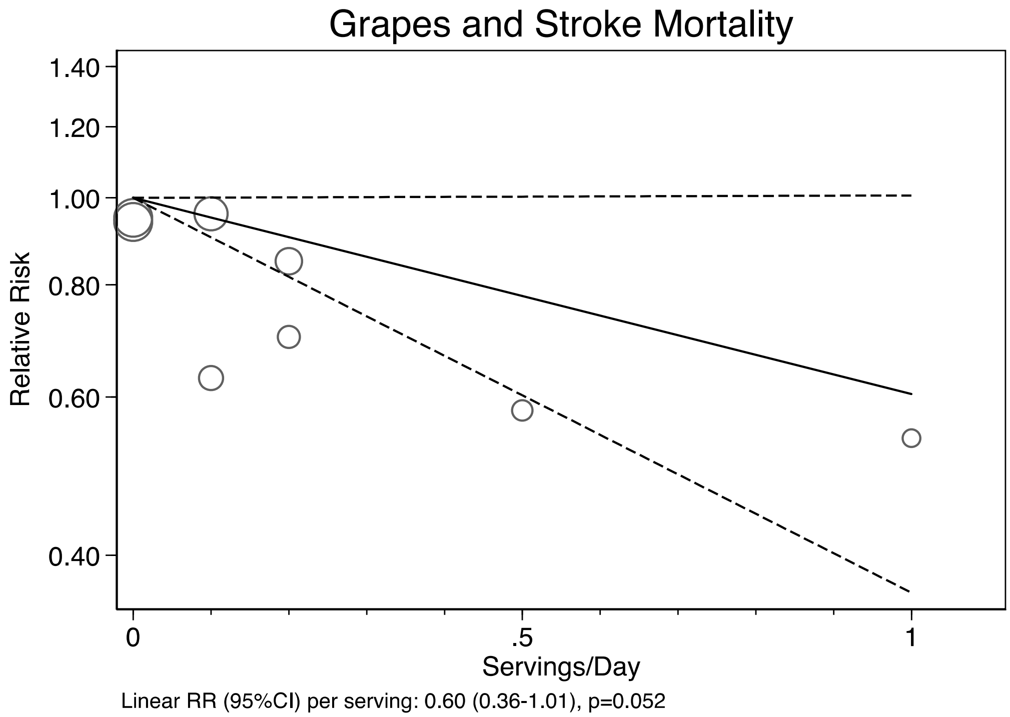


Figure S165. Linear dose-response relation between increasing grapes intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

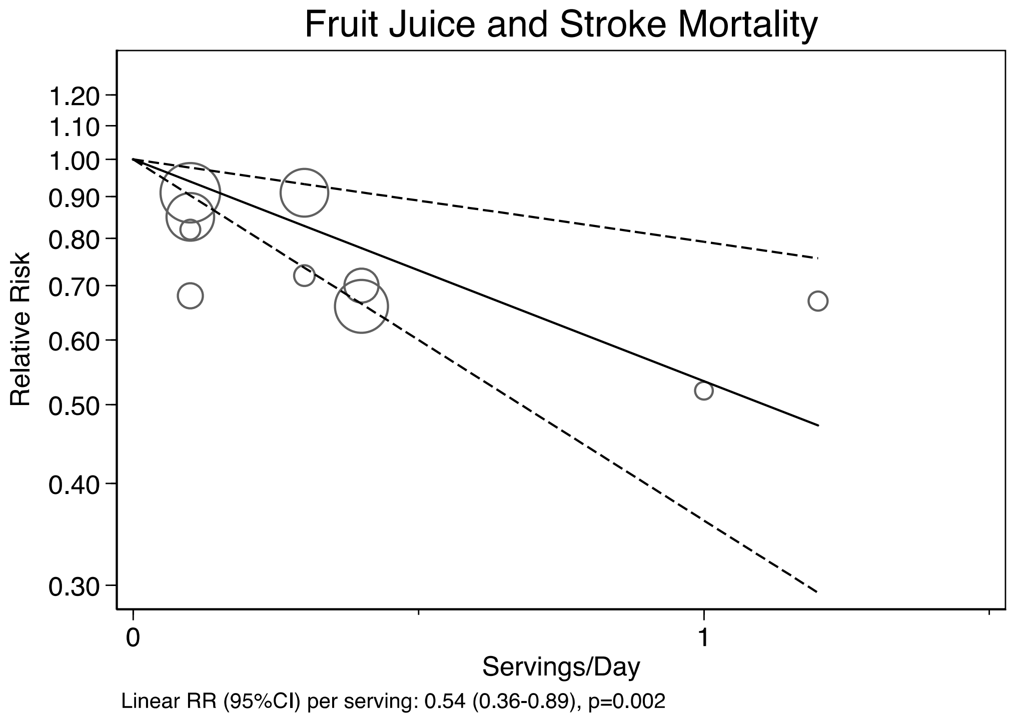


Figure S166. Linear dose-response relation between increasing fruit juice intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

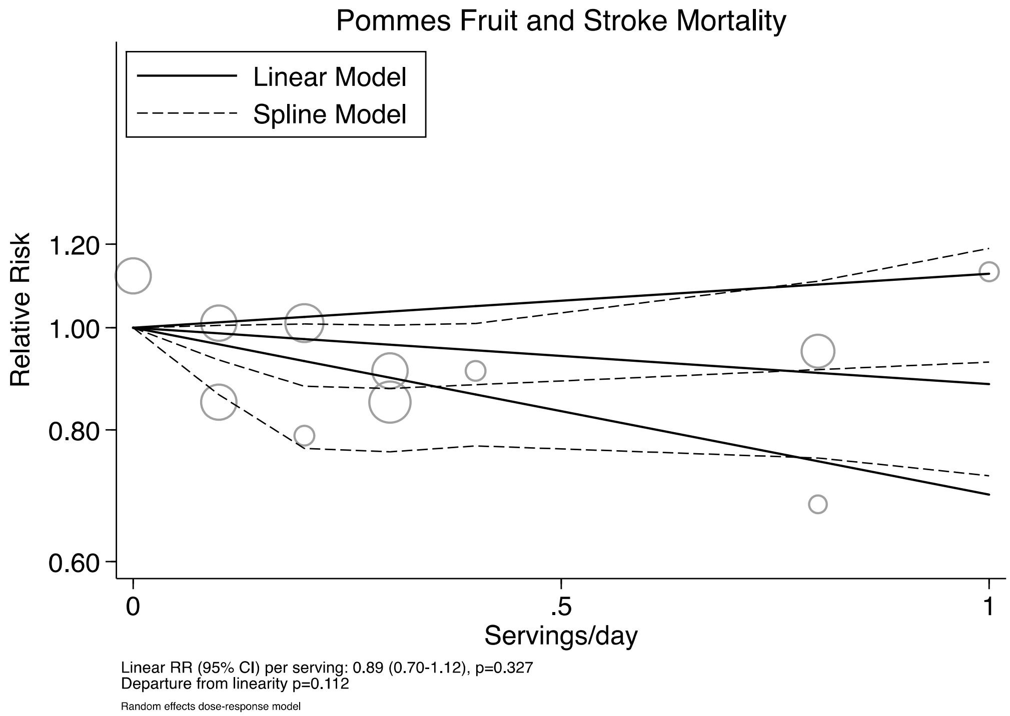


Figure S167. Linear and cubic-spline dose-response relation between increasing pomme fruit intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

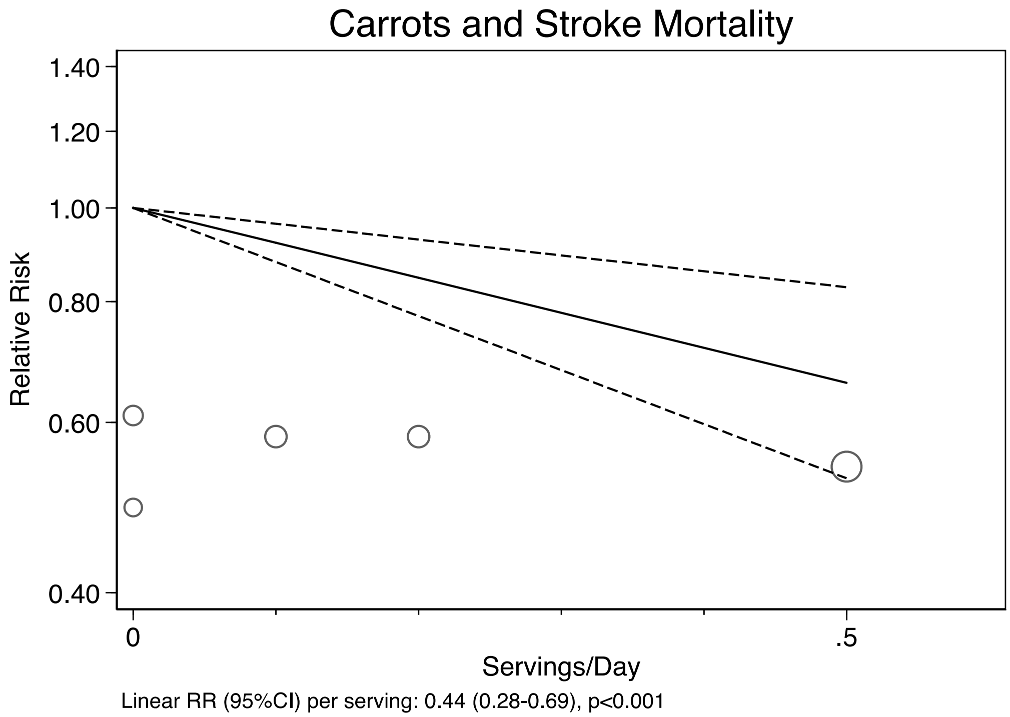


Figure S168. Linear dose-response relation between increasing intake of carrots and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

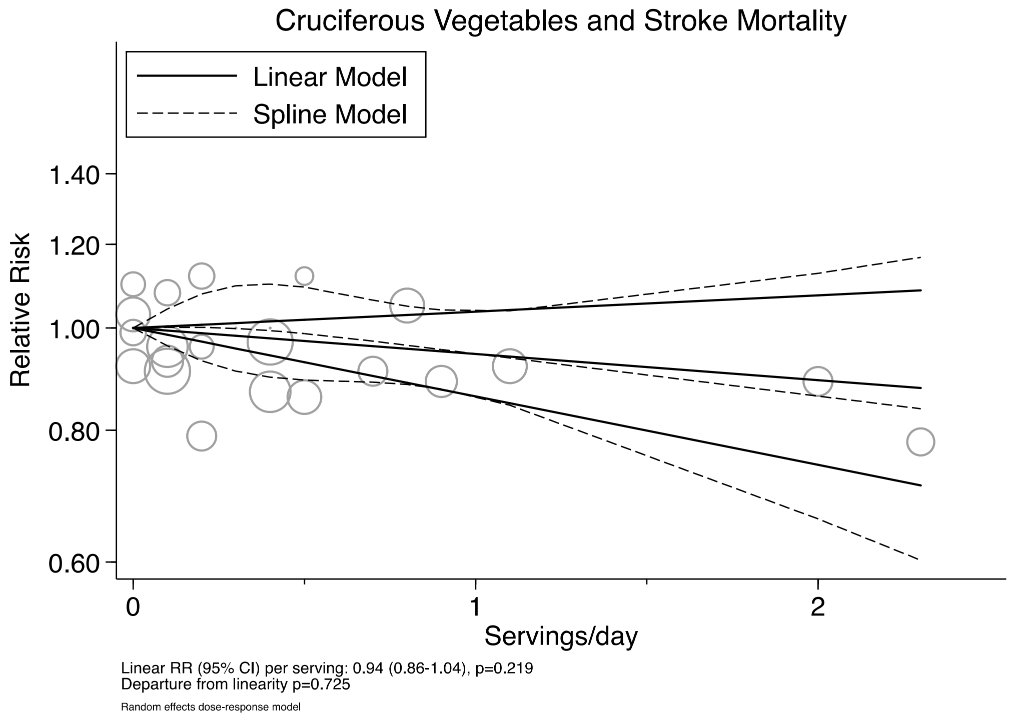


Figure S169. Linear and cubic-spline dose-response relation between increasing cruciferous vegetable intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

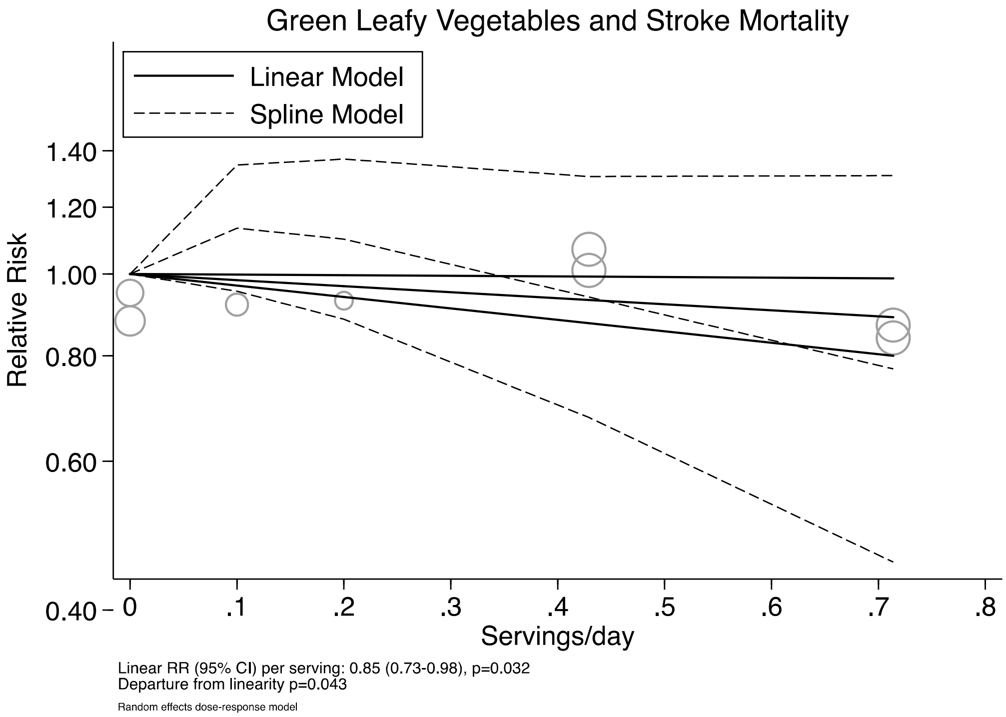


Figure S170. Linear and cubic-spline dose-response relation between increasing green leafy vegetable intake and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. Cubic spline data were modeled with fixed-effects restricted cubic spline with 3 knots and using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk. All data was kept on the original dose scale. The fitted trend for each model is represented by a central line (solid lines for linear model; dashed lines for cubic spline model) with 95% confidence intervals represented by the outer lines. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

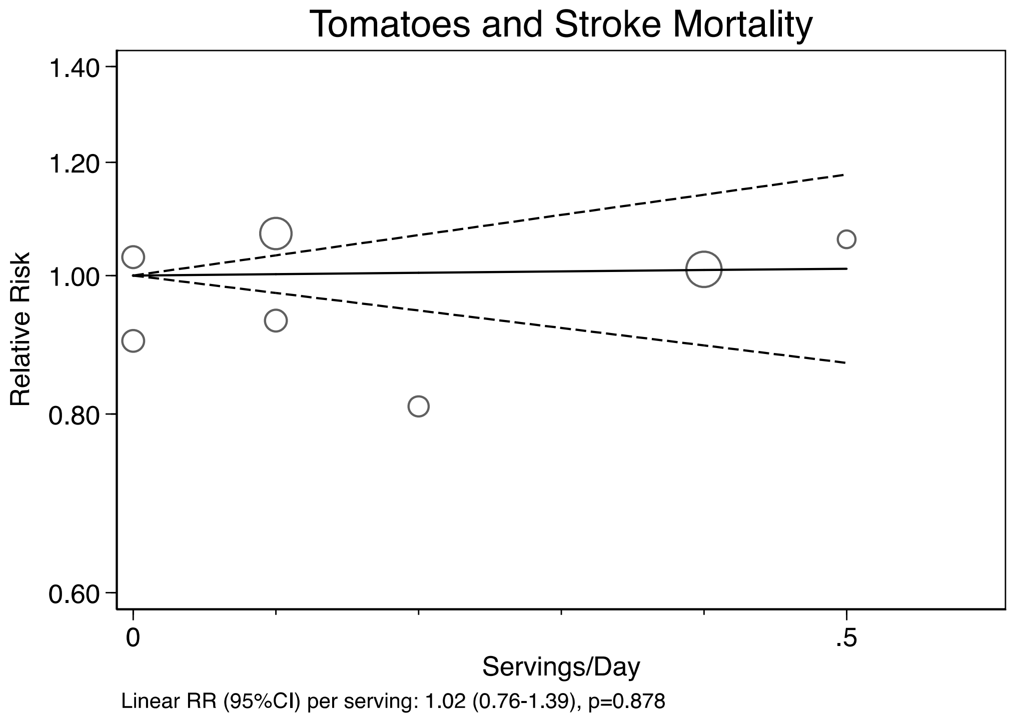


Figure S171. Linear dose-response relation between increasing intake of tomatoes and stroke mortality. Linear dose-response data was modeled using the Greenland and Longnecker[23] method to estimate the covariances of multivariable-adjusted relative risk, with kept on the original dose scale. Dashed lines represent the pointwise 95% confidence intervals for the fitted linear trend represented by a solid line. Individual observations are represented by the circles, with the weight of the study in the overall analysis represented by the size of the circles.

TOTAL FRUIT AND VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and Vegetables and Incident CVD – Within Subgr	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	-	**12**	**501,744**	**24,310**	**0.92 [0.88, 0**	-	-	-	-
Sex	Females	3	174,785	6,980	0.91 [0.80, 1	F vs. M: 0.95 [0.79, 1.16]	34.01%	0.88	0.007
	Males	4	49,532	2,776	0.95 [0.83, 1	F vs. Mix: 0.99 [0.85, 1.16]			
	Mxed	7	277,427	14,554	0.92 [0.84, 1	M vs. Mix: 1.03 [0.87, 1.23]			
Age (y)	<60	6	209,845	12,102	0.89 [0.82, 0	0.95 [0.86, 1.04]	22.88%	0.23	0.008
	≥60	6	291,899	291,899	0.94 [0.89, 0				
Follow Up (y)	<10	4	259,569	6,930	0.88 [0.74, 1	0.95 [0.79, 1.13]	28.44%	0.53	0.010
	≥10	10	242,175	17,380	0.93 [0.88, 0				
Statistical Adjustments	<8	2	5,563	1,334	0.98 [0.79, 1	1.06 [0.86, 1.33]	28.70%	0.54	0.013
	≥8	10	496,181	22,976	0.92 [0.87, 0				
NOS	<6	-	-	-	-	-	-	-	0.017
	≥6	12	501,744	24,310	0.92 [0.88, 0				
Exposure Assessment Tool	Validated FFQ	9	474,421	18,022	0.93 [0.89, 0	vFFQ vs. uFFQ: 1.06 [0.89, 1.27]	17.71%	0.19	0.025
	Unvalidated FFQ	2	4,331	1,323	0.99 [0.83, 1	vFFQ vs. record: 0.90 [0.80, 1.03]			
	Food Record	1	22,992	4,965	0.84 [0.75, 0	uFFQ vs. record: 0.85 [0.69, 1.05]			
Location	Asia	1	77,891	1,386	0.93 [0.72, 1	†	39.02%	0.98	0.050
	Europe	5	22,935	2,859	0.95 [0.82, 1				
	North America	5	265,583	15,281	0.92 [0.85, 0				
	Global	1	135,335	4,784	0.93 [0.63, 1				

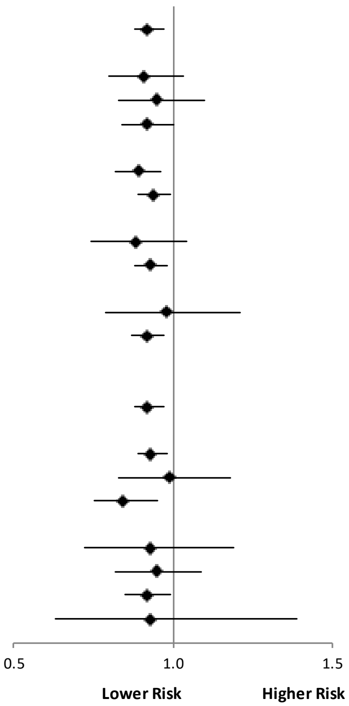


Figure S172. Categorical subgroup analyses of total fruit and vegetable intake and cardiovascular disease incidence. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CVD – cardiovascular disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals. † Europe vs. Asia 0.98 [0.74, 1.31]; Europe vs. Global 0.99 [0.64, 1.51]; Europe vs. North America 0.97 [0.83, 1.14]; Asia vs. Global 0.99 [0.62, 1.60]; Asia vs. North America 1.00 [0.78, 1.32]; Global vs. North America 1.02 [0.68, 1.53];

FRUIT AND CARDIOVASCULAR DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% Cis] for Fruit and Incident CVD — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
			0.0471227						
Total	-	**16**	**577,323**	**27,205**	**0.91 [0.86, 0.97]**	-	-	-	-
Sex	Females	5	189,962	9,212	0.90 [0.78, 1.03]	F vs. M: 0.96 [0.79, 1.18]	45.27%	0.91	0.007
	Males	5	58,075	3,944	0.93 [0.80, 1.09]	F vs. Mix: 0.98 [0.83, 1.16]			
	Mxed	8	329,286	14,049	0.92 [0.83, 1.01]	M vs. Mix: 1.02 [0.85, 1.22]			
Age (y)	<59	8	255,899	11,747	0.92 [0.83, 1.01]	1.01 [0.88, 1.15]	42.56%	0.94	0.008
	≥59	8	321,424	15,458	0.91 [0.83, 1.00]				
Follow Up (y)	<10	5	247,053	7,204	0.93 [0.82, 1.06]	1.02 [0.88, 1.19]	40.64%	0.88	0.010
	≥10	11	330,270	20,001	0.91 [0.84, 0.98]				
Statistical Adjustments	<8	4	8,987	1,892	0.87 [0.72, 1.05]	0.94 [0.78, 1.15]	41.21%	0.57	0.013
	≥8	12	568,336	24,953	0.92 [0.86, 0.99]				
NOS	<6	2	37,907	1,423	0.86 [0.66, 1.12]	0.94 [0.72, 1.23]	41.54%	0.63	0.017
	≥6	14	539,416	25,782	0.92 [0.86, 0.98]				
Exposure Assessment Tool	Validated FFQ	13	571,664	25,895	0.86 [0.67, 1.10]	vFFQ vs. uFFQ: 1.07 [0.83, 1.38]	44.25%	0.85	0.025
	Unvalidated FFQ	2	3,810	555	0.92 [0.85, 0.99]	vFFQ vs. record: 1.02 [0.62, 1.67]			
	Food record	1	1,849	755	0.88 [0.58, 1.35]	uFFQ vs. record: 0.96 [0.63, 1.47]			
Location	Asia	1	77,891	1,386	0.80 [0.62, 1.03]	†	43.21%	0.65	0.050
	Europe	10	125,806	10,043	0.94 [0.85, 1.03]				
	North America	4	238,291	10,992	0.91 [0.80, 1.03]				
	Global	1	135,335	4,784	0.89 [0.69, 1.13]				

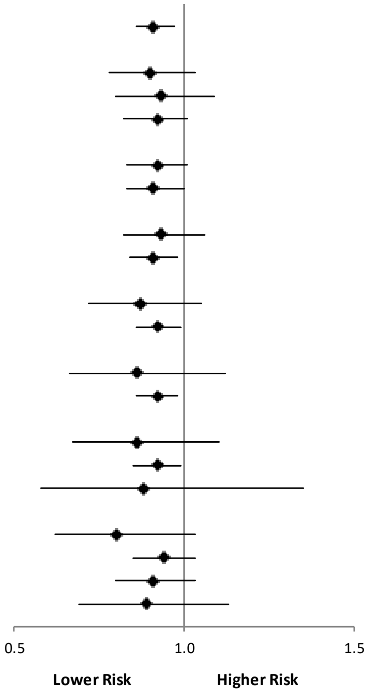


Figure S173. Categorical subgroup analyses of fruit intake and cardiovascular disease incidence. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CVD – cardiovascular disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 0.85 [0.65, 1.12]; Europe vs. Global 0.94 [0.73, 1.23]; Europe vs. North America 0.96 [0.82, 1.13]; Asia vs. Global 0.90 [0.63, 1.29]; Asia vs. North America 0.88 [0.67, 1.18]; Global vs. North America 0.98 [0.74, 1.29]

VEGETABLES AND CARDIOVASCULAR DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Vegetables and Incident CVD — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	-	**14**	**539,683**	**22,810**	**0.92 [0.88, 0.97]**	-	-	-	-
Sex	Females	3	170,485	7,656	0.93 [0.79, 1.09]	F vs. M: 0.98 [0.80, 1.20]	50.46%	0.97	0.007
	Males	4	48,027	1,985	0.95 [0.84, 1.07]	F vs. Mix: 0.98 [0.82, 1.19]			
	Mxed	7	321,171	13,169	0.94 [0.85, 1.03]	M vs. Mix: 1.00 [0.86, 1.18]			
Age (y)	<59	7	197,808	15,244	0.95 [0.86, 1.04]	1.01 [0.89, 1.15]	47.34%	0.86	0.008
	≥59	7	318,344	7,566	0.93 [0.85, 1.03]				
Follow Up (y)	<10	3	220,442	6,264	0.98 [0.87, 1.11]	1.06 [0.91, 1.22]	44.16%	0.44	0.010
	≥10	11	319,241	16,546	0.93 [0.86, 1.00]				
Statistical Adjustments	<8	3	5,907	1,546	0.86 [0.72, 1.03]	0.91 [0.75, 1.10]	42.70%	0.29	0.013
	≥8	11	533,776	21,264	0.95 [0.89, 1.02]				
NOS	<6	1	34,827	1,094	0.89 [0.66, 1.19]	0.94 [0.69, 1.28]	46.72%	0.68	0.017
	≥6	13	504,856	21,716	0.94 [0.88, 1.01]				
Exposure Assessment Tool	Validated FFQ	12	537,104	21,846	0.95 [0.89, 1.02]	vFFQ vs. uFFQ: 0.80 [0.59, 1.11]	42.86%	0.32	0.025
	Unvalidated FFQ	1	730	209	0.77 [0.57, 1.05]	vFFQ vs. record: 0.92 [0.72, 1.18]			
	Food record	1	1,849	755	0.88 [0.69, 1.12]	uFFQ vs. record: 1.13 [0.77, 1.69]			
Location	Asia	1	77,891	1,138	0.96 [0.76, 1.23]	†	53.51%	0.99	0.050
	Europe	9	88,166	5,896	0.94 [0.85, 1.03]				
	North America	3	238,291	10,992	0.93 [0.81, 1.06]				
	Global	1	135,335	4,784	0.95 [0.73, 1.24]				

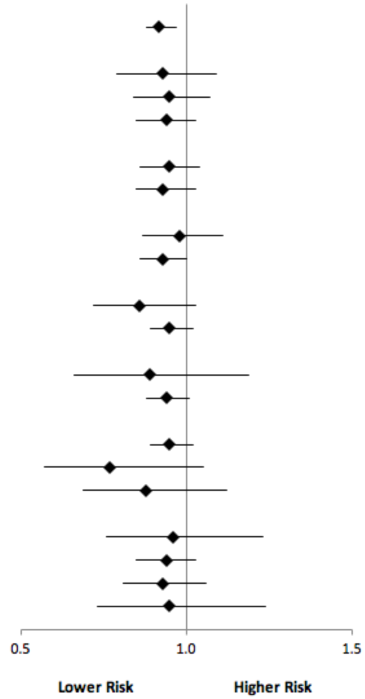


Figure S174. Categorical subgroup analyses of intake of vegetables and cardiovascular disease incidence. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CVD – cardiovascular disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.
† Europe vs. Asia 1.03 [0.79, 1.33]; Europe vs. Global 1.01 [0.76, 1.34]; Europe vs. NA 0.99 [0.84, 1.16]; Asia vs. Global 1.01 [0.71, 1.45]; Asia vs. NA 1.04 [0.79, 1.37]; Global vs. NA 1.03 [0.76, 1.38]

TOTAL FRUIT AND VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and Vegetables and CVD Mortality – Within Subgroups	Pooled Effect Estimates: RR [95% CIs] for Fruit and Vegetables and CVD Mortality – Between Subgroups	Residual I^2	*p* -value	Adjusted Alpha Level
Total	**-**	**14**	**798,391**	**17,439**	**0.84 [0.76, 0.94]**	-	-	-	-
Sex	Females	1	71,243	755	0.84 [0.53, 1.33]	F vs. M: 0.90 [0.52, 1.58]	63.21%	0.73	0.007
	Males	3	15,044	5,037	0.93 [0.68, 1.29]	F vs. Mix: 1.03 [0.63, 1.68]			
	Mxed	10	712,104	11,647	0.82 [0.69, 0.95]	M vs. Mix: 1.14 [0.80, 1.64]			
Age (y)	<55	7	616,198	9,288	0.81 [0.67, 0.97]	0.92 [0.70,1.20]	65.40%	0.49	0.008
	≥55	7	182,193	8,151	0.88 [0.73, 1.07]				
Follow Up (y)	<10	5	298,283	4,500	0.73 [0.59, 0.92]	0.82 [0.63, 1.07]	64.71%	0.14	0.010
	≥10	9	500,108	12,939	0.89 [0.77, 1.03]				
Statistical Adjustments	<8	3	13,655	705	0.93 [0.69, 1.24]	1.13 [0.81, 1.57]	70.67%	0.44	0.013
	≥8	11	784,736	16,734	0.82 [0.71, 0.95]				
NOS	<6	-	-	-	-	-	-	-	0.017
	≥6	14	798,391	17,439	0.84 [0.76, 0.94]				
Exposure Assessment Tool	Validated FFQ	8	703,295	9,921	0.84 [0.76, 0.94]	vFFQ vs. uFFQ: 1.21 [1.03, 1.41]	30.71%	<0.01	0.025
	Unvalidated FFQ	2	14,632	5,026	1.01 [0.91, 1.14]	vFFQ vs. record: 0.85 [0.69, 1.03]			
	Food record	4	80,464	9,921	0.71 [0.60, 0.85]	uFFQ vs. record: 0.70 [0.57, 0.86]			
Location	Asia	3	84,531	1,578	0.76 [0.58, 1.00]	†	68.09%	0.61	0.050
	Europe	8	562,766	12,689	0.87 [0.72 1.06]				
	North America	2	15,759	1,523	0.95 [0.66, 1.38]				
	Global	1	135335	1649	0.69 [0.38, 1.26]				

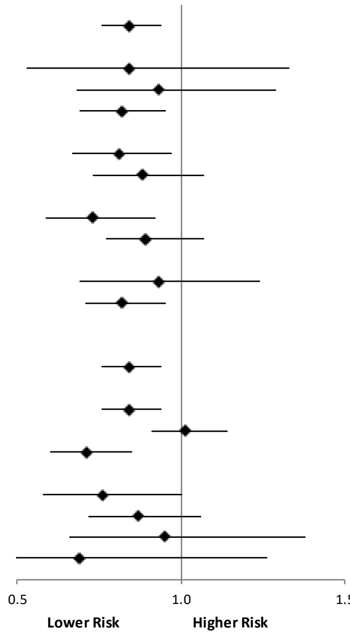


Figure S175. Categorical subgroup analyses of total fruit and vegetable intake and cardiovascular disease mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CVD – cardiovascular disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals. † Europe vs. Asia 0.87 [0.63, 1.22]; Europe vs. Global 0.79 [0.42, 1.49]; Europe vs. North America 1.09 [0.72, 1.66]; Asia vs. Global 1.10 [0.57, 2.13]; Asia vs. North America 0.80 [0.50, 1.27]; Global vs. North America 0.73 [0.36, 1.47]

FRUIT AND CARDIOVASCULAR DISEASE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and CVD Mortality — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	**-**	**27**	**1,581,506**	**39,623**	**0.83 [0.77, 0.89]**	-	-	-	-
Sex	Females	5	135,154	5,157	0.76 [0.63, 0.91]	F vs. M: 0.84 [0.66, 1.07]	77.74%	0.33	0.007
	Males	7	101,605	8,641	0.92 [0.75, 1.13]	F vs. Mix: 0.92 [0.75, 1.13]			
	Mxed	17	329,286	14,049	0.82 [0.75, 0.90]	M vs. Mix: 1.10 [0.92, 1.31]			
Age (y)	<54	10	1,115,225	15,507	0.77 [0.69, 0.86]	0.88 [0.77, 1.02]	71.00%	0.08	0.008
	≥54	17	466,281	24,116	0.87 [0.80, 0.94]				
Follow Up (y)	<11	13	916,897	17,780	0.80 [0.72, 0.90]	0.95 [0.82, 1.09]	76.29%	0.44	0.010
	≥11	14	664,609	21,843	0.85 [0.77, 0.93]				
Statistical Adjustments	<8	8	57,260	5,303	0.88 [0.78, 0.99]	1.10 [0.95, 1.27]	79.15%	0.22	0.013
	≥8	19	1,524,246	34,320	0.80 [0.73, 0.88]				
NOS	<6	2	20,531	1,717	0.89 [0.73, 1.08]	1.08 [0.88, 1.33]	78.84%	0.45	0.017
	≥6	24	1,560,975	37,906	0.82 [0.76, 0.89]				
Exposure Assessment Tool	Validated FFQ	15	990,789	22,863	0.84 [0.76, 0.93]	vFFQ vs. uFFQ: 0.97 [0.80, 1.17]	78.17%	0.93	0.025
	Unvalidated FFQ	4	483,979	12,238	0.81 [0.69, 0.95]	vFFQ vs. record: 0.99 [0.83, 1.18]			
	Food record	6	106,738	4,522	0.83 [0.72, 0.96]	uFFQ vs. record: 1.02 [0.83, 1.27]			
Location	Asia	6	752,255	20,127	0.80 [0.71, 0.89]	†	78.55%	0.32	0.050
	Australia	1	40,653	697	0.69 [0.46, 1.05]				
	Europe	14	629,562	16,072	0.83 [0.75, 0.91]				
	North America	2	13,944	563	1.02 [0.77, 1.38]				
	Global	2	145,092	2,164	0.94 [0.75 1.19]				

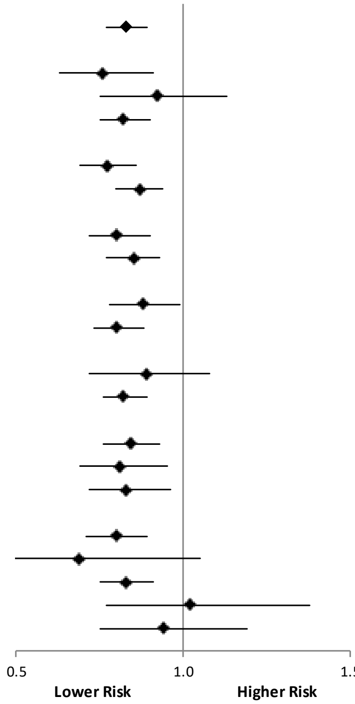


Figure S176. Categorical subgroup analyses of fruit intake and cardiovascular disease mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CVD – cardiovascular disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 0.96 [0.83, 1.13]; Europe vs Australia 0.84 [0.55, 1.28]; Europe vs. Global 1.14 [0.89, 1.47]; Europe vs. North America 1.25 [0.92, 1.70]; Asia vs. Australia 1.15 [0.75, 1.77]; Asia vs. Global 0.85 [0.65, 1.10]; Asia vs. North America 0.77 [0.56, 1.06]; Australia vs. Global 0.73 [0.46, 1.18]; Australia vs. North America 0.67 [0.41, 1.12]; Global vs. North America 0.92 [0.63, 1.33]

VEGETABLES AND CARDIOVASCULAR DISEASE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Vegetables and CVD Mortality – Within Subgroups	Pooled Effect Estimates: RR [95% CIs] for Vegetables and CVD Mortality – Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	-	**21**	**1,101,435**	**33,516**	**0.83 [0.78, 0.89]**	-	-	-	-
Sex	Females	4	99,506	4,498	0.90 [0.74, 1.09]	F vs. M: 1.07 [0.82, 1.38]	59.31%	0.69	0.007
	Males	6	97,280	8,050	0.85 [0.72, 1.00]	F vs. Mix: 1.10 [0.88, 1.37]			
	Mxed	14	904,649	20,968	0.82 [0.74, 0.91]	M vs. Mix: 1.03 [0.85 1.25]			
Age (y)	<55	12	733,002	13,359	0.82 [0.74, 0.91]	0.95 [0.82, 1.10]	54.86%	0.47	0.008
	≥55	9	368,433	20,157	0.86 [0.78, 0.96]				
Follow Up (y)	<10	7	352,675	7582	0.77 [0.68, 0.89]	0.88 [0.76, 1.03]	52.02%	0.11	0.010
	≥10	14	748,760	25,934	0.87 [0.81, 0.95]				
Statistical Adjustments	<8	7	47,233	4,788	0.88 [0.78, 1.00]	1.07 [0.92, 1.25]	57.47%	0.38	0.013
	≥8	11	1,054,202	28,728	0.82 [0.75, 0.90]				
NOS	<6	1	10,471	1,202	0.94 [0.71, 1.25]	1.13 [0.84, 1.52]	56.90%	0.40	0.017
	≥6	20	1,090,964	32,314	0.83 [0.79, 0.90]				
Exposure Assessment Tool	Validated FFQ	10	942,971	21,958	0.84 [0.75, 0.94]	vFFQ vs. uFFQ: 0.99 [0.81, 1.21]	59.53%	0.99	0.025
	Unvalidated FFQ	4	22,593	6,310	0.83 [0.70, 0.98]	vFFQ vs. record: 1.00 [0.83, 1.21]			
	Food record	7	135,871	5,248	0.84 [0.73, 0.98]	uFFQ vs. record: 1.01 [0.81, 1.27]			
Location	Asia	5	289,553	13,961	0.85 [0.73, 0.99]	†	59.70%	0.87	0.050
	Australia	2	41,879	935	0.76 [0.57, 1.01]				
	Europe	11	591,591	15,682	0.86 [0.76, 0.96]				
	North America	2	43,077	1289	0.77 [0.59, 1.00]				
	Global	1	135,335	1,649	0.87 [0.59, 1.28]				

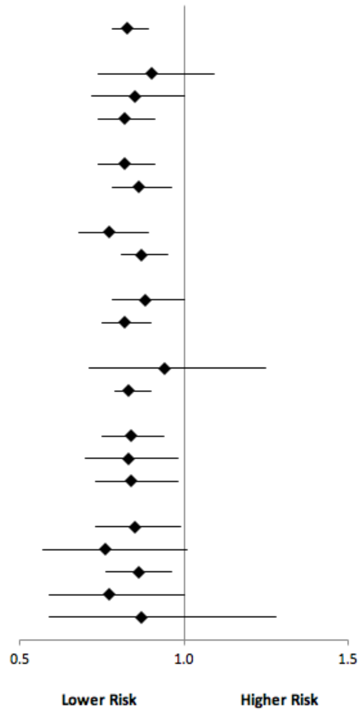


Figure S177. Categorical subgroup analyses of intake of vegetables and cardiovascular disease mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CVD – cardiovascular disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 0.99 [0.82, 1.19]; Europe vs Australia 0.88 [0.65, 1.20]; Europe vs. Global 1.01 [0.68, 1.52]; Europe vs. North America 0.90 [0.67, 1.20]; Asia vs. Australia 1.12 [0.81, 1.56]; Asia vs. Global 0.98 [0.64, 1.48]; Asia vs. North America 1.11 [0.81, 1.50]; Australia vs. Global 0.87 [0.54, 1.41]; Australia vs. North America 0.98 [0.66, 1.46]; Global vs. North America 1.13 [0.71, 1.81]

TOTAL FRUIT AND VEGETABLES AND CORONARY HEART DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and Vegetables and Incident CHD — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
			0.02904962						
Total	-	**19**	**619,182**	**17,987**	**0.88 [0.82, 0.93]**	-	-	-	-
Sex	Females	4	195,199	3,069	0.84 [0.76, 0.94]	F vs. M: 0.96 [0.80, 1.14]	9.65%	0.18	0.007
	Males	5	122,472	4,715	0.81 [0.70, 0.93]	F vs. Mix: 0.88 [0.75, 1.03]			
	Mxed	10	301,511	10,203	0.92 [0.85, 0.99]	M vs. Mix: 0.92 [0.81, 1.05]			
Age (y)	<54	10	406,180	11,508	0.87 [0.80, 0.95]	0.99 [0.87, 1.13]	20.41%	0.85	0.008
	≥54	9	213,002	6,479	0.88 [0.80, 0.98]				
Follow Up (y)✱	<10	7	342,908	3412	0.85 [0.76, 0.95]	0.95 [0.82, 1.10]	24.09%	0.45	0.010
	≥10	11	265,140	13,897	0.90 [0.82, 0.99]				
Statistical Adjustments	<8	2	5,066	445	0.85 [0.65, 1.14]	0.97 [0.72, 1.31]	20.60%	0.82	0.013
	≥8	17	614,116	17,542	0.88 [0.82, 0.94]				
NOS	<6	4	126,148	7,005	0.82 [0.75, 0.91]	0.91 [0.81, 1.02]	9.12%	0.10	0.017
	≥6	15	493,034	10,982	0.91 [0.85, 0.97]				
Exposure Assessment Tool	Validated FFQ	15	521,931	13,968	0.88 [0.83, 0.94]	vFFQ vs. uFFQ: 0.84 [0.62, 1.14]	16.44%	0.37	0.025
	Unvalidated FFQ	3	82,361	3,481	0.74 [0.55, 1.00]	vFFQ vs. record: 1.18 [0.76, 1.84]			
	Food record	1	14,890	538	1.04 [0.67, 1.61]	uFFQ vs. record: 1.41 [0.83, 2.38]			
Location	Asia	4	140,365	1,300	0.92 [0.70, 1.19]	†	23.70%	0.71	0.050
	Australia	1	14,890	538	0.74 [0.54, 1.02]				
	Europe	8	154,641	5,370	0.90 [0.81, 1.00]				
	North America	5	173951	8636	0.86 [0.77, 0.95]				
	Global	1	135,335	2,143	0.95 [0.68, 1.34]				

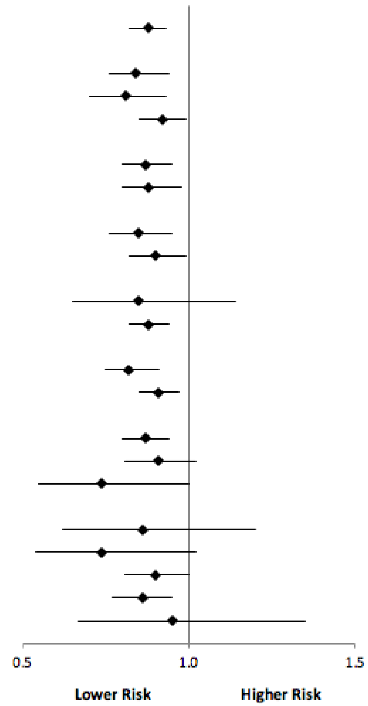


Figure S178. Categorical subgroup analyses of total fruit and vegetable intake and incident coronary heart disease. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals. * Follow-up years incudes 17 cohorts as Bingham et al. 2008 (EPIC Norfolk) did not report follow-up time. † Europe vs. Asia 1.02 [0.77, 1.35]; Europe vs. Australia 0.82 [0.59, 1.14]; Europe vs. Global 1.06 [0.74, 1.51]; Europe vs. North America 0.95 [0.83, 1.10]; Asia vs. Australia 1.24 [0.82, 1.87]; Asia vs. Global 0.96 [0.63, 1.48]; Asia vs. North America 1.07 [0.81, 1.42]; Australia vs. Global 0.78 [0.49, 1.24]; Australia vs. North America 0.86 [0.62, 1.21]; Global vs. North America 1.11 [0.78, 1.58]

FRUIT AND CORONARY HEART DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and Incident CHD – Within Subgroups	Pooled Effect Estimates: RR [95% CIs] for Fruit and Incident CHD – Between Subgroups	Residual I^2	*p* -value	Adjusted Alpha Level
Total	**-**	**20**	**1,170,021**	**23,856**	**0.88 [0.84, 0.93]**	-	-	-	-
Sex	Females	6	251,883	3,255	0.86 [0.76, 1.00]	F vs. M: 0.97 [0.82, 1.15]	11.32%	0.88	0.007
	Males	6	166,015	9,697	0.90 [0.82, 0.99]	F vs. Mix: 1.00 [0.85, 1.19]			
	Mxed	10	752,123	10,904	0.87 [0.79, 0.96]	M vs. Mix: 1.03 [0.90, 1.18]			
Age (y)	<55	10	899,185	13,731	0.86 [0.80, 0.93]	0.94 [0.84, 1.06]	3.79%	0.31	0.008
	≥55	10	270,836	10,125	0.91 [0.83, 0.99]				
Follow Up (y)	<10	9	865,523	6,656	0.82 [0.74, 0.92]	0.92 [0.82, 1.04]	0.00%	0.16	0.010
	≥10	11	304,498	17,200	0.90 [0.85, 0.95]				
Statistical Adjustments	<8	4	206,008	11,296	0.91 [0.77, 1.09]	1.04 [0.87, 1.25]	8.05%	0.63	0.013
	≥8	16	964,013	12,560	0.88 [0.82, 0.93]				
NOS	<6	2	113,276	6,189	0.87 [0.77, 0.99]	0.99 [0.86, 1.14]	8.97%	0.89	0.017
	≥6	18	1,056,745	17,667	0.88 [0.82, 0.95]				
Exposure Assessment Tool	Validated FFQ	17	637,980	18,321	0.90 [0.85, 0.95]	vFFQ vs. uFFQ: 0.87 [0.76, 0.99]	0.00%	0.07	0.025
	Unvalidated FFQ	2	530,192	5,374	0.78 [0.69, 0.88]	vFFQ vs. record: 1.12 [0.80, 1.57]			
	Food record	1	1,849	161	1.01 [0.72, 1.41]	uFFQ vs. record: 1.29 [0.91, 1.84]			
Location	Asia	4	590,798	3,755	0.76 [0.65, 0.89]	†	0.00%	0.22	0.050
	Europe	11	265,012	11,509	0.90 [0.84, 0.97]				
	North America	4	178876	6449	0.87 [0.80, 0.96]				
	Global	1	135,335	2,143	0.91 [0.73, 1.15]				

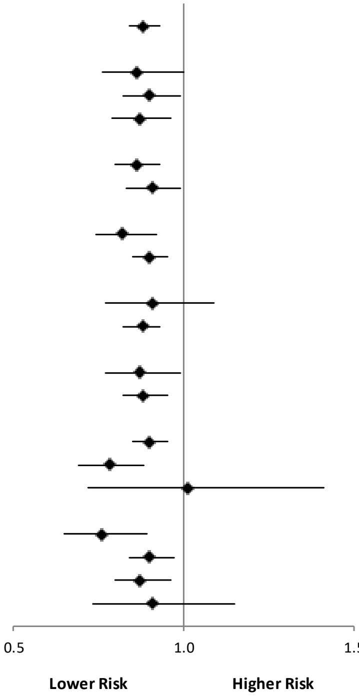


Figure S179. Categorical subgroup analyses of fruit intake and incident coronary heart disease. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals. † Europe vs. Asia 0.84 [0.71, 0.99]; Europe vs. Global 1.01 [0.79, 1.29]; Europe vs. North America 0.96 [0.85, 1.08]; Asia vs. Global 0.83 [0.63, 1.10]; Asia vs. North America 0.87 [0.73, 1.04]; Global vs. North America 1.05 [0.82, 1.34]

VEGETABLE AND CORONARY HEART DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Vegetables and Incident CHD – Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
			0.0246607						
Total	-	**18**	**696,330**	**17,172**	**0.92 [0.85, 0.99]**	-	-	-	-
Sex	Females	6	251,883	3,820	0.87 [0.77, 0.98]	F vs. M: 0.99 [0.86, 1.14]	0.00%	0.86	0.007
	Males	8	184,953	7,023	0.88 [0.81, 0.95]	F vs. Mix: 0.96 [0.82, 1.13]			
	Mxed	6	259,494	6,329	0.91 [0.81, 1.01]	M vs. Mix: 0.97 [0.85, 1.11]			
Age (y)	<55	11	422,076	10,304	0.88 [0.81, 0.94]	0.98 [0.87, 1.09]	0.00%	0.67	0.008
	≥55	7	274,254	6,868	0.90 [0.82, 0.97]				
Follow Up (y)	<10	9	403,213	5986	0.83 [0.74, 0.94]	0.95 [0.83, 1.09]	0.00%	0.43	0.010
	≥10	9	252,241	10,712	0.88 [0.82, 0.95]				
Statistical Adjustments	<8	2	5,177	468	0.96 [0.73, 1.26]	1.09 [0.82, 1.44]	0.00%	0.53	0.013
	≥8	16	691,153	16,704	0.88 [0.83, 0.93]				
NOS	<6	2	113,276	6,189	0.87 [0.80, 0.96]	0.99 [0.88, 1.11]	0.00%	0.78	0.017
	≥6	16	583,054	10,983	0.89 [0.83, 0.95]				
Exposure Assessment Tool	Validated FFQ	16	615,954	14,188	0.88 [0.83, 0.94]	vFFQ vs. uFFQ: 0.99 [0.84, 1.16]	0.00%	0.69	0.025
	Unvalidated FFQ	1	78,527	2,823	0.87 [0.75, 1.01]	vFFQ vs. record: 1.15 [0.82, 1.61]			
	Food record	1	1,849	161	1.01 [0.72, 1.41]	uFFQ vs. record: 1.16 [0.81, 1.68]			
Location	Asia	3	139,133	1,204	0.96 [0.73, 1.25]	†	0.00%	0.79	0.050
	Europe	10	253,939	6,362	0.89 [0.83, 0.97]				
	North America	4	167,923	7,463	0.86 [0.79, 0.94]				
	Global	1	135,335	2,143	0.91 [0.73, 1.15]				

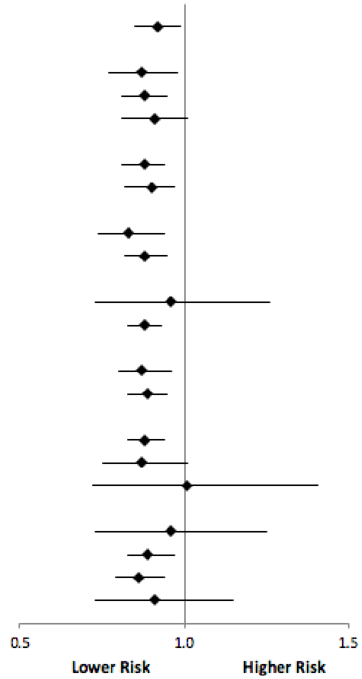


Figure S180. Categorical subgroup analyses of intake of vegetables and incident coronary heart disease. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 1.07 [0.81, 1.41]; Europe vs. Global 1.02 [0.80, 1.30]; Europe vs. NA 0.96 [0.85, 1.08]; Asia vs. Global 1.05 [0.74, 1.49]; Asia vs. NA 1.11 [0.84, 1.48]; Global vs. NA 1.07 [0.83, 1.37]

CITRUS FRUIT AND CORONARY HEART DISEASE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Citrus Fruit and Incident CHD — Within Subgroups	Between Subgroups	Residual I^2	*p* -value	Adjusted Alpha Level
Total	**-**	**10**	**364,978**	**8,333**	**0.91 [0.85, 0.98]**	-	-	-	-
Sex	Females	5	202,835	3,152	0.90 [0.80, 1.02]	F vs. M: 0.99 [0.84, 1.17]	0.00%	0.76	0.007
	Males	5	134,858	4,830	0.91 [0.82, 1.02]	F vs. Mix: 0.88 [0.60, 1.29]			
	Mxed	2	27,285	351	1.02 [0.72, 1.47]	M vs. Mix: 0.89 [0.61, 1.29]			
Age (y)	<55	7	293,756	7,064	0.90 [0.83, 0.98]	0.91 [0.74, 1.14]	0.00%	0.38	0.008
	≥55	3	71,222	1,269	0.99 [0.81, 1.20]				
Follow Up (y)	<10	5	212,923	1702	0.97 [0.82, 1.15]	1.08 [0.90, 1.31]	0.00%	0.38	0.010
	≥10	5	152,055	6,631	0.90 [0.82, 0.98]				
Statistical Adjustments	<8	-	-	-	-	-	-	-	0.013
	≥8	10	364,978	8,333	0.91 [0.85, 0.98]				
NOS	<6	2	113,276	6,189	0.91 [0.82, 1.00]	0.97 [0.82, 1.15]	0.00%	0.73	0.017
	≥6	8	251,702	2,144	0.93 [0.81, 1.07]				
Exposure Assessment Tool	Validated FFQ	10	364,978	8,333	0.91 [0.85, 0.98]	-	-	-	0.025
	Unvalidated FFQ	-	-	-	-				
	Food record	-	-	-	-		-		
Location	Asia	3	133,258	441	0.81 [0.58, 1.12]	Europe vs. Asia: 0.84 [0.58, 1.20]	0.00%	0.54	0.050
	Europe	5	118,444	1,703	0.96 [0.82, 1.13]	Europe vs. NA: 0.94 [0.78, 1.13]			
	North America	2	113,276	6,189	0.91 [0.82, 1.00]	Asia vs. NA: 0.89 [0.64, 1.25]			

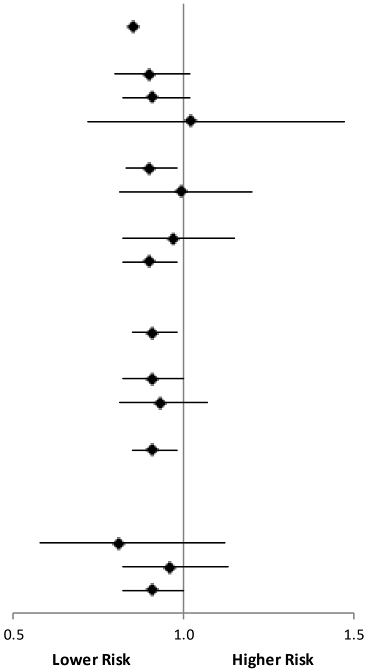


Figure S181. Categorical subgroup analyses of citrus fruit intake and incident coronary heart disease. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

FRUIT AND CORONARY HEART DISEASE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and CHD Mortality — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	-	**21**	**1,398,863**	**14,786**	**0.84 [0.76, 0.91]**	-	-	-	-
Sex	Females	5	160,978	1,903	0.69 [0.56, 0.85]	F vs. M: 0.75 [0.58, 0.97]	52.61%	0.1	0.007
	Males	7	139,080	5,967	0.92 [0.80, 1.07]	F vs. Mix: 0.83 [0.65, 1.06]			
	Mxed	13	1,237,885	12,883	0.84 [0.74, 0.95]	M vs. Mix: 1.10 [0.91, 1.34]			
Age (y)	<55	10	1,014,095	6,488	0.79 [0.71, 0.89]	0.89 [0.75, 1.06]	54.99%	0.1	0.008
	≥55	11	384,768	8,298	0.89 [0.78, 1.02]				
Follow Up (y)	<10	6	708,590	5637	0.86 [0.73, 1.02]	1.05 [0.85, 1.28]	60.64%	0.65	0.010
	≥10	15	690,273	9,149	0.82 [0.74, 0.92]				
Statistical Adjustments	<8	10	237,290	4,289	0.86 [0.75, 0.99]	1.05 [0.88, 1.27]	62.86%	0.57	0.013
	≥8	11	1,161,573	10,497	0.82 [0.72, 0.92]				
NOS	<6	4	178,483	3,012	0.83 [0.70, 0.98]	0.99 [0.80, 1.21]	63.13%	0.9	0.017
	≥6	17	1,220,380	11,774	0.84 [0.75, 0.94]				
Exposure Assessment Tool	Validated FFQ	10	881,744	8,315	0.85 [0.74, 0.97]	vFFQ vs. uFFQ: 0.94 [0.77, 1.14]	64.54%	0.63	0.025
	Unvalidated FFQ	6	500,949	5,772	0.80 [0.68, 0.92]	vFFQ vs. record: 1.07 [0.79, 1.45]			
	Food record	4	16,170	699	0.91 [0.69, 1.19]	uFFQ vs. record: 1.14 [0.84, 1.56]			
Location	Asia	5	586,853	4,670	0.78 [0.66, 0.91]	†	60.03%	0.44	0.050
	Australia	1	40,653	407	0.76 [0.45, 1.30]				
	Europe	11	579,086	7,123	0.84 [0.73, 0.96]				
	North America	4	192,271	2,586	0.96 [0.77, 1.20]				

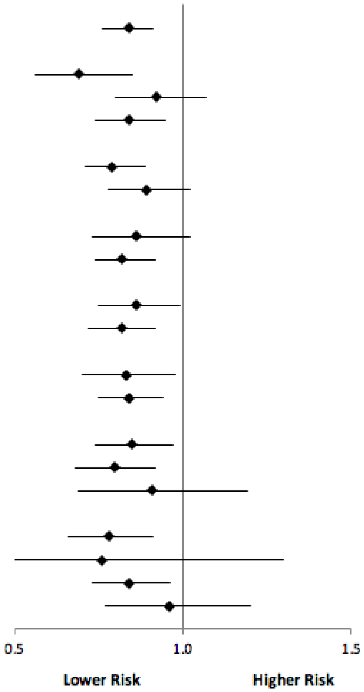


Figure S182. Categorical subgroup analyses of fruit intake and coronary heart disease mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 0.93 [0.76, 1.14]; Europe vs. Australia 0.91 [0.53, 1.57]; Europe vs. North America 1.15 [0.89, 1.47]; Asia vs. Australia 1.01 [0.59, 1.77]; Asia vs. North America 0.81 [0.62, 1.06]; Australia vs. North America 0.80 [0.45, 1.41]

VEGETABLES AND CORONARY HEART DISEASE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Vegetables and CHD Mortality — Within Subgroup	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	**-**	**18**	**1,968,325**	**26,007**	**0.84 [0.80, 0.8**	-	-	-	-
Sex	Females	4	704,423	5,693	0.85 [0.76, 0.9	F vs. M: 0.96 [0.88, 1.06]	26.01%	0.73	0.007
	Males	6	592,634	13,892	0.86 [0.78, 0.9	F vs. Mix: 0.98 [0.89, 1.09]			
	Mxed	12	671,268	6,422	0.83 [0.76, 0.9	M vs. Mix: 1.02 [0.93 1.11]			
Age (y)	<56	10	1,054,654	14,251	0.87 [0.83, 0.9	1.04 [0.96, 1.13]	20.98%	0.31	0.008
	≥56	10	913,671	11,756	0.84 [0.78, 0.8				
Follow Up (y)	<13	9	1,404,076	18332	0.84 [0.78, 0.9	0.98 [0.89, 1.10]	25.06%	0.73	0.010
	≥13	9	564,249	7,675	0.85 [0.79, 0.9				
Statistical Adjustments	<8	5	205,972	3,242	0.86 [0.78, 0.9	1.01 [0.91, 1.14]	24.96%	0.81	0.013
	≥8	13	1,762,353	22,765	0.84 [0.80, 0.9				
NOS	<6	3	167,742	2,407	0.86 [0.77, 0.9	1.02 [0.90, 1.15]	24.72%	0.73	0.017
	≥6	15	1,800,583	23,600	0.84 [0.80, 0.8				
Exposure Assessment Tool	Validated FFQ	7	814,011	7,649	0.82 [0.75, 0.9	vFFQ vs. uFFQ: 1.07 [0.96, 1.18]	0.00%	0.02	0.025
	Unvalidated FFQ	5	1,109,011	17,103	0.88 [0.84, 0.9	vFFQ vs. record: 0.77 [0.62, 0.96]			
	Food record	6	45,303	1,255	0.64 [0.52, 0.7	uFFQ vs. record: 0.72 {0.59, 0.89]			
Location	Asia	4	124,511	2,632	0.85 [0.74, 0.9	†	32.13%	0.98	0.050
	Australia	2	41,879	535	0.83 [0.66, 1.0				
	Europe	7	543,981	6,400	0.85 [0.75, 0.9				
	North America	5	1,257,954	16,440	0.82 [0.75, 0.9				

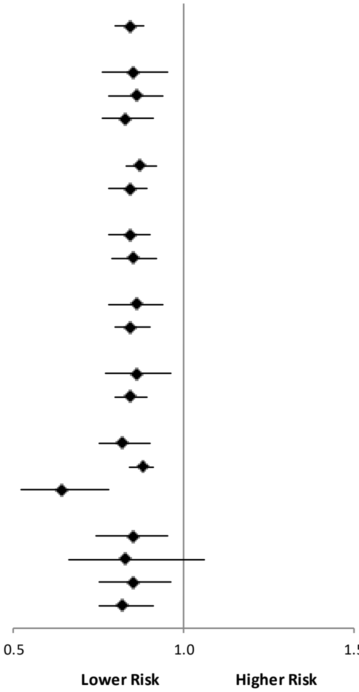


Figure S183. Categorical subgroup analyses of intake of vegetables and coronary heart disease mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 0.98 [0.83, 1.17]; Europe vs. Australia 0.98 [0.75, 1.28]; Europe vs. North America 0.97 [0.83, 1.14]; Asia vs. Australia 1.01 [0.77, 1.32]; Asia vs. North America 1.02 [0.87, 1.19]; Australia vs. North America 1.01 [0.78, 1.30]

TOTAL FRUIT AND VEGETABLES AND STROKE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and Vegetables and Incident Stroke — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	**-**	**14**	**532,667**	**11,091**	**0.80 [0.73, 0.89]**	-	-	-	-
Sex	Females	2	120,372	1,046	0.71 [0.57, 0.88]	F vs. M: 1.09 [0.80, 1.48]	0.00%	0.03	0.007
	Males	3	76,998	1,142	0.65 [0.52, 0.82]	F vs. Mix: 0.80 [0.63, 1.01]			
	Mxed	10	335,297	8,903	0.89 [0.80, 0.99]	M vs. Mix: 0.74 [0.57, 0.94]			
Age (y)	<55	6	373,490	5,660	0.74 [0.66, 0.84]	0.84 [0.70, 1.00]	10.79%	0.05	0.008
	≥55	8	159,177	5,431	0.89 [0.78, 1.01]				
Follow Up (y)	<9	7	394,374	8713	0.75 [0.65, 0.87]	0.86 [0.68, 1.07]	29.24%	0.16	0.010
	≥9	7	138,293	2,378	0.88 [0.74, 1.04]				
Statistical Adjustments	<8	3	86,841	2,193	0.71 [0.59, 0.85]	0.83 [0.67, 1.03]	14.30%	0.09	0.013
	≥8	11	445,826	8,898	0.85 [0.76, 0.96]				
NOS	<6	-	-	-	-	-	-	-	0.017
	≥6	14	532,667	11,091	0.80 [0.73, 0.89]				
Exposure Assessment Tool	Validated FFQ	12	528,085	10,449	0.78 [0.70, 0.87]	vFFQ vs. uFFQ: 0.79 [0.42, 1.46]	65.82%	0.06	0.025
	Unvalidated FFQ	1	3,750	545	0.61 [0.33, 1.13]	vFFQ vs. record: 1.36 [1.04, 1.78]			
	Food record	1	832	97	1.06 [0.83, 1.36]	uFFQ vs. record: 1.73 [0.90, 3.35]			
Location	Asia	2	17,912	265	1.03 [0.85, 1.24]	†	0.00%	0.02	0.050
	Europe	6	160,502	5,302	0.87 [0.77, 0.98]				
	North America	5	218,918	3,290	0.70 [0.62, 0.79]				
	Global	1	135,335	2,234	0.89 [0.62, 1.26]				

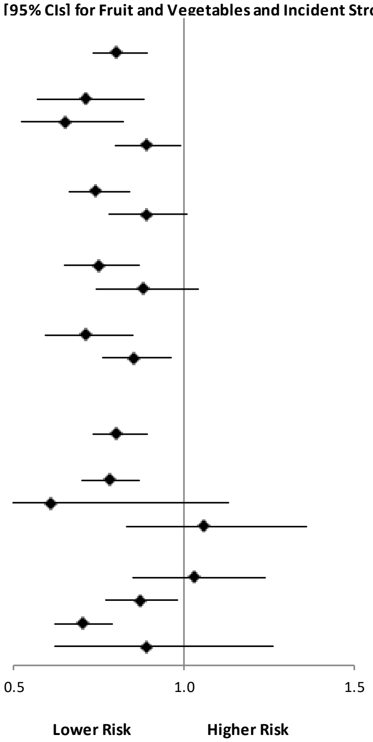


Figure S184. Categorical subgroup analyses of total fruit and vegetable intake and stroke incidence. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.
† Europe vs Asia 1.17 [0.94, 1.47]; Europe vs Global 1.02 [0.70, 1.48]; Europe vs NA 0.81 [0.68, 0.96]; Asia vs Global 1.16 [0.77, 1.72]; Asia vs NA 1.46 [1.16, 1.84]; Global vs NA 1.27 [0.87, 1.84]

FRUIT AND STROKE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Within Subgroups	Between Subgroups	Residual I^2	*p* -value	Adjusted Alpha Level
Total	-	**17**		**43,702**	**0.83 [0.78, 0.8**	-	-	-	-
Sex	Females	3	93,234	309	0.86 [0.68, 1.1	F vs. M: 1.06 [0.80, 1.41]	39.25%	0.89	0.007
	Males	6	77,551	3,877	0.81 [0.70, 0.9	F vs. Mix: 1.04 [0.80, 1.34]			
	Mxed	10	817,208	39,516	0.83 [0.77, 0.9	M vs. Mix: 0.97 [0.83, 1.15]			
Age (y)	<56	9	779,138	35,462	0.82 [0.75, 0.8	0.96 [0.84, 1.10]	33.59%	0.53	0.008
	≥56	8	208,855	8,240	0.85 [0.77, 0.9				
Follow Up (y)	<14	8	827,457	41206	0.82 [0.76, 0.8	0.95 [0.82, 1.09]	33.91%	0.44	0.010
	≥14	9	160,536	2,496	0.86 [0.75, 0.9				
Statistical Adjustments	<8	3	3,233	306	0.79 [0.58, 1.0	0.95 [0.69, 1.31]	36.97%	0.74	0.013
	≥8	14	984,760	43,396	0.83 [0.78, 0.8				
NOS	<6	-	-	-	-	-	-	-	0.017
	≥6	17	987,993	43,702	0.83 [0.78, 0.8				
Exposure Assessment Tool	Validated FFQ	10	490,356	11,941	0.85 [0.79, 0.9	vFFQ vs. uFFQ: 0.91 [0.79, 1.04]	26.76%	0.28	0.025
	Unvalidated FFQ	2	453,786	29,352	0.78 [0.70, 0.8	vFFQ vs. record: 1.02 [0.85, 1.23]			
	Food record	5	43,851	2,409	0.87 [0.74, 1.0	uFFQ vs. record: 1.13 [0.93, 1.37]			
Location	Asia	3	470,284	29,549	0.79 [0.72, 0.8	†	17.05%	0.25	0.050
	Europe	10	267,263	11,252	0.86 [0.79, 0.9				
	North America	3	115,111	667	0.69 {0.51, 0.9				
	Global	1	135335	2234	0.93 [0.72, 1.2				

Pooled Effect Estimates — RR [95% CIs] for Fruit and Incident Stroke

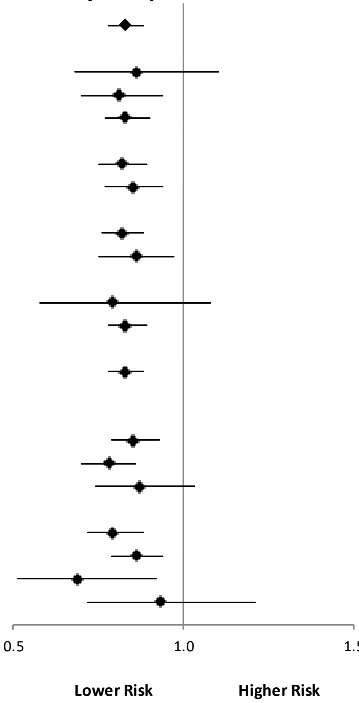


Figure S185. Categorical subgroup analyses of fruit intake and stroke incidence. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals. † Europe vs. Asia 0.92 [0.81, 1.05]; Europe vs. Global 1.09 [0.82, 1.42]; Europe vs. North America 0.80 [0.59, 1.09]; Asia vs. Global 0.85 [0.65, 1.12]; Asia vs. North America 1.15 [0.85, 1.57]; Global vs. North America 1.36 [0.92, 2.01]

VEGETABLES AND STROKE INCIDENCE

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and CVD Mortality — Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
			0.0241						
Total	-	**16**	**564,531**	**13,607**	**0.89 [0.81, 0.97]**	-	-	-	-
Sex	Females	3	93,234	309	0.82 [0.61, 1.09]	F vs. M: 1.00 [0.72, 1.38]	41.34%	0.18	0.007
	Males	9	134,595	4,472	0.82 [0.70, 0.95]	F vs. Mix: 0.84 [0.62, 1.16]			
	Mxed	8	336,702	8,826	0.97 [0.85, 1.10]	M vs. Mix: 0.85 [0.69, 1.03]			
Age (y)	<58	8	437,979	9,019	0.88 [0.78, 1.00]	0.99 [0.78, 1.22]	50.42%	0.89	0.008
	≥58	9	126,552	4,588	0.90 [0.75, 1.06]				
Follow Up (y)	<14	8	432,836	12,645	0.88 [0.78, 1.00]]	0.97 [0.80, 1.20]	49.72%	0.80	0.010
	≥14	8	131,695	962	0.90 [0.76, 1.07]				
Statistical Adjustments	<8	3	3,233	306	0.82 [0.58, 1.15]	0.92 [0.64, 1.31]	52.43%	0.62	0.013
	≥8	13	561,298	13,301	0.89 [0.81, 0.99]				
NOS	<6	-	-	-	-	-	-	-	0.017
	≥6	16	564,531	13,607	0.87 [0.80, 0.94]				
Exposure Assessment Tool	Validated FFQ	10	512,840	11,401	0.91 [0.81, 1.01]	vFFQ vs. uFFQ: 0.47 [0.21, 1.05]	49.62%	0.17	0.025
	Unvalidated FFQ	1	2,121	196	0.43 [0.19, 0.95]	vFFQ vs. record: 0.95 [0.76, 1.20]			
	Food record	5	49,570	2,010	0.86 [0.70, 1.06]	uFFQ vs. record: 2.02 [0.89, 4.58]			
Location	Asia	3	28,270	619	1.03 [0.82, 1.30]	†	41.17%	0.23	0.050
	Europe	9	285,815	10,117	0.85 [0.77, 0.95]				
	North America	3	115,111	637	0.82 [0.60, 1.12]				
	Global	1	135,335	2,234	1.09 [0.79, 1.52]				

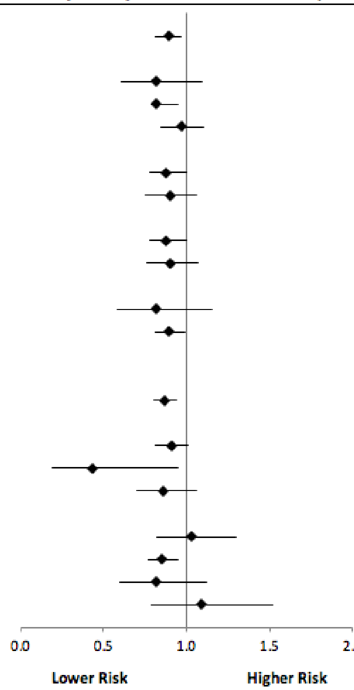


Figure S186. Categorical subgroup analyses of intake of vegetables and stroke incidence. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. CHD – coronary heart disease; FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.
† Europe vs. Asia 1.21 [0.94, 1.56]; Europe vs. Global 1.28 [0.91, 1.81]; Europe vs. NA 0.96 [0.69, 1.33]; Asia vs. Global 0.94 [0.63, 1.40]; Asia vs. NA 1.26 [0.86, 1.86]; Global vs. NA 1.34 [0.85, 2.10]

FRUIT AND STROKE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Fruit and Stroke Mortality – Within Subgroups	Between Subgroups	Residual I^2	*p*-value	Adjusted Alpha Level
Total	**-**	**14**	**1,282,756**	**10,899**	**0.79 [0.71, 0.89]**	-	-	-	-
Sex	Females	4	155,963	2,022	0.76 [0.59, 0.99]	F vs. M: 0.90 [0.64, 1.29}	75.38%	0.8	0.007
	Males	4	107,467	2,302	0.85 [0.67, 1.07]	F vs. Mix: 0.98 [0.72, 1.32]			
	Mxed	9	1,126,793	8,877	0.78 [0.67, 0.91]	M vs. Mix: 1.08 [0.81, 1.44]			
Age (y)	<55	8	972,126	5,691	0.80 [0.69, 0.93]	1.02 [0.81, 1.28]	71.67%	0.85	0.008
	≥55	6	310,630	5,208	0.78 [0.66, 0.93]				
Follow Up (y)	<10	3	655,633	3905	0.76 [0.61, 0.95]	0.95 [0.73, 1.22]	69.52%	0.65	0.010
	≥10	14	627,123	6,994	0.81 [0.71, 0.92]				
Statistical Adjustments	<8	5	193,091	1,791	0.88 [0.673, 1.06]	1.15 [0.92, 1.44]	58.65%	0.19	0.013
	≥8	9	1,089,665	9,108	0.76 [0.67, 0.86]				
NOS	<6	3	187,214	1,668	0.92 [0.76, 1.12]	1.23 [0.99, 1.54]	54.86%	0.07	0.017
	≥6	11	1,095,542	9,231	0.75 [0.67, 0.85]				
Exposure Assessment Tool	Validated FFQ	7	772,822	5,387	0.80 [0.68, 0.96]	vFFQ vs. uFFQ: 1.01 [0.80, 1.29]	74.29%	0.49	0.025
	Unvalidated FFQ	5	494,945	5,004	0.82 [0.69, 0.97]	vFFQ vs. record: 0.81 [0.54, 1.21]			
	Food record	2	14,989	508	0.65 [0.45, 0.94]	uFFQ vs. record: 0.79 [0.53, 1.19]			
Location	Asia	6	581,472	6,978	0.74 [0.65, 0.85]	Europe vs. NA: 1.12 [0.75, 1.68]	77.24%	0.25	0.050
	Europe	7	527,256	3,061	0.86 [0.71, 1.03]	Europe vs. Asia: 0.87 [0.69, 1.10]			
	North America	1	174,028	860	0.96 [0.67, 1.37]	Asia vs. NA: 0.77 [0.53, 1.13]			

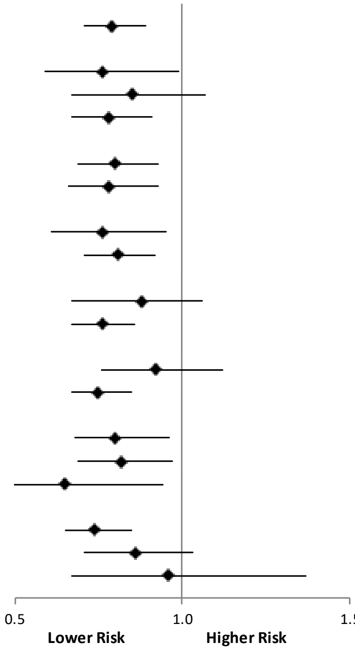


Figure S187. Categorical subgroup analyses of fruit intake and stroke mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

VEGETABLES AND STROKE MORTALITY

Subgroup	Level	Cohorts	N	Events	Pooled Effect Estimates: RR [95% CIs] for Vegetables and Stroke Mortality — Within Subgroups	Between Subgroups	Residual I^2	*p* -value	Adjusted Alpha Level
Total	-	**12**	**780,441**	**7,551**	**0.86 [0.78, 0.96]**	-	-	-	-
Sex	Females	3	120,315	1,752	0.80 [0.63, 1.02]	F vs. M: 0.90 [0.64, 1.27]	59.38%	0.76	0.007
	Males	4	103,142	2,160	0.89 [0.70, 1.13]	F vs. Mix: 0.91 [0.68, 1.22]			
	Mxed	7	556,984	3,639	0.88 [0.75, 1.03]	M vs. Mix: 1.01 [0.76, 1.35]			
Age (y)	<58	7	497,499	258	0.84 [0.71, 1.00]	0.95 [0.75, 1.19]	62.43%	0.63	0.008
	≥58	5	282,942	7,293	0.88 [0.76, 1.03]				
Follow Up (y)	<10	1	193,291	969	0.85 [0.61, 1.18]	0.98 [0.69, 1.38]	64.65%	0.9	0.010
	≥10	9	587,150	6,582	0.87 [0.77, 0.98]				
Statistical Adjustments	<8	3	182,350	1,425	0.92 [0.75, 1.13]	1.08 [0.85, 1.38]	49.01%	0.51	0.013
	≥8	7	598,091	6,126	0.85 [0.75, 0.97]				
NOS	<6	1	174,028	860	0.97 [0.79, 1.19]	1.16 [0.91, 1.47]	44.20%	0.21	0.017
	≥6	11	606,413	6,691	0.84 [0.74, 0.94]				
Exposure Assessment Tool	Validated FFQ	5	742,364	5,239	0.83 [0.72, 0.96]	vFF vs. uFFQ: 1.15 {0.92, 1.43]	45.92%	0.26	0.025
	Unvalidated FFQ	4	23,088	1,804	0.95 [0.81, 1.12]	vFFQ vs. record: 0.90 [0.62, 1.29]			
	Food record	3	14,989	508	0.75 [0.53, 1.04]	uFFQ vs. record: 0.78 [0.54, 1.13]			
Location	Asia	5	116,685	3,590	0.92 [0.79, 1.07]	†	57.00%	0.50	0.050
	Australia	1	1,226	92	0.80 [0.53, 1.21]				
	Europe	5	486,057	2,557	0.76 [0.61, 0.96]				
	North America	1	174,028	860	0.90 [0.62, 1.29]				

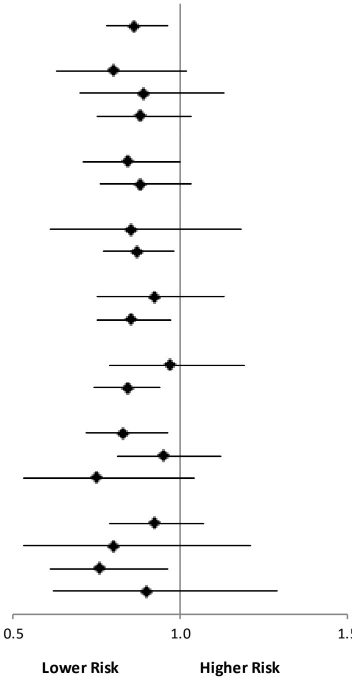


Figure S188. Categorical subgroup analyses of intake of vegetables and stroke mortality. Point estimates for within subgroup level are the pooled effect estimates and are represented by a black diamond. The residual I^2 value indicates the inter-study heterogeneity unexplained by the subgroup. FFQ – food frequency questionnaire; NOS – Newcastle-Ottawa Scale; RR – relative risk; 95% CIs – 95% confidence intervals.

† Europe vs. Asia 1.20 [0.92, 1.57]; Europe vs. Australia 1.05 [0.66, 1.67]; Europe vs. North America 1.17 [0.76, 1.80]; Asia vs. Australia 1.44 [0.74, 1.77]; Asia vs. North America 1.03 [0.69, 1.53]; Australia vs. North America 0.90 [0.52, 1.55

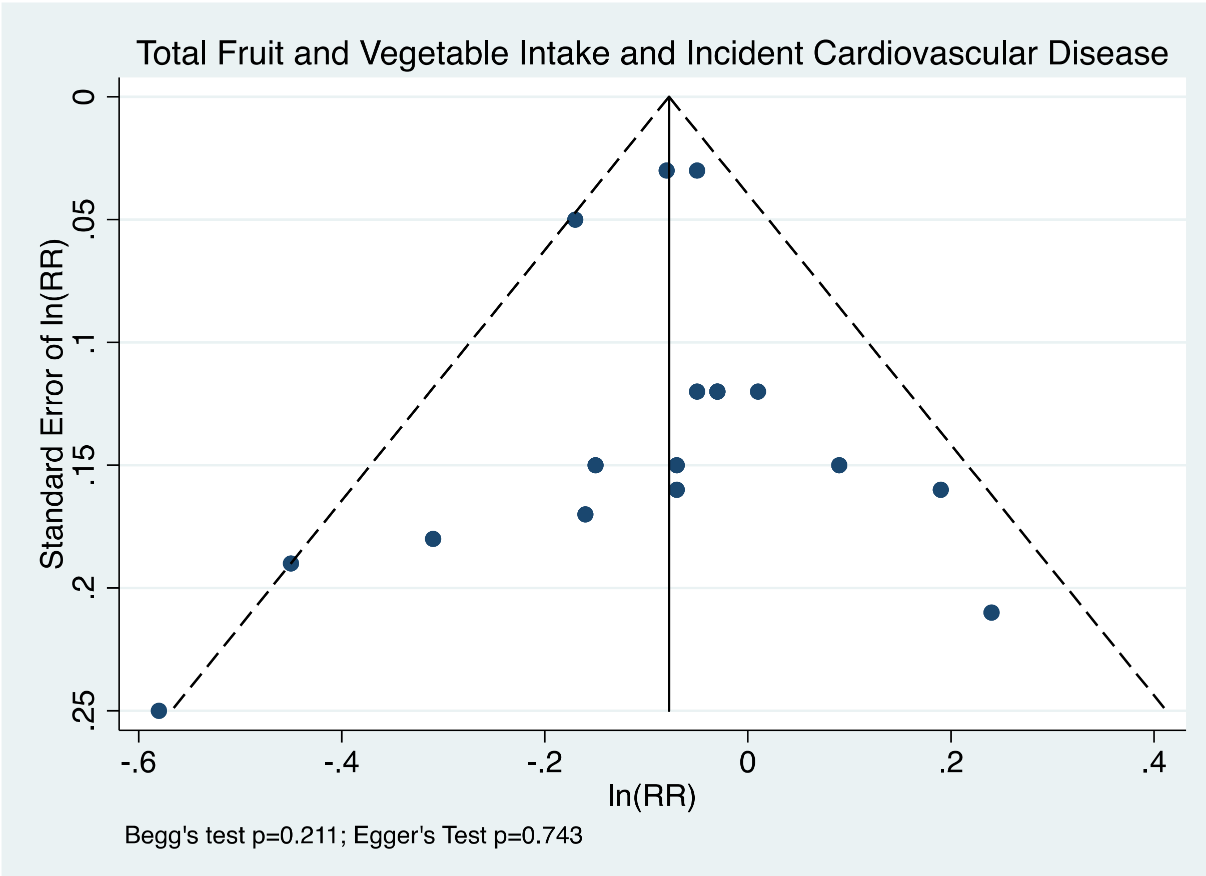


Figure S189. Funnel plot of natural logarithm relative risk [Ln(RR)] for cardiovascular disease incidence comparing the highest and lowest quantiles of total fruit and vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

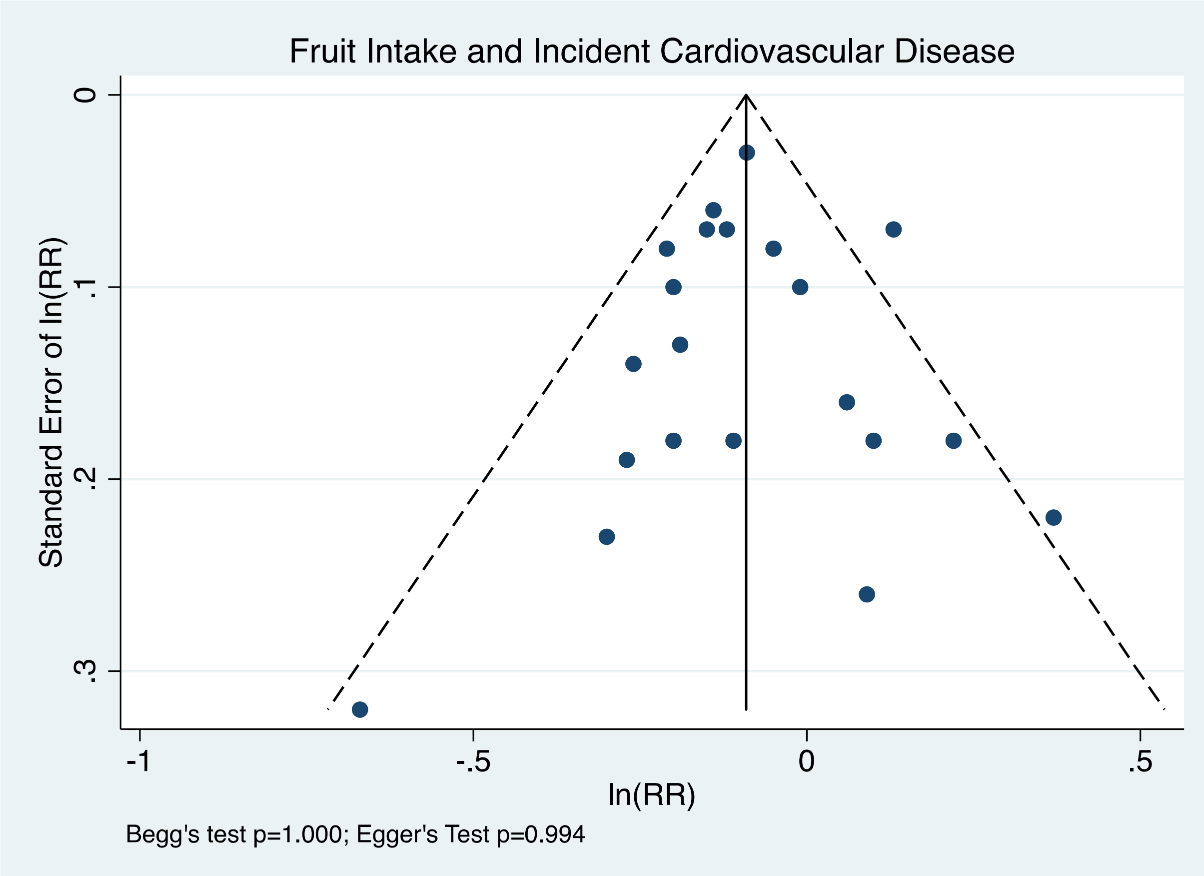


Figure S190. Funnel plot of natural logarithm relative risk [Ln(RR)] for cardiovascular disease incidence comparing the highest and lowest quantiles of fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

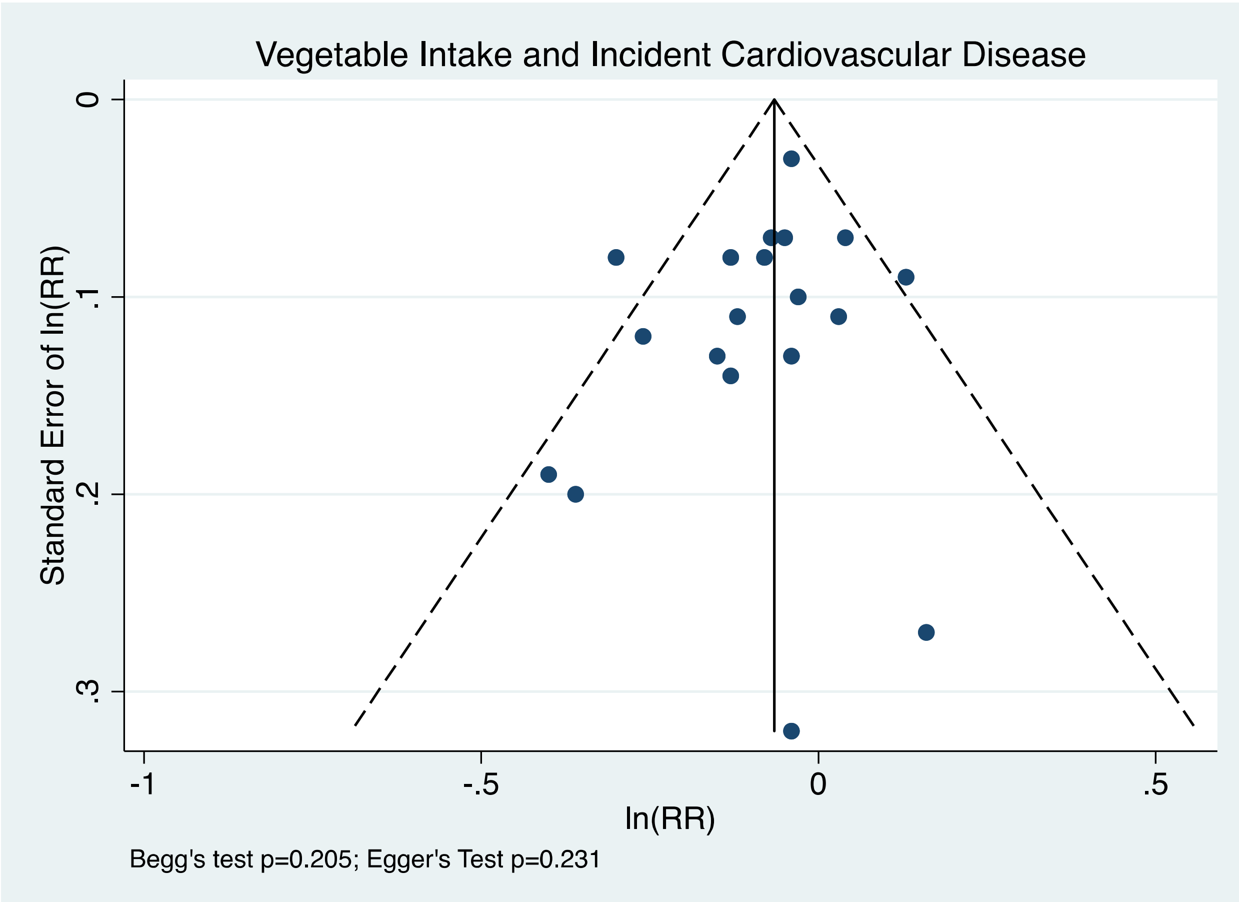


Figure S191. Funnel plot of natural logarithm relative risk [Ln(RR)] for cardiovascular disease incidence comparing the highest and lowest quantiles of vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

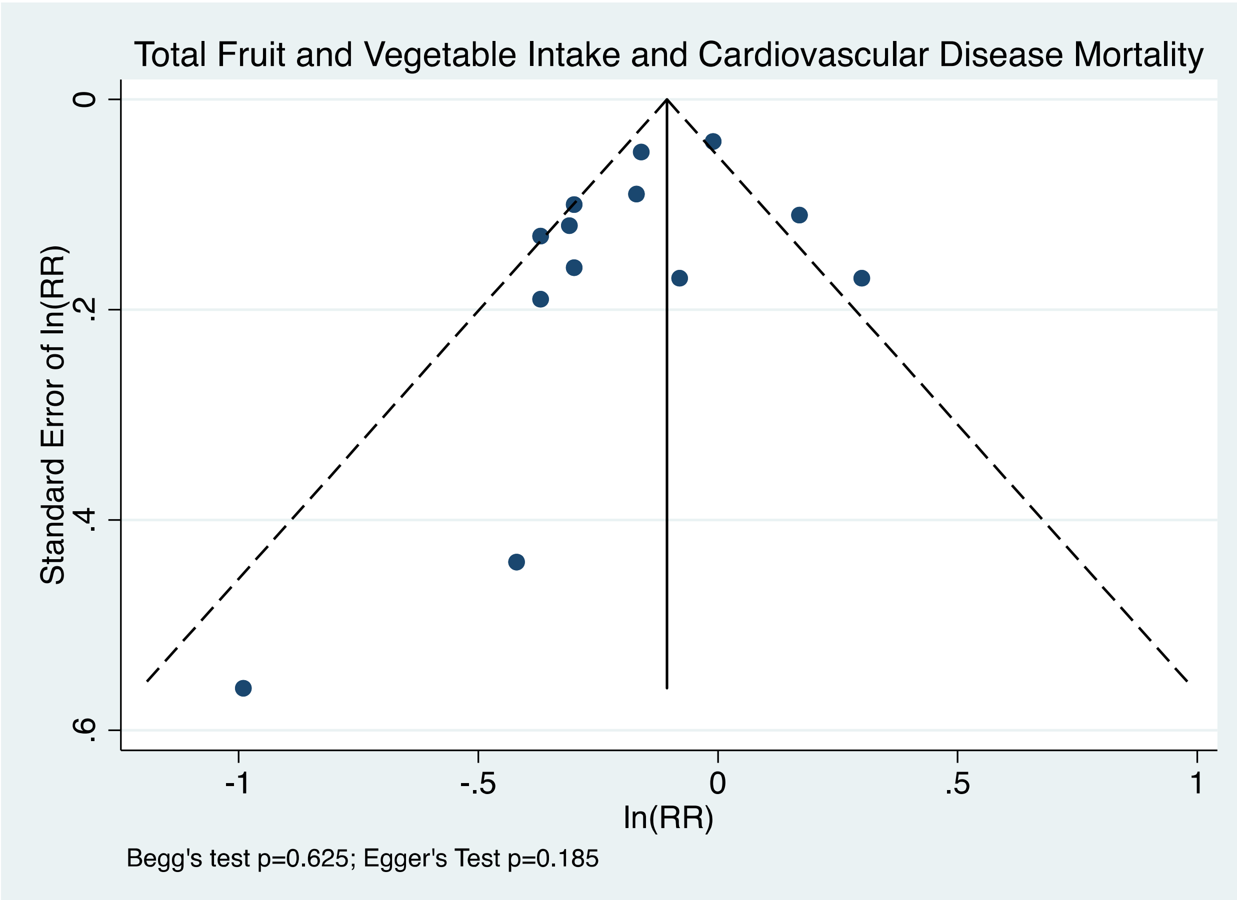


Figure S192. Funnel plot of natural logarithm relative risk [Ln(RR)] for cardiovascular disease mortality comparing the highest and lowest quantiles of total fruit and vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

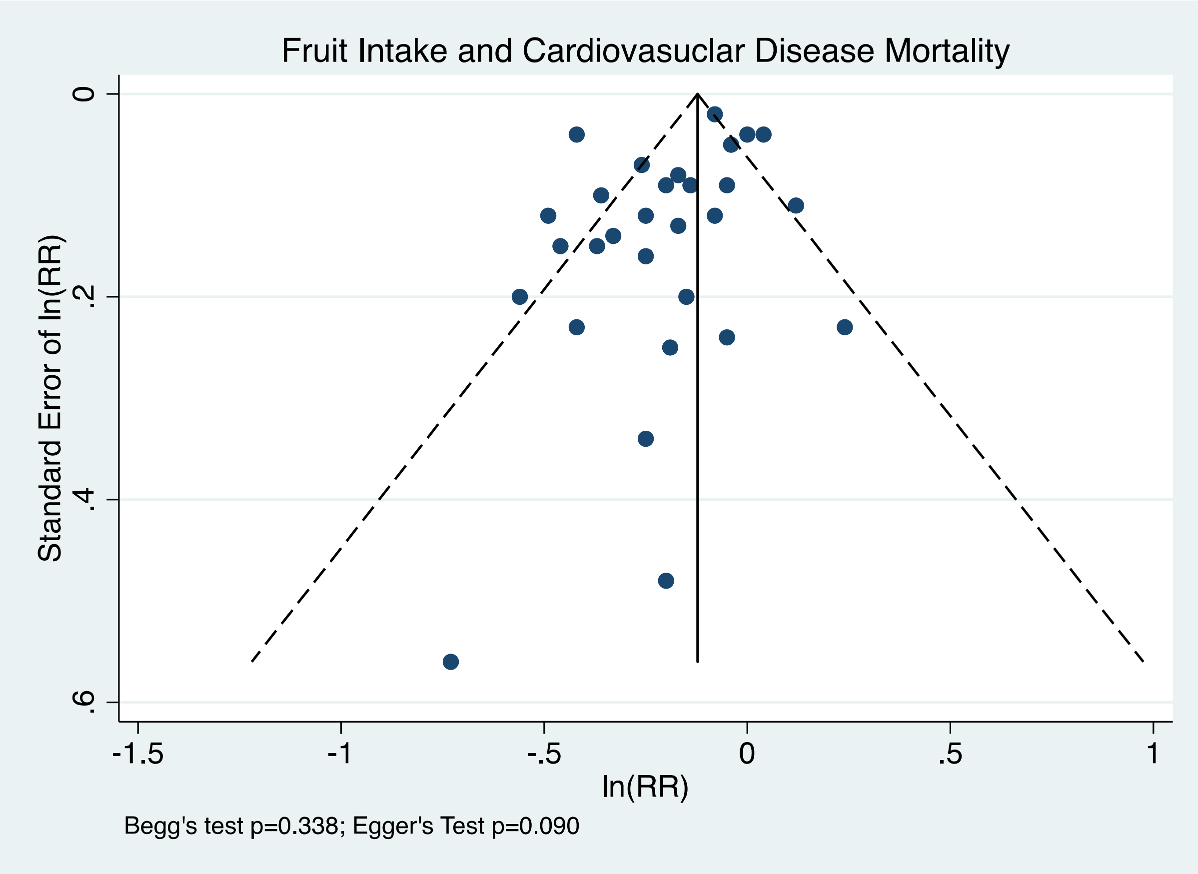
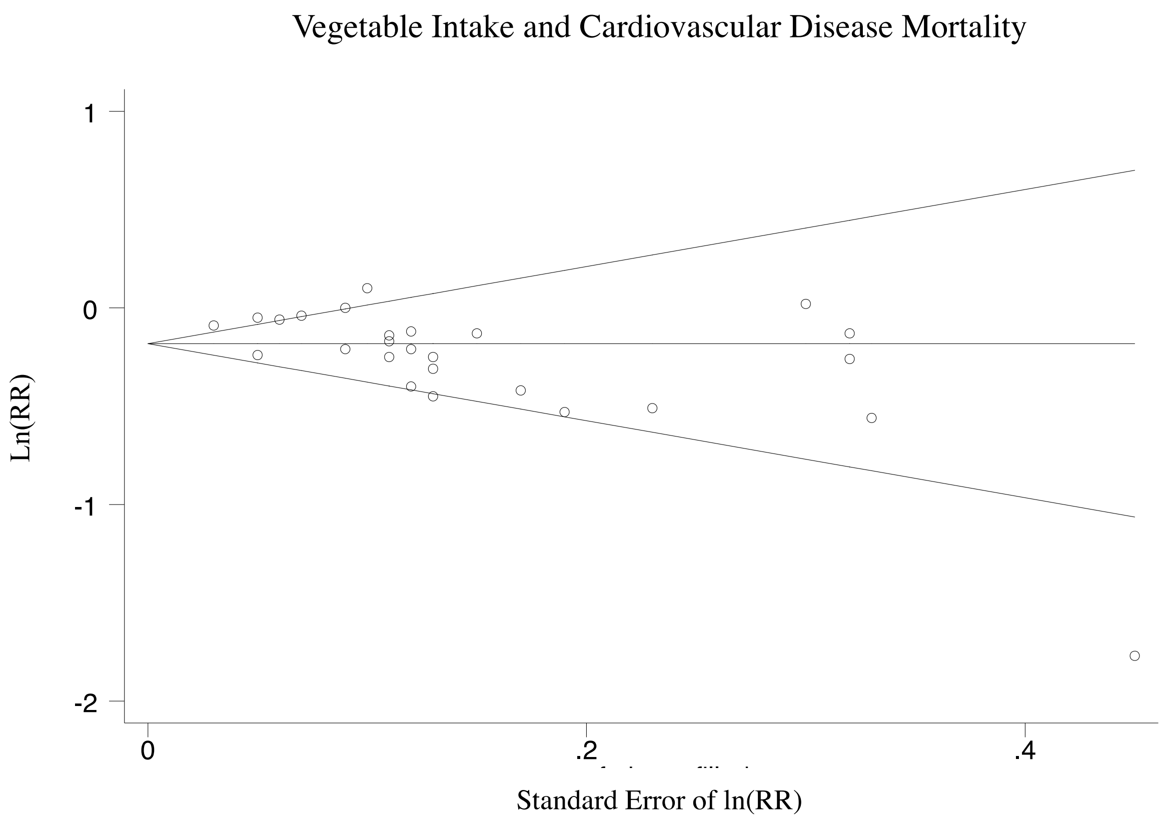


Figure S193. Funnel plot of natural logarithm relative risk [Ln(RR)] for cardiovascular disease mortality comparing the highest and lowest quantiles of fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).



Imputed RR accounting for publication bias: N/A
P-value: N/A

Figure S194. Funnel plot for trim-and-fill analysis for coronary heart disease mortality comparing the highest and lowest quantiles of vegetable intake. The horizontal line represents the pooled effect estimate expressed as the natural logarithm of relative risk [ln(RR)]. The diagonal lines represent the pseudo-95% confidence intervals of the RR. The clear circles represent the effect estimates for each included study.

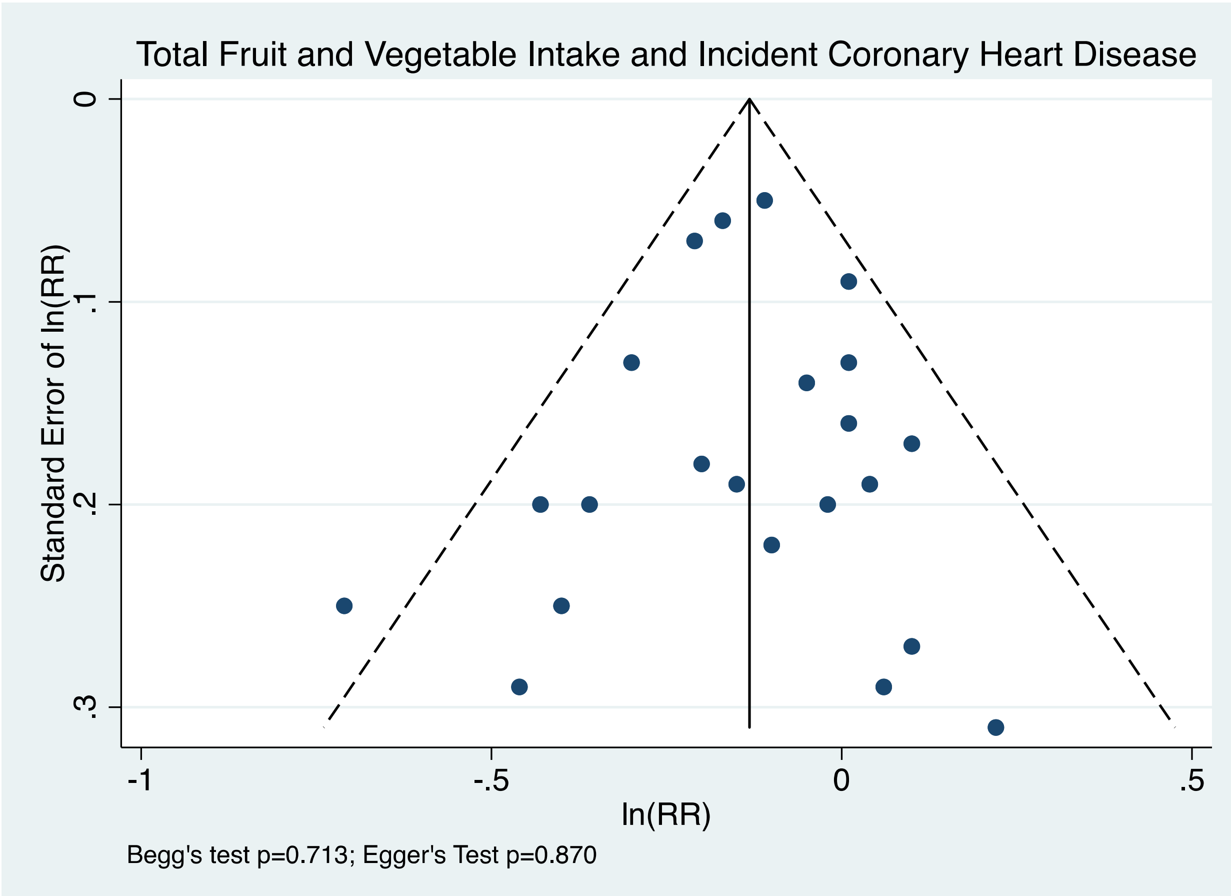


Figure S195. Funnel plot of natural logarithm relative risk [Ln(RR)] for coronary heart disease incidence comparing the highest and lowest quantiles of total fruit and vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

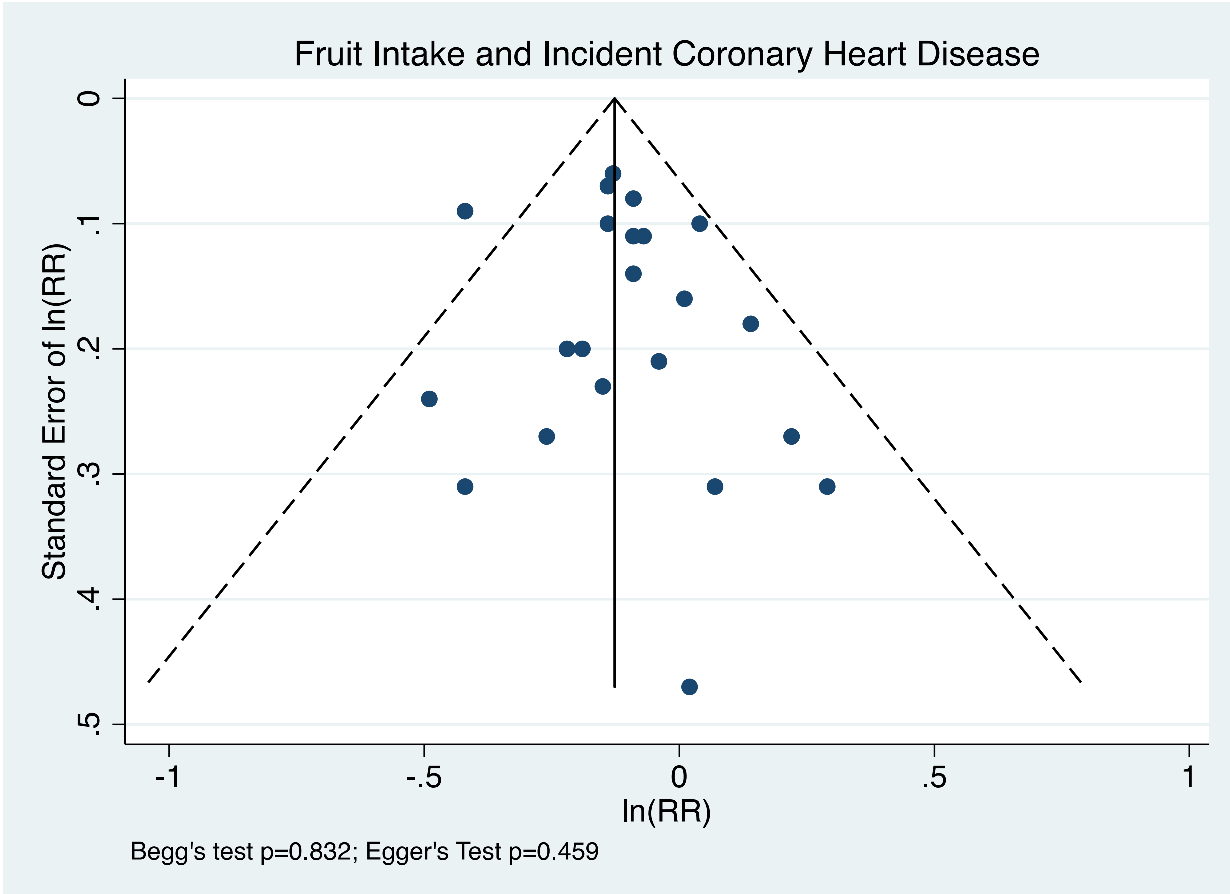


Figure S196. Funnel plot of natural logarithm relative risk [Ln(RR)] for coronary heart disease comparing the highest and lowest quantiles of fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

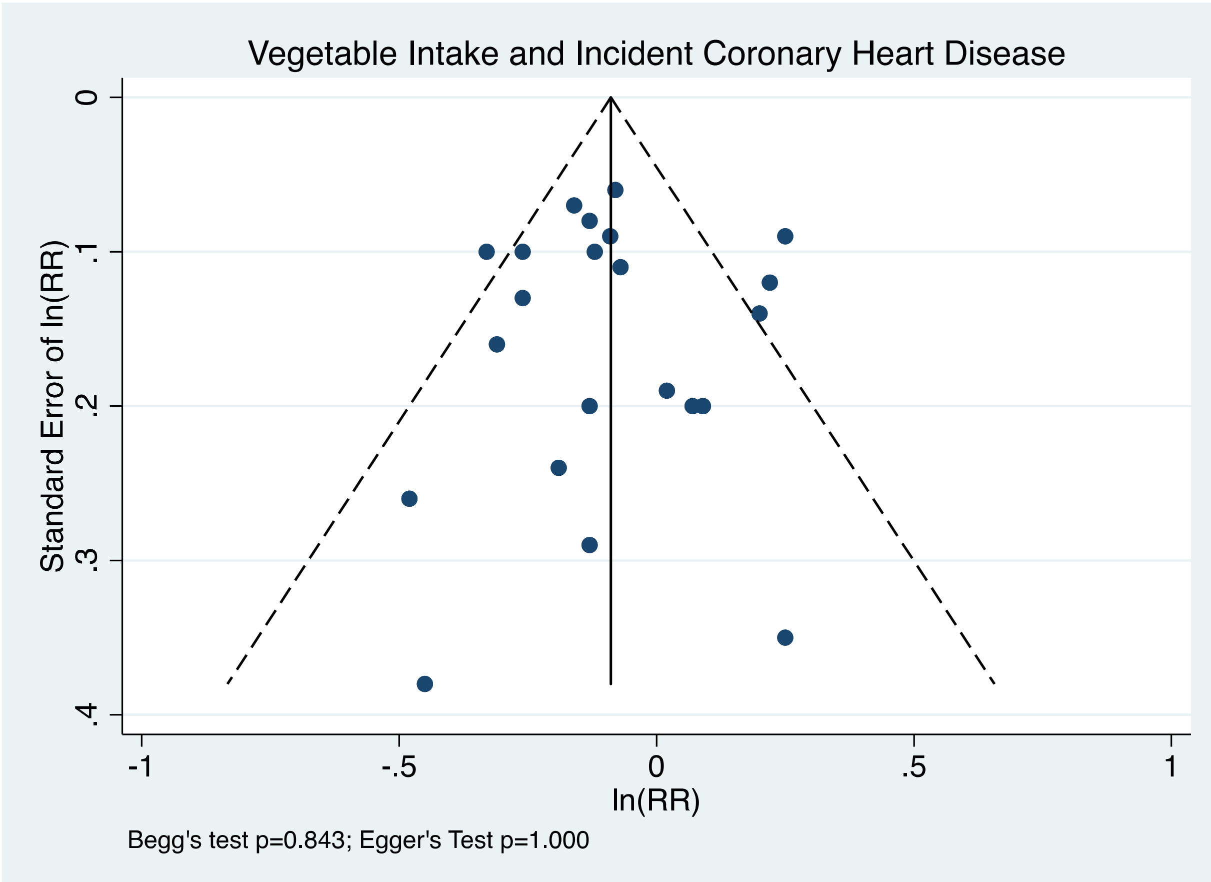


Figure S197. Funnel plot of natural logarithm relative risk [Ln(RR)] for coronary heart disease incidence comparing the highest and lowest quantiles of vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

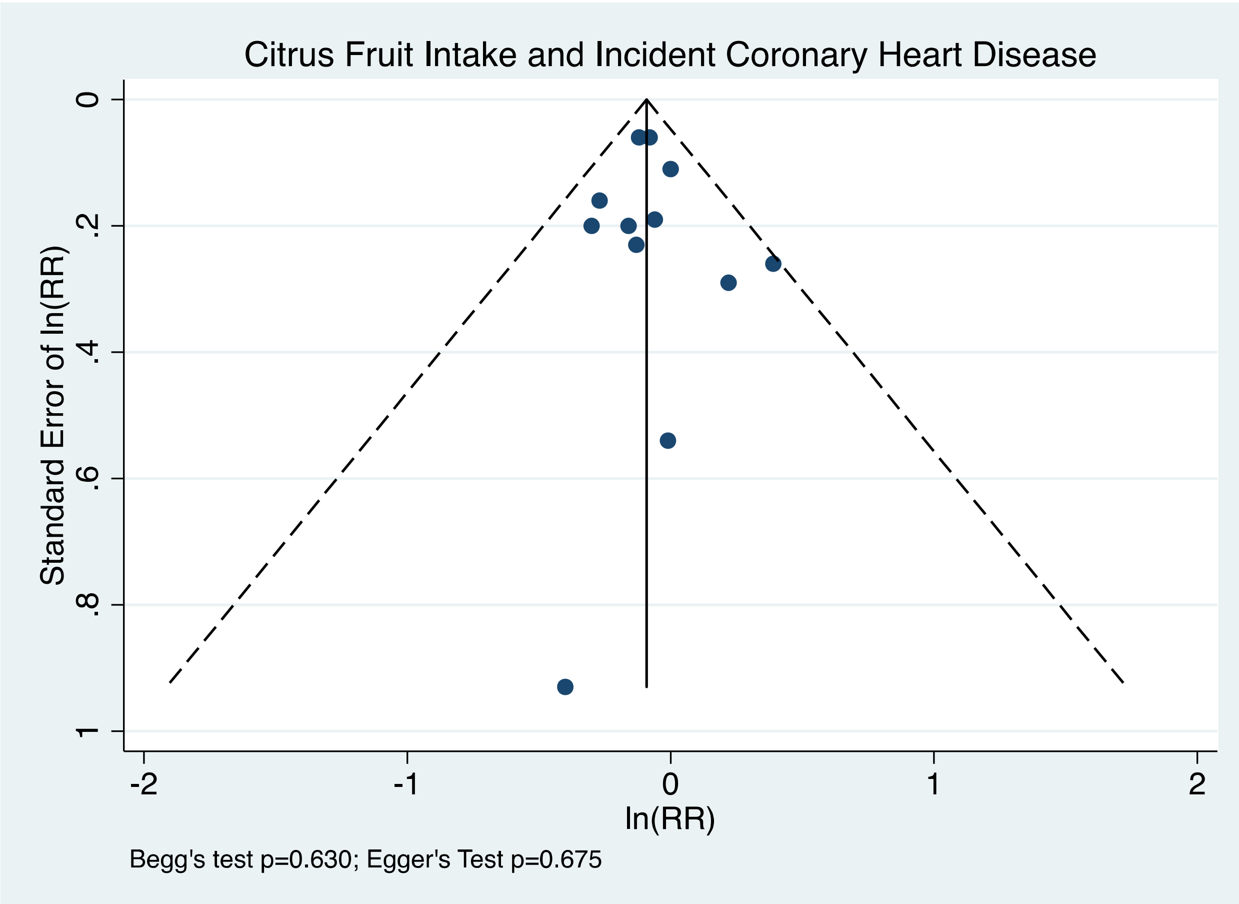


Figure S198. Funnel plot of natural logarithm relative risk [Ln(RR)] for coronary heart disease incidence comparing the highest and lowest quantiles of citrus fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

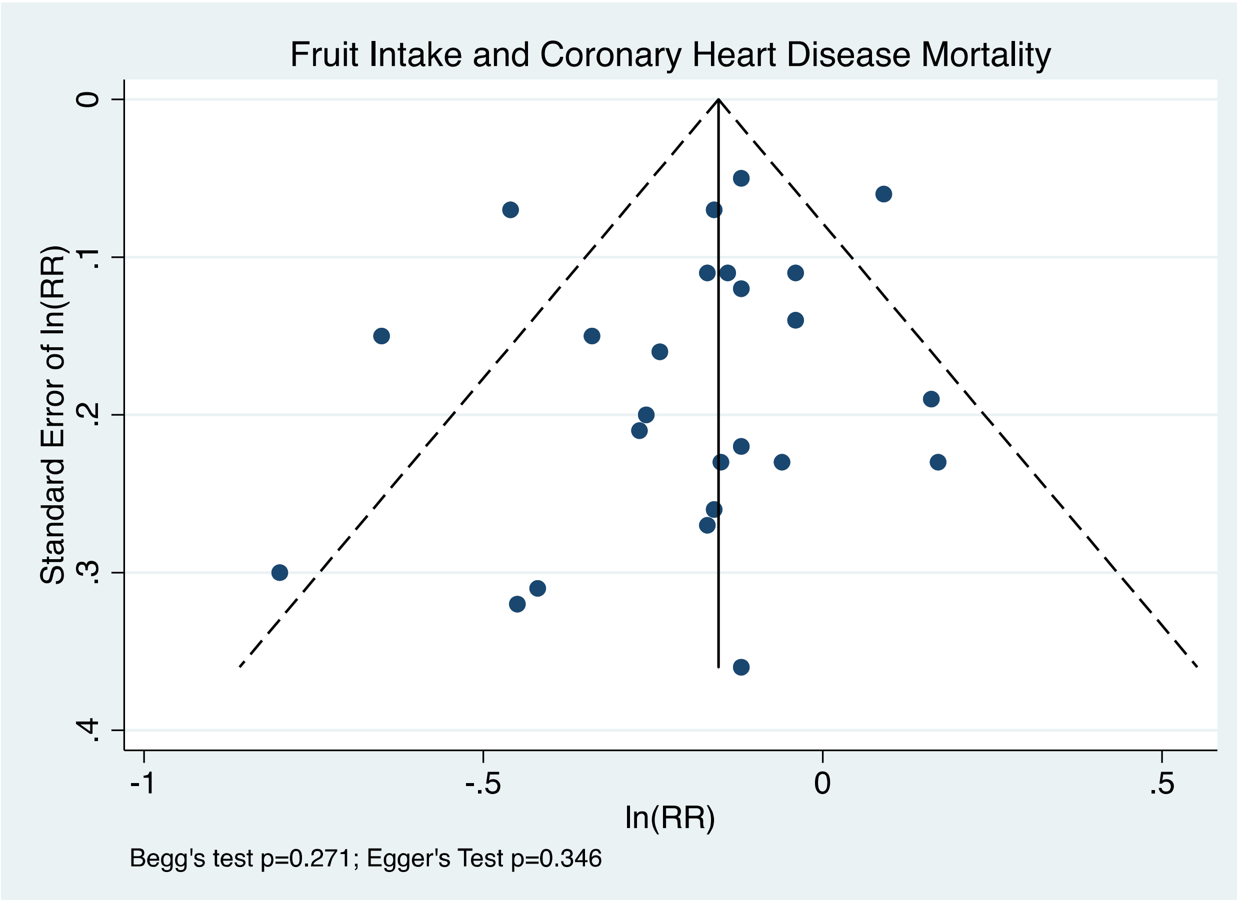
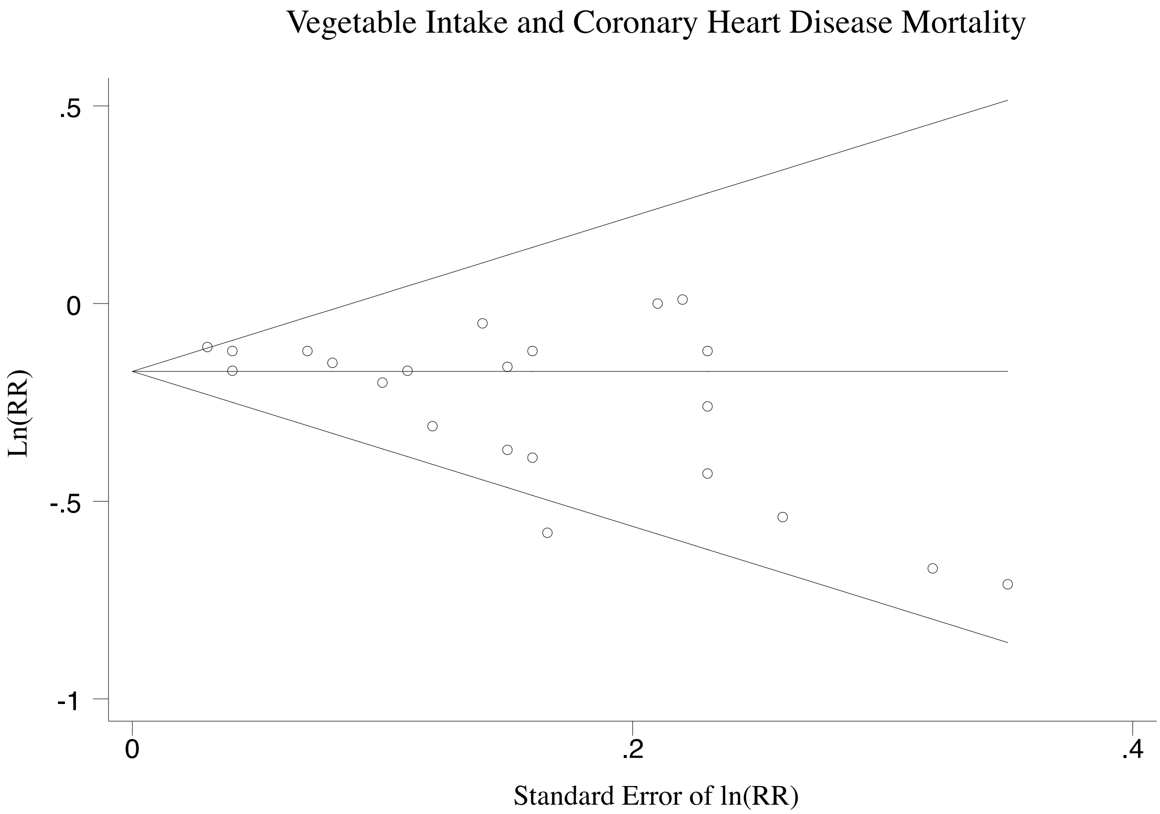


Figure S199. Funnel plot of natural logarithm relative risk [Ln(RR)] for coronary heart disease mortality comparing the highest and lowest quantiles of fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).



Imputed RR accounting for publication bias: N/A
P-value: N/A

Figure S200. Funnel plot for trim-and-fill analysis for coronary heart disease mortality comparing the highest and lowest quantiles of vegetable intake. The horizontal line represents the pooled effect estimate expressed as the natural logarithm of relative risk [ln(RR)]. The diagonal lines represent the pseudo-95% confidence intervals of the RR. The clear circles represent the effect estimates for each included study.

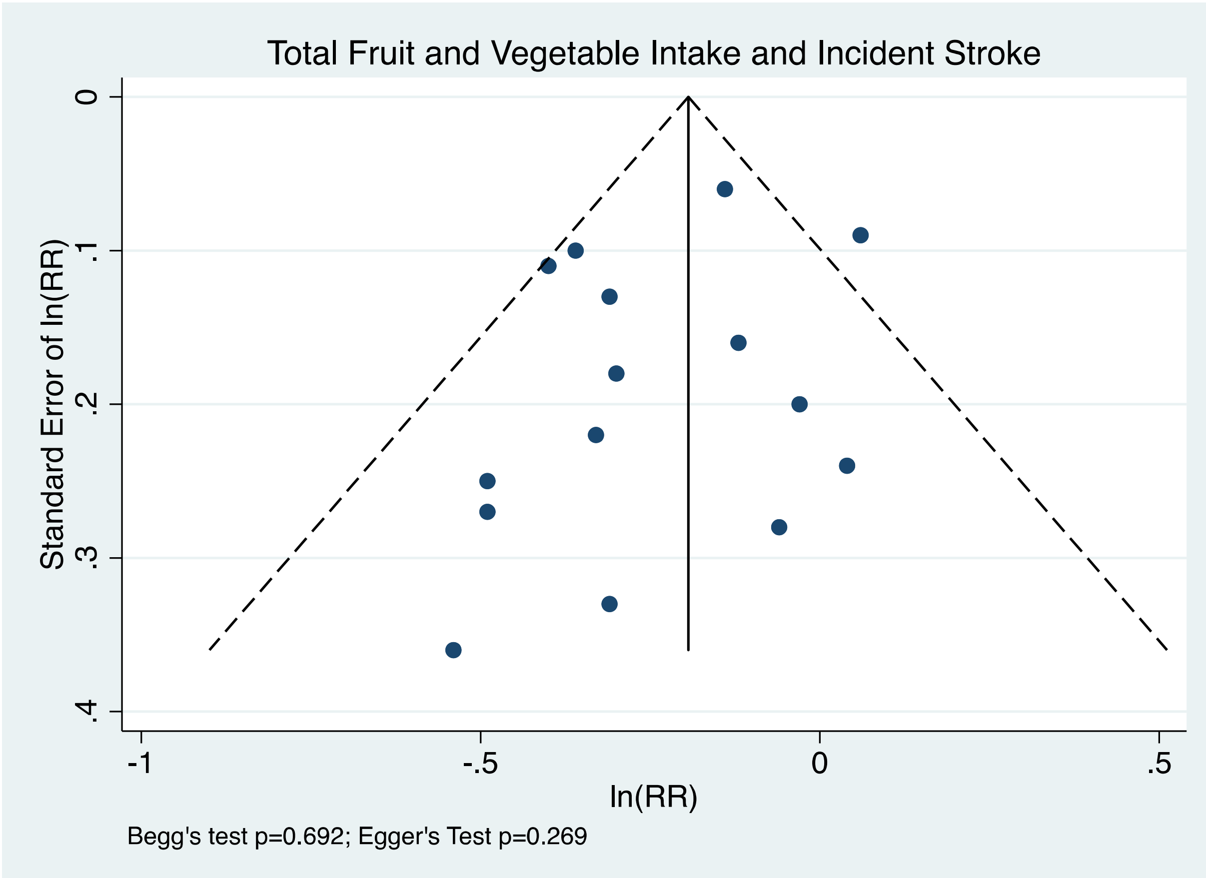


Figure S201. Funnel plot of natural logarithm relative risk [Ln(RR)] for stroke incidence comparing the highest and lowest quantiles of total fruit and vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

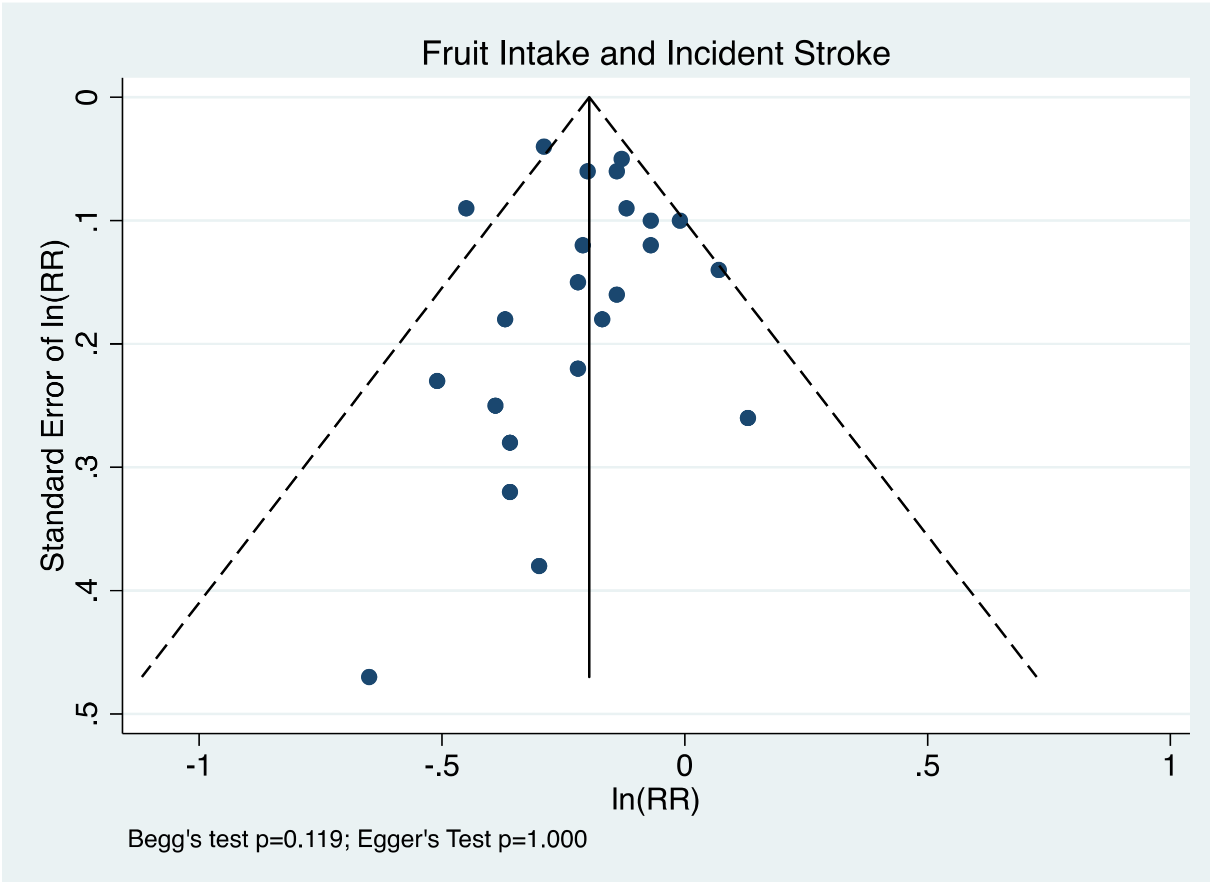


Figure S202. Funnel plot of natural logarithm relative risk [Ln(RR)] for stroke incidence comparing the highest and lowest quantiles of fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

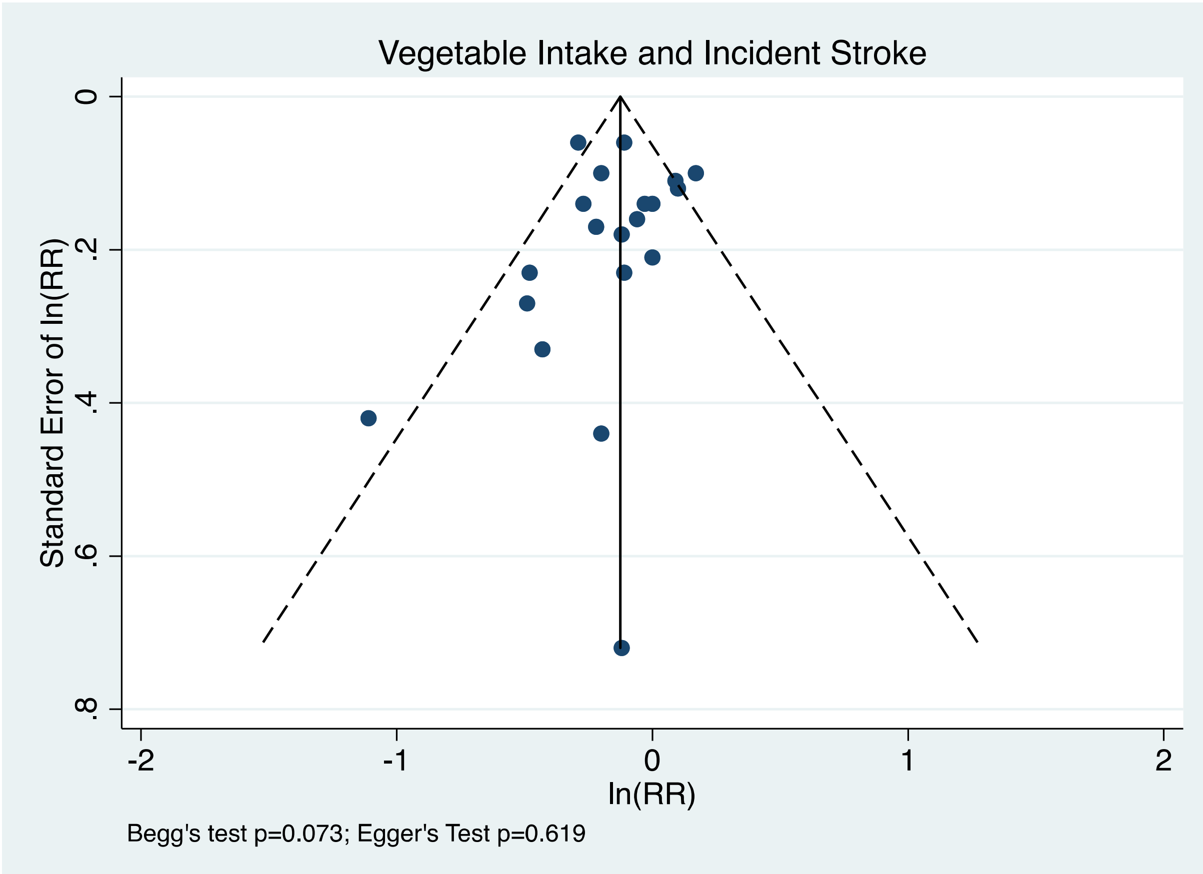
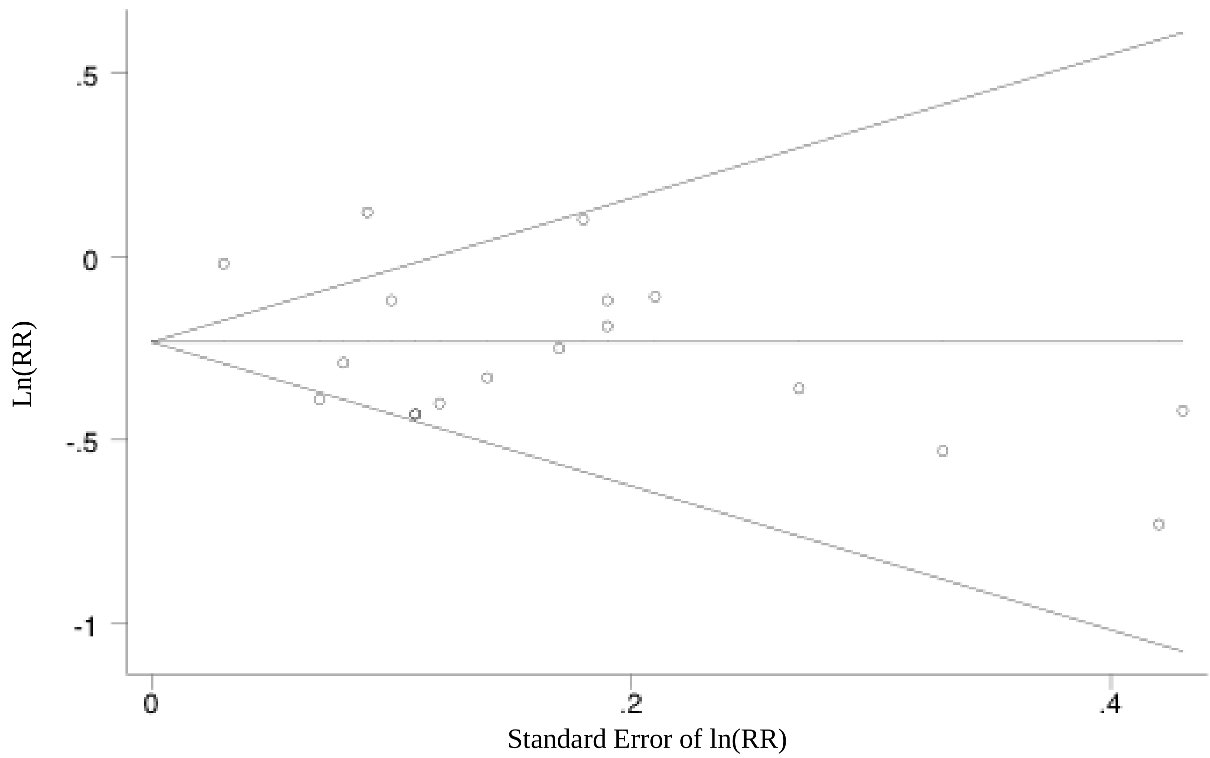


Figure S203. Funnel plot of natural logarithm relative risk [Ln(RR)] for stroke incidence comparing the highest and lowest quantiles of vegetable intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

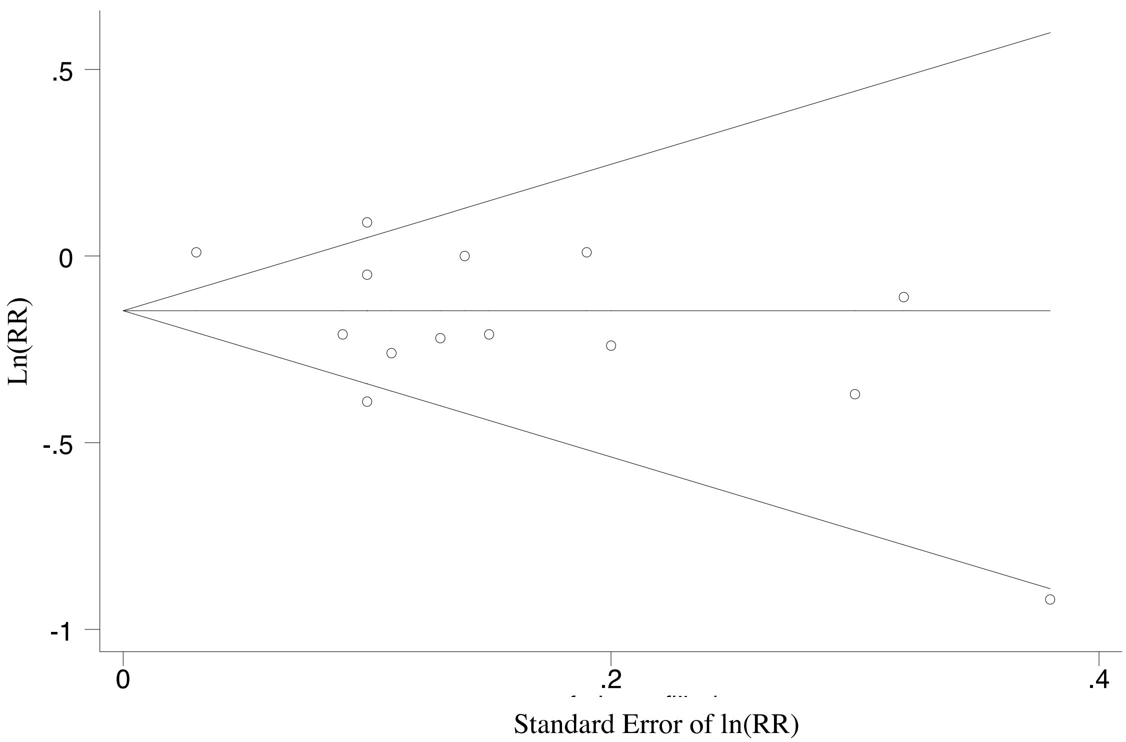
Fruit Intake and Stroke Mortality



Imputed RR accounting for publication bias: N/A
P-value: N/A

Figure S204. Funnel plot of natural logarithm relative risk [Ln(RR)] for stroke mortality comparing the highest and lowest quantiles of fruit intake. The vertical line represents the pooled effect estimated expressed as ln(RR). Dashed lines represent pseudo-95% confidence intervals. The circles represent risk estimates for each comparison, and the horizontal lines represent standard errors of the ln(RR).

Vegetable Intake and Stroke Mortality



Imputed RR accounting for publication bias: N/A
P-value: N/A

Figure S205. Funnel plot for trim-and-fill analysis for stroke mortality comparing the highest and lowest quantiles of vegetable intake. The horizontal line represents the pooled effect estimate expressed as the natural logarithm of relative risk [ln(RR)]. The diagonal lines represent the pseudo-95% confidence intervals of the RR. The clear circles represent the effect estimates for each included study.