

Does milk consumption contribute to cardiometabolic health and overall diet quality?

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Review

Does Milk Consumption Contribute to Cardiometabolic Health and Overall Diet Quality?

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ABSTRACT

Although milk consumption is recommended in most dietary guidelines around the world, its contribution to overall diet quality remains a matter of debate in the scientific community as well as in the public domain. This article summarizes the discussion among experts in the field on the place of milk in a balanced healthy diet. The evidence to date suggests at least a neutral effect of milk intake on health outcomes. The possibility that milk intake is simply a marker of diets higher in nutritional quality cannot be ruled out. This review also identifies a number of key research gaps pertaining to the impact of milk consumption on health. These need to be addressed to better inform future dietary guidelines.

RÉSUMÉ

Bien que dans le monde entier la plupart des lignes directrices en matière d'alimentation recommandent la consommation de lait, sa contribution à la qualité globale du régime alimentaire reste un sujet de controverse dans le milieu scientifique ainsi que dans la sphère publique. Cet article résume les discussions entre les experts de ce domaine sur la place du lait dans un régime alimentaire sain et équilibré. Les données probantes disponibles à ce jour suggèrent pour le moins que la consommation de lait a un effet neutre sur la santé. La possibilité que la consommation de lait soit simplement un marqueur des régimes alimentaires de qualité nutritionnelle supérieure ne peut pas être exclue. Cette revue identifie également plusieurs lacunes importantes de la recherche concernant les effets de la consommation de lait sur la santé. On doit remédier à ces lacunes pour mieux orienter les futures lignes directrices en matière d'alimentation.

Primordial and primary prevention is essential for improving the cardiovascular health of the population in years to come.¹ Primordial prevention hinges on the American Heart Association's "Life's Simple Seven," which targets 4 health behaviours (diet quality, physical activity, smoking, and body

weight) and 3 health factors (cholesterol and glucose levels and blood pressure). Nutritional quality in this paradigm is assessed using 5 criteria: (1) fruit and vegetable consumption, (2) fish consumption, (3) intake of whole grain cereal products, (4) salt intake, and (5) consumption of sugar-sweetened beverages (SSBs).² Although the contribution of each of these foods to cardiovascular health is widely accepted, the extent to which other foods, such as milk, contribute to the overall nutritional quality of diets remains uncertain. Indeed, despite the fact that milk/dairy consumption is recommended in most dietary guidelines around the world, the role and place of these commodities in a healthy/balanced diet has given rise to

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a highly polarized debate within scientific, media, and public circles. On the positive side, milk contributes a significant proportion of daily requirements for protein and calcium at a population level.³ When fortified, milk also contributes to vitamin D intake. As discussed further on, calcium, vitamin D, and dairy proteins are key nutrients for bone health.^{4,5} Adequate vitamin D status has also been associated with a lower risk of some cancers and mortality,^{6,7} but conclusive evidence awaits the results from ongoing large trials of vitamin D supplementation. Milk consumption also contributes to dietary intake of magnesium, potassium, phosphorus, vitamin B₁₂, riboflavin, and vitamin A.

In addition to having potential biological and physiological effects per se, what milk displaces in the diet (for example SSBs or sugary juice) is a key consideration because it may yield further effects on health. Finally, reduced-fat milk consumption has been associated with a prudent dietary pattern in epidemiologic studies,⁸ raising the possibility that milk intake may simply be a marker of a high-quality diet, having no favorable effect per se.

On the potentially negative side, consumption of full-fat milk contributes to saturated fat intake.³ Allergies and other forms of intolerance to milk protein and lactose are also seen as barriers to milk consumption.⁹ Finally, milk production is facing significant challenges related to sustainability, not only from an economic profitability perspective but also because of environmental and societal concerns.¹⁰

Revisiting the place and role of milk in the diet is therefore an important and timely topic, especially considering that milk consumption is deep rooted in many occidental cultures and is increasing markedly in many South Asian and East Asian countries.

The International Chair on Cardiometabolic Risk (*International Chair on Cardiometabolic Risk and Lifestyle Risk Factors* section of the [Supplementary Material](#)) convened a group of experts to assess the evidence linking milk intake with health. Data from epidemiologic studies and randomized controlled trials (RCTs) were reviewed. The consistency of associations across countries and across various health outcomes such as coronary heart disease (CHD), stroke, and type 2 diabetes was discussed. Challenges in assessing the association between milk intake and health were discussed, and knowledge gaps requiring future research were identified.

Milk Consumption and Health Outcomes

Cardiovascular diseases

The perspective on milk and health varied minimally among the experts, despite differences in areas of interest, expertise, and geographic location. There was a unanimous sense that milk intake per se was not associated with a risk of clinical outcomes such as total cardiovascular disease (CVD), CHD, stroke, and type 2 diabetes. Several meta-analyses on the topic support this conclusion. Soedamah-Muthu et al.¹¹ examined the dose-response relationship between milk intake and overall CVD incidence in a meta-analysis of 4 cohort studies published before 2011 based on data from a combined sample of 13,518 individuals. Increased consumption of milk was associated with a slightly reduced risk of CVD (composite relative risk [RR] per 200 mL/d, 0.94; 95% confidence interval

[CI], 0.89-0.99). However, this was not substantiated in a subsequent meta-analysis by O'Sullivan et al.,¹² of cohort studies combining data from more than 330,000 individuals; they reported no significant association between milk intake and CVD mortality (RR per 200 mL/d, 0.96; 95% CI, 0.81-1.13). A number of important cohort studies have been published subsequent to these meta-analyses. For example, data from the Japan Collaborative Cohort comprising a total of 94,980 Japanese adults aged 40-79 years followed over a period of 19 years showed that drinking milk 1-2 times a month vs never drinking milk was associated with lower mortality from CVD in men (RR, 0.89; 95% CI, 0.82-0.98) but not in women (RR, 0.99; 95% CI, 0.89-1.08).¹³ Among the very few reports of a positive association between milk intake and risk of total CVD is a recent publication from the Swedish Mammography Cohort and the Cohort of Swedish Men involving slightly more than 100,000 individuals who were followed for 11-20 years.¹⁴ The study revealed a significant increase in the risk of CVD mortality with milk consumption among both women (RR per 200 g/d, 1.15; 95% CI, 1.12-1.19) and men (RR per 200g/d, 1.05; 95% CI, 1.03-1.07). The authors were very careful in formulating their conclusions by emphasizing the importance of confounding issues and reverse causation to explain the discordance between their findings and those from other groups.¹⁴ More recently, Larsson et al.¹⁵ in their meta-analysis of the association between milk intake and all-cause mortality concluded that there was no consistent association between milk consumption and mortality, including mortality from CVD, and that additional prospective studies were needed.

Soedamah-Muthu et al.¹¹ further examined the dose-response association between milk consumption and risk of CHD specifically (data from 259,162 men and women) and stroke (data from 375,381 men and women). Increased milk intake showed no significant association with the risk of CHD (RR per 200mL/d, 1.00; 95% CI, 0.96-1.04) or stroke (RR, RR per 200 mL/d, 0.87; 95% CI, 0.72-1.07). In a meta-analysis of 15 prospective cohort studies (n = 28,138 stroke events among 764,635 participants), Hu et al.¹⁶ reported no significant linear association between milk intake and the risk of stroke. However, a highly significant nonlinear dose-response relationship between milk intake and risk of stroke was observed, with the lowest risk found in the groups consuming 200 mL/day (RR vs nonconsumers, 0.82; 95% CI, 0.79-0.86) and 300 mL/day (RR, 0.83; 95% CI, 0.79-0.86).

Milk fat intake can be ascertained using the plasma concentrations of fatty acids that are found specifically in dairy fat, primarily C15:0 and C17:0.¹⁷ This approach is based on the premise that humans have a very low endogenous production of these fatty acids. Levels of C17:0 in plasma were associated with a reduced risk of CHD in a meta-analysis by Chowdhury et al.¹⁸ Recent data from Swedish studies in men and women are at odds with previous nested case-control data from the same cohorts,¹⁴ according to which milk fat intake assessed by plasma concentrations of the fatty acids C15:0 and C17:0 was inversely correlated with risk factors for metabolic syndrome and inversely associated with the risk of myocardial infarction in women but not in men.¹⁹ It must be stressed that the use of such biomarkers of dairy fat intake has been challenged recently based on data indicating active metabolic pathways potentially influencing C15:0 and C17:0 levels in

Table 1. Summary of the association between milk consumption and risk of disease and clinical outcomes

Outcome	Association with milk intake
Total CVD	Uncertain
CHD	Neutral
Stroke	Neutral
Type 2 diabetes	Neutral
Fractures	Neutral

CHD, coronary heart disease; CVD, cardiovascular disease.

humans.²⁰ However, it must be kept in mind that even in its regular fat form, milk contributes a small proportion of total dietary fat. The extent to which variations in plasma concentrations of C15:0 and C17:0 reflect variations in milk intake remains uncertain.

In summary, although the association between milk intake and CVD risk and morbidity remains uncertain to a degree, the evidence so far from existing meta-analyses and subsequent cohort studies points toward a neutral association between milk intake and CHD risk (Table 1). More studies are warranted to provide a more definitive answer to this question.

Type 2 diabetes

Four meta-analyses combining data from 4-14 studies and 167,000-459,790 individuals have been relatively consistent in showing no significant association between milk intake and the risk for type 2 diabetes (RR, ranging from 0.87-0.95; 95% CI, ranging from 0.69-1.67, depending on whether total, low-fat, or whole-fat milk was considered).²¹⁻²⁴ Using a mendelian randomization approach in a cohort of 97,811 Danish individuals, Bergholdt et al.²⁵ showed that milk intake as assessed by genetic variations related to lactose tolerance was also not associated with the risk of type 2 diabetes. Taken together, current data pertaining to the risk of type 2 diabetes suggest no association with milk intake.

Bone/muscle health

The unique sets of nutrients provided by milk are believed to be beneficial for bone and muscle strength. This is a topic of particular significance in aging populations because costs of treating a patient with hip fracture are about 3 times greater than those of caring for a person without a history of hip fracture.²⁶ In a meta-analysis of large cohort studies including 195,102 women and 75,149 men, milk intake was not significantly associated with the risk of hip fracture in women (RR per glass of milk per day, 0.99; 95% CI, 0.96-1.02), whereas a trend toward a benefit in men was suggested (RR per glass of milk per day, 0.91; 95% CI, 0.81-1.01).²⁷ Notably, after excluding the influential Swedish cohort study by Michaelsson et al.,²⁸ there was a marginally significant 5% reduction of hip fracture risk per glass of milk intake per day in women as well (pooled RR, 0.95; 95% CI, 0.90-1.00; $P = 0.049$).²⁷ A more recent analysis of another Swedish cohort (104,000 individuals) suggested, in fact, a small increase in the risk of any fracture (RR, 1.02; 95% CI, 1.00-1.04) or of hip fracture (RR, 1.09; 95% CI, 1.05-1.13) per glass of milk intake among women but no association for the risk of all fractures (RR, 1.01; 95% CI, 0.99-1.03) or hip

fractures (RR, 1.03; 95% CI, 0.99-1.07) in men.¹⁴ The extent to which the higher rates of hip fracture in these Swedish cohorts, compared with data from other studies,²⁷ may have influenced results is unclear.

Calcium from foods including milk is found mainly in the form of calcium phosphate, whereas most studies on supplementation have used either calcium citrate or calcium carbonate. This is important because the different forms of calcium have highly variable bioavailability and, hence, potentially different effects on bone health.²⁹ It has been suggested that milk intake may plausibly reduce fracture risk through its specific calcium content and the potential synergistic effect of vitamin D in promoting calcium and phosphate absorption. In the most recent meta-analysis, calcium supplementation was shown to reduce the risk of total fracture (RR, 0.89; 95% CI, 0.81-0.96) and vertebral fracture (RR, 0.86; 95% CI, 0.74-1.00) but not hip (RR, 0.95; 95% CI, 0.76-1.18) or forearm fracture (RR, 0.96; 95% CI, 0.85-1.09). However, in the RCTs at lowest risk of bias (4 studies; $N = 44\,505$), there was no effect of calcium supplementation on risk of fracture at any site. In another meta-analysis based on 4 double-blind RCTs,³⁰ no significant overall benefit of calcium supplementation on risk of nonvertebral fractures was observed. In fact, a possible adverse effect of calcium supplementation on hip fracture risk was found (among 6504 individuals and 139 hip fractures: pooled RR, 1.64; 95% CI, 1.02-2.64).³⁰

Milk may reduce fracture risk through vitamin D fortification. Much of Europe, however, does not add vitamin D to milk. This is of particular concern in Northern European countries (including Sweden), where endogenous production of vitamin D by the skin is limited because of reduced exposure to sunshine. A recent individual participant data pooled analysis of 11 double-blind RCTs with 30,000 seniors showed that high doses of supplemented vitamin D (median, 800 IU/20 µg daily) reduces risk of hip fracture by 30% (hazard ratio [HR], 0.70; 95% CI, 0.58-0.86) and of any nonvertebral fracture by 14% (HR, 0.86; 95% CI, 0.76-0.96).³¹ Benefits at the highest level of vitamin D intake were fairly consistent across subgroups defined by age group, type of dwelling, baseline 25-hydroxyvitamin D level, and calcium intake.³¹

To summarize, the association between milk intake and bone strength and fractures appears to be neutral, but this needs to be substantiated further through cohort studies and RCTs (Table 1). Additional mechanistic studies are also needed to better understand how milk affects bone strength and if, and to what extent, vitamin D fortification is critical to support milk's benefits for bone.

Cardiometabolic risk factors

Data from observational cohort studies are fairly consistent with data from RCTs, which in general suggest a neutral effect of milk consumption on cardiometabolic risk factors. Lowering plasma low-density lipoprotein cholesterol (LDL-C) concentrations and blood pressure is considered to be the primary clinical intervention for reducing CVD risk. However, LDLs are heterogeneous in size and density, and smaller LDL particles have been reported to be associated with an overall atherogenic dyslipidemic phenotype generally associated with

an increased risk of CHD.³² Data also suggest that LDL particle number may be more important than LDL-C concentration in determining the risk of CHD.³³ Meta-analyses of RCTs have shown that dietary saturated fatty acids (SFAs) increase plasma LDL-C compared with carbohydrates, monounsaturated fatty acids, and polyunsaturated fatty acids.³⁴ However, SFAs from dairy may have no effect on LDL particle number and cholesterol levels.^{35,36} In fact, studies have shown that SFAs from dairy tend to increase levels of larger, but not smaller, LDL particles, in contrast to carbohydrates, which increase smaller LDLs.³⁷ The clinical significance of this increase in large LDLs with consumption of SFAs from dairy remains to be determined.

In a small randomized controlled feeding trial, Drouin-Chartier et al.³⁸ showed that consumption of 4 cups of partly skimmed milk (2% fat) for 6 weeks vs no milk had virtually no impact on a wide spectrum of cardiometabolic risk factors in postmenopausal women, including LDL-C and other lipid risk factors, markers of vascular function, and markers of inflammation. In an RCT with 158 overweight and obese men and women, neither high protein nor SFAs from dairy affected insulin sensitivity or plasma LDL-C, high-density lipoprotein cholesterol, or triglyceride concentrations.³⁹

There has been some evidence that specific fatty acids found in dairy fat may be associated with health benefits. For example, trans-palmitoleate (trans 16:1n-7) is a trans fatty acid found primarily in dairy fat, and its blood phospholipid concentrations have been associated with lower insulin resistance, a more favourable lipid profile, and a reduced incidence of diabetes,⁴⁰ but results have not been consistent.¹⁸ Vaccenic acid, a trans fatty acid found in dairy fat but also in partially hydrogenated vegetable oil, has also drawn the attention of the research community. Several studies in animals have shown that intake of vaccenic acid may have favourable effects on cardiometabolic risk factors and immune function.^{41,42} However, these data have not yet been replicated in human studies.⁴³ Although of interest, studying the health impacts of individual trans fatty acids specific to dairy fat will not fully resolve the question of how milk as a complex food influences health.

The association between milk intake and hypertension/blood pressure has been quite consistent in observational cohort studies. The meta-analysis of 7 cohort studies by Soedamah-Muthu et al.⁴⁴ assessed the dose-response association between milk intake and the risk of hypertension. Based on data from 47,647 individuals, each increment of 200g/d of milk was associated with a significant 4% reduction in the risk of hypertension (RR, 0.96; 95% CI, 0.94-0.98). In contrast, Benatar et al.⁴⁵ in a meta-analysis of 7 RCTs published before 2013, could not confirm a significant blood pressure-lowering effect of total dairy intake on systolic and diastolic blood pressure. Meta-analyses of RCTs showed inconsistent results regarding the impact of probiotic fermented milk, with favourable as well as neutral effects on systolic and diastolic blood pressure.^{46,47} More recently, Drouin-Chartier et al.⁴⁸ showed in an RCT with 76 patients with mild to moderate hypertension that daily consumption of milk (low fat), yogurt (low fat), and cheese (regular fat) for a total of 3 servings per day significantly reduced mean daytime systolic blood pressure (−2 mm Hg; $P = 0.05$) in men but not in women when

Table 2. Key knowledge gaps related to milk and health and research opportunities

- Do regular/full fat and reduced/nonfat milk products have similar or different effects on health outcomes?
- To what extent are potential health effects of milk consumption modulated by the foods it is replacing in the diet?
- What is the impact of milk consumption on other vascular-related disease outcomes such as peripheral arterial disease, chronic kidney disease and cognitive decline?
- Does milk powder have similar health properties as liquid milk?
- How do different cattle feeding practices, which modify the fatty acid profiles of dairy fat, influence the effect of milk on health?
- Do age, weight status, sex, and ethnicity influence the impact of milk consumption on health?
- Is the effect of milk consumption on health outcomes similar among populations with traditionally low vs high intakes?

compared with a dairy-free control diet. Because most of the existing RCTs have assessed the impact of total dairy rather than milk per se on blood pressure, more studies on this topic are clearly needed.

Both cross-sectional and longitudinal cohort studies have shown significant inverse relationships between dairy product intake and measures of arterial stiffness,^{49,50} which has been proposed to be a more holistic marker of vascular health and predictor of cardiovascular events and mortality than blood pressure per se.⁵¹ This remains controversial, however, and more clinical studies assessing the impact of milk intake on arterial stiffness are clearly warranted to pursue this hypothesis.

In summary, it appears that milk consumption per se may have relatively neutral effects on a wide spectrum of cardiometabolic risk factors, which overall is consistent with data from observational cohort studies. One exception pertains to a potentially favourable effect of dairy/milk intake on blood pressure. However, several key questions remain, as discussed in the following section.

Complexities in Assessing the Impact of Milk on Health and Research Opportunities

Assessing the effect of milk consumption on health is complex and requires further studies to address several important questions relevant to clinical practice and public health (Table 2).

Effect of replacement foods

One of the key aspects to consider when assessing the place of milk in a healthy dietary pattern is to consider what it displaces in the diet. This issue requires considerable attention because the impact of milk per se on health cannot be fully dissociated from that of the foods it replaces. Data from a 6-month RCT indicated that isocaloric replacement of milk by SSBs increases fat storage in the liver, muscle, and visceral fat.⁵² Results from observational cohort studies based on modelling of dietary data are consistent with this in suggesting that “substituting” SSBs for milk is associated with an increased risk of weight gain.⁵³ Data from 2 large US cohort studies have shown that compared with 1 serving per day of red meat, 1 serving per day of dairy including milk was associated with an 11% (95% CI, 5%-17%) lower risk of stroke in men and women and a 13% (95% CI, 6%-19%) lower risk of CHD in

women.^{54,55} In contrast, dairy consumption in place of fish was associated with a higher risk of CHD in women.⁵⁵ However, as emphasized earlier, milk may not be comparable to other solid sources of protein in the context of hydration and protein functionality. This issue deserves more consideration in future studies so that the impact of solid vs liquid foods on health can be assessed separately, according to their specific contribution to the overall diet.

Factors affecting nutrient composition of milk

Other aspects to consider pertain to seasonal and feeding practice-related variations in milk nutrient content. For example, indoor feeding of dairy cows increases the SFA content of fat in milk by almost 10% compared with outdoor feeding at high altitudes.⁵⁶ Accordingly, studies in Europe and the United States have documented seasonal changes in the fat content of milk,^{57,58} with a decrease in the proportion of SFAs and an increase trans fatty acids during the grazing season. However, the statistically significant differences in the fatty acid content of milk between seasons and regions in the United States appeared to be minor from an overall human nutrition perspective, with SFA profiles that were numerically similar.⁵⁸ Assessment of food intake in observational cohort studies certainly does not capture such variation in milk nutrient composition, whether important or not. Hence, the extent to which accounting for such variation in milk nutrient profile will enhance our understanding of the impact of milk consumption on health is uncertain. Whether a reduced-SFA milk is healthier than unmodified milk is certainly an area with great research potential.⁵⁹

Whole milk (3.25% fat) in most observational cohort studies has generally been considered a high/regular-fat product, which may be inappropriate considering that other full-fat dairy such as cheese contains as much as 40%-45% fat. This is a significant shortcoming in several of the existing studies on milk and health. To better address this limitation, future studies should also examine how different types of milk based on fat content, but also perhaps on other aspects such as fermentation and vitamin D fortification, relate to cardiometabolic health.

Geographic considerations

Vitamin D fortification of milk is not systematic in Europe but is so in the United States and Canada. The extent to which this leads to inconsistent associations between milk intake and health is unclear. Consumption of milk is highly variable around the world, with trends toward reduced consumption in North America and increased consumption in Asia,⁶⁰ where consumption has traditionally been very low. It will be challenging for ongoing observational cohort studies in these populations to account for acute upward and downward trends in milk/dairy consumption. Asian countries are also important consumers of milk protein powders. The impact of this nonliquid form of milk on health is poorly characterized compared with its liquid parent. Lactose intolerance also needs to be factored in when assessing the impact of milk intake on health in Asian countries.

Other disease outcomes

Further research is needed to document how milk consumption influences vascular-related disease outcomes other

Table 3. Key summary points

- Milk consumption is part of many cultures and is recommended in most dietary guidelines around the world
- Evidence available to date suggests that milk has a neutral effect on most cardiovascular outcomes, whereas milk intake may be associated with a lower risk of hypertension
- Important research gaps need to be addressed to better understand the impact of milk intake on health

than heart disease and stroke, eg, peripheral arterial disease, chronic kidney disease, and cognitive decline.⁶¹ The extent to which weight status, age, ethnicity, and sex modify the impact of milk consumption on health outcomes also needs further consideration. The expert panel did not discuss the impact of milk intake on cancer risk. Briefly, several reports and meta-analyses of observational cohort studies have been conducted on this topic, suggesting no detrimental effect of milk consumption on the risk of a variety of cancers,⁶²⁻⁶⁴ with the exception perhaps of prostate cancer,⁶⁵ although this has not been a consistent finding.⁶⁶

Conclusions

Although in principle, RCTs would be the optimal means of assessing the impact of milk consumption per se on clinical outcomes such as CVD, type 2 diabetes, or cancer, such studies are for the most part not practicable, and hence it is necessary to rely on high-quality observational cohort studies as well as on smaller-scale clinical studies of milk effects on surrogates of disease outcome such as cardiometabolic risk factors. The available body of evidence is relatively consistent in supporting a neutral effect of milk intake on multiple health outcomes (Table 3). This raises the question about the relevance of including milk (and dairy) as part of the guidelines for promoting healthy eating. However, milk consumption does contribute to the intake of several important nutrients, and this needs to be factored in when considering the place of milk in current dietary guidelines.

This review also identifies key research gaps that need to be addressed in the future (Table 2). It will be important to determine the intrinsic health properties of milk (eg, vitamin D fortification vs no fortification) vs the effects mediated through foods it replaces or displaces in the diet. In this regard, the difference between regular-fat and reduced-fat milk in influencing health outcomes needs to be specifically documented. The extent to which nutrient variations in milk, including milk SFAs, influence its association with health outcomes also needs consideration. Potential variations by sex, obesity status, and geographic locations regarding the impact of milk intake on health are poorly understood. Finally, the possibility that milk intake is simply a marker of diets with good nutritional quality cannot be ruled out, and this concept needs further research as well. Addressing these research gaps will help resolve the place of milk in the healthy eating paradigm, hence contributing to better informed evidence-based dietary guidelines.

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Disclosures

Please see the *Disclosures* section of the [Supplementary Material](#).

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Supplementary Material

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