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The World Health Organization estimates a daily intake of dietary acrylamide in the range of 0.3–2.0 μg/kg/body wt for the general population (74). For high-percentile consumers (90th to 97.5th), daily intakes of dietary acrylamide vary in the range of 0.6–3.5 μg/kg/body wt, and as high as 5.1 μg/kg/body wt for the 99th-percentile consumers. The daily intakes of dietary acrylamide in children are estimated to be 2–3 times those of adults based on average body weight ratios. The daily intakes of dietary acrylamide for the general population and high consumers (including children) are estimated to be on average 1 and 4 μg/kg/body wt, respectively. The main sources of dietary acrylamide are potato chips (16–30%), potato crisps (6–46%), coffee (13–39%), pastry and sweet biscuits (10–20%) and bread and rolls/toasts (10–30%). Other food products can account for <10% of the total intake of dietary acrylamide (see Table I) (74).
So far, several epidemiologic studies have attempted to find a link between dietary acrylamide exposure and human cancers (17 , 18 , 75–78). However, no association has been found between the intake of dietary acrylamide and the risk for development of any type of cancer (75 , 79–81). The absence of positive results in these observational studies, however, cannot be interpreted as proof of no carcinogenicity of acrylamide to humans (75 , 79–81). Obviously, the conducted studies have potential limitations, including inadequate statistical power due to the small size of study populations and the narrow range of exposure between cases and controls.

By virtue of design, case–control studies require a reasonable difference in exposure levels between cases and controls; yet, acrylamide is abundantly present in foods eaten nearly universally, e.g. bread products. Also, the observational studies are prone to misclassification of acrylamide exposure as a result of reliance on crude estimates of dietary intake using food frequency questionnaires. Notwithstanding is that the administered questionnaires of some of these studies have been originally tailored to elicit information regarding exposure to carcinogens other than acrylamide, e.g. heterocyclic amines (17); at the original design of these studies, the presence of acrylamide in foods was not even discovered. Other drawbacks of these studies include selection and recall biases, especially in hospital-based case–control studies in which cases tend to modify their dietary habits soon after the appearance of early symptoms of the disease, as well as report their dietary intakes more accurately than controls (75 , 79–81

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