Fish Intake and Risk of Incident Atrial Fibrillation

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Background—Atrial fibrillation (AF) is the most common arrhythmia in clinical practice and is particularly common in the elderly. Although effects of fish intake, including potential antiarrhythmic effects, may favorably influence risk of AF, relationships between fish intake and AF incidence have not been evaluated.

Methods and Results—In a prospective, population-based cohort of 4815 adults ≥ age 65 years, usual dietary intake was assessed at baseline in 1989 and 1990. Consumption of tuna and other broiled or baked fish correlated with plasma phospholipid long-chain n-3 fatty acids, whereas consumption of fried fish or fish sandwiches (fish burgers) did not. AF incidence was prospectively ascertained on the basis of hospital discharge records and annual electrocardiograms. During 12 years’ follow-up, 980 cases of incident AF were diagnosed. In multivariate analyses, consumption of tuna or other broiled or baked fish was inversely associated with incidence of AF, with 28% lower risk with intake 1 to 4 times per week (HR=0.72, 95% CI=0.58 to 0.91, P=0.005), and 31% lower risk with intake ≥5 times per week (HR=0.69, 95% CI=0.52 to 0.91, P=0.008), compared with <1 time per month (P trend=0.004). Results were not materially different after adjustment for preceding myocardial infarction or congestive heart failure. In similar analyses, fried fish/fish sandwich consumption was not associated with lower risk of AF.

Conclusions—Among elderly adults, consumption of tuna or other broiled or baked fish, but not fried fish or fish sandwiches, is associated with lower incidence of AF. Fish intake may influence risk of this common cardiac arrhythmia. (Circulation. 2004;110:368-373.)

Key Words: fibrillation, atrial ■ diet ■ fish ■ aging ■ nutrition

Atrial fibrillation (AF) is the most common cardiac arrhythmia, affecting more than 2 million individuals in the United States.1 Risk increases markedly with advancing age.1–3 After age 65 years, the incidence of AF is approximately 2% per year, with risk factors including older age; presence of valvular or coronary heart disease; greater systolic blood pressure, left atrial size, serum glucose, and C-reactive protein levels; and lower alcohol use, serum cholesterol, and forced expiratory volume in 1 second.3–4 AF results in significant morbidity, including fatigue, reduced exercise tolerance, increased stroke risk, and potential bleeding complications from anticoagulant therapy.1,5

Little is known about relationships of nutritional factors with incidence of AF. Fish intake may lower blood pressure, reduce systemic inflammation, and improve left ventricular diastolic function,6–16 each of which could favorably affect risk of AF. Fish consumption also appears to reduce risk of AF, relationships between fish intake and AF incidence have not been evaluated.

The design and recruitment process of CHS have been described.26–27 Briefly, 5201 men and women ≥ age 65 years were randomly selected and enrolled from Medicare eligibility lists in 4 US communities in 1989 and 1990; an additional 687 black participants enrolled in 1992 were not included in this analysis because a food frequency questionnaire (FFQ) was not administered to these subjects at baseline. Each center’s institutional review committee approved the study, and all subjects gave informed consent. Mean age at enrollment was 72.8 years (range, 65 to 100). We excluded 284 participants with prevalent AF at baseline28 and 102 participants...
with incomplete data on fish consumption, resulting in 4815 participants included in this analysis. At baseline, participants responded to questionnaires on health status, medical history, and cardiovascular risk factors and underwent standardized clinical examination, resting 12-lead ECG, 2-dimensional echocardiography, pulmonary function testing, and laboratory evaluation. Dietary Assessment Usual dietary intake was assessed at baseline with the use of a picture-sort version of the National Cancer Institute FFQ. Participants were asked to indicate how often, on average, they had consumed various specific foods during the past year, including tuna fish, other broiled or baked fish, and fried fish or fish sandwiches (fish burgers). Macronutrient intakes were estimated from questionnaire responses and adjusted for total caloric intake by using regression analyses. When macronutrients were not estimated because of missing FFQ responses (n=500), analyses were performed with a missing indicator category. As a biomarker of n-3 fatty acid content, we have previously evaluated correlations of fish intake with plasma phospholipid eicosapentaenoic acid (EPA; 20:5n-3) and docosahexaenoic acid (DHA; 22:6n-3) in a subset of participants. Combined EPA+DHA levels correlated with intake of tuna fish (Spearman correlation =0.35, P<0.01) and other fish (r=0.59, P<0.001) but not fried fish or fish sandwiches (r=0.04, P=0.78), consistent with lean types of fish typically fried (cod, pollock, etc).

Identification of AF Participants were followed up via annual examinations, including annual resting 12-lead ECGs through year 9 and interim 6-month telephone contacts. Hospital records were obtained for all hospit-
Statistical Analysis

Cox proportional-hazards models were used to estimate risk, censoring at first event (earliest date of ECG or hospital discharge diagnosis of AF), death, or last day of follow-up through June 30, 2001. Intakes of tuna and other broiled or baked fish were correlated with each other ($r=0.36$, $P<0.001$) and with n-3 fatty acids as described above. Tuna consumption and other fish consumption were therefore evaluated together, summing median intakes of their respective response categories (combined correlation with EPA+$\text{DHA}=0.55$, $P<0.001$). Fried fish/fish sandwich consumption was modestly positively correlated with tuna/other fish intake ($r=0.14$) and was evaluated separately. To minimize potential confounding, covariates were selected on the basis of clinical interest, published associations with AF,2,3,25 or associations with exposures or outcomes in the current cohort. Three multivariate models were presented: (1) adjusted for age, gender, race (white, nonwhite), education (<high school, high school, >high school), diabetes mellitus, body mass index, prevalent coronary heart disease, prevalent valvular disease, smoking status (never, former, current), pack-years of smoking, leisure-time activity, tuna/other fish intake or fried fish/fish sandwich intake, and total caloric intake; (2) further adjusted for other dietary factors (alcohol, saturated fat, beef/pork, fruits, vegetables, cereal fiber); fried fish/fish sandwich consumption was positively associated with intake of saturated fat, beef/pork, and vegetables. As noted previously, in a subsample of participants, greater tuna/other fish intake was also associated with higher LDL cholesterol.

Results

Mean fried fish/fish sandwich and tuna/other fish consumption were 0.7 and 2.2 servings per week, respectively. Tuna/other fish consumption was associated with younger age, female gender, and higher education, whereas fried fish/fish sandwich consumption was associated with male gender, nonwhite race, and lower education (Table 1). Tuna/other fish consumption was generally associated with a more favorable cardiovascular risk profile, although tuna/other fish intake was also associated with higher LDL cholesterol.

Tuna/other fish consumption was inversely associated with saturated fat intake and positively associated with intake of alcohol, fruits, vegetables, and cereal fiber; fried fish/fish sandwich consumption was positively associated with intake of saturated fat, beef/pork, and vegetables. As noted previously, in a subsample of participants, greater tuna/other fish intake but not fried fish/fish sandwich intake was associated with higher plasma phospholipid EPA+$\text{DHA}$.

During 12 years’ follow-up, 980 participants developed incident AF. Of these, 739 persons (75%) were diagnosed by hospital records, 54 (6%) by annual ECG, and 187 (19%) by both methods. Figure 1 presents AF-free survival according to fish consumption. Among persons consuming tuna/other fish χ5 times per week, AF incidence was 19 per 1000 person-years, compared with 33 per 1000 person-years with intake <1 time per month ($P<0.0001$). Among persons consuming fried fish/fish sandwich χ1 time per week, AF incidence was 27 per 1000 person-years, compared with 22 per 1000 person-years with intake <1 time per month ($P=0.0009$).
Age- and multivariate-adjusted risks are presented in Table 2. After adjustment for potential confounders (Model 1), there was 24% lower risk with tuna/other fish intake 1 to 3 times per month (HR = 0.76, 95% CI = 0.61 to 0.95, \( P = 0.02 \)), 30% lower risk with intake 1 to 4 times per week (HR = 0.70, 95% CI = 0.57 to 0.87, \( P = 0.001 \)), and 35% lower risk with intake \( \geq 5 \) times per week (HR = 0.65, 95% CI = 0.51 to 0.84, \( P = 0.001 \)), compared with \(<1\) time per month (P trend = 0.001). Results were not greatly altered by further adjustment for other dietary factors (Model 2) or other potential confounders/mediators (Model 3).

In contrast, fried fish/fish sandwich consumption was not associated with lower AF risk (Table 2). After adjustment for potential confounders (Model 1), intake \( \geq 5 \) time per week was associated with 24% higher risk (HR = 1.24, 95% CI = 1.03 to 1.49, \( P = 0.03 \)). This positive association was attenuated by adjustment for other dietary factors (Model 2) and potential confounders/mediators (Model 3). Of potential mediators, adjustment for baseline left ventricular systolic function, treated hypertension, and C-reactive protein levels appeared to have the greatest effect (not shown).

Exclusion of participants taking fish oil supplements (n = 183) or with prevalent coronary heart disease, stroke, or transient ischemic attack at baseline (n = 1018) did not materially alter results (not shown). There was little evidence for interaction between tuna/other fish and fried fish/fish sandwich consumption (\( P \) for interaction > 0.05) (Figure 2). There was also little evidence that findings varied according to age, gender, education, prevalent coronary heart disease, treated hypertension, systolic blood pressure, or study site (\( P > 0.05 \) for each interaction).

Because AF may occur as a result of preceding MI or CHF, we also evaluated the extent to which observed relationships between fish intake and AF might be mediated by MI or CHF (Table 3). After adjustment for MI or CHF as time-varying covariates, relationships between tuna/other fish intake and AF incidence were not greatly altered, with 29% lower risk with consumption 1 to 4 times per week (HR = 0.71, 95% CI = 0.55 to 0.88, \( P = 0.001 \)) and 31% lower risk with consumption \( \geq 5 \) times per week (HR = 0.69, 95% CI = 0.54 to 0.89, \( P = 0.004 \)) compared with \(<1\) time per month (P trend = 0.003). Findings were similar among persons without MI or CHF or evaluating only persons with prevalent MI or CHF, although confidence intervals for intake \( \geq 5 \) times per week included unity due to fewer numbers of events. In similar analyses, relationships between fried fish/fish sandwich intake and AF risk were not greatly altered by adjustment for preceding MI or CHF; however, associations appeared attenuated among persons without MI or CHF (Table 3).

**Discussion**

In this population-based, prospective study among elderly adults, greater consumption of tuna or other broiled or baked fish was associated with lower risk of incident AF. This observed relationship does not prove causality and may be related to other factors associated with both fish intake and risk of AF. However, the association persisted after adjust-
ment for a variety of demographic, clinical, lifestyle, laboratory, and dietary characteristics, including preceding MI and CHF. These results suggest that regular intake of tuna or other broiled or baked fish may be a simple and important deterrent of AF among older men and women.

It is biologically plausible that this observed relationship is due to effects of long-chain n-3 fatty acids in fatty fish. In experimental studies, fish oil has favorable effects on several hemodynamic, vascular, and left ventricular indices. In rats, intake of fish oil reduces peripheral vascular resistance,6 reduces markers of ischemia and increases contractile recovery after ischemia and reperfusion,7 and reduces left ventricular hypertrophy in hypertensive animals.8 In nonhuman primates, fish oil enhances left ventricular diastolic function.9–10 In humans, fish oil supplementation lowers blood pressure,11 reduces markers of systemic inflammation,12 attenuates vasoconstrictive responses to angiotensin II,13–14 improves arteriolar wall compliance,15 and improves left ventricular diastolic filling.16 Considerable epidemiological, clinical trial, and animal-experimental evidence also points to antiarrhythmic effects of n-3 fatty acids in fish,17–24 which decrease excitability and cytosolic calcium fluctuations of ventricular myocytes via inhibition of Na+/H+ and L-type Ca++ channels.24 In vitro, n-3 fatty acids also reduce induced asynchronous contractile activity of atrial myocytes,25 suggesting that antiarrhythmic effects may extend to atrial myocardium. Each of these effects may plausibly reduce risk of AF.

We did not observe lower risk of AF with intake of fried fish or fish sandwiches, which generally are made from lean fish and did not correlate with n-3 fatty acid levels; rather, we observed a positive association. This observed higher risk might be a result of residual confounding, for example, from other lifestyle or dietary factors. The preparation method

![Figure 2. AF incidence according to both tuna/other fish and fried fish/fish sandwich consumption. For groups consuming tuna/other fish ≥1/week, AF cases/numbers at risk were 161/781, 213/1031, and 234/1362 for fried fish/fish sandwich intake ≥1/week, 1–3/month, and <1/month, respectively; for groups consuming tuna/other fish 1–3/month, the corresponding numbers were 29/99, 78/416, and 134/613; and for groups consuming tuna/other fish <1/month, the corresponding numbers were 20/60, 32/119, and 79/334.](image)

### Table 3. Risk of Incident AF According to Fish Consumption, Adjusting for Preceding MI or CHF

<table>
<thead>
<tr>
<th></th>
<th>AF Cases</th>
<th>Person-Years</th>
<th>Hazard Ratio (95% CI)</th>
<th>P trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;1/mo</td>
<td>1–3/mo</td>
</tr>
<tr>
<td>Tuna/other fish</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusting for MI/CHF*</td>
<td>980</td>
<td>42 544</td>
<td>1.0 (referent)</td>
<td>0.79 (0.63–0.98)</td>
</tr>
<tr>
<td>No MI/CHF†</td>
<td>483</td>
<td>36 669</td>
<td>1.0 (referent)</td>
<td>0.75 (0.55–1.04)</td>
</tr>
<tr>
<td>Prevalent MI/CHF†</td>
<td>190</td>
<td>36 232</td>
<td>1.0 (referent)</td>
<td>0.73 (0.44–1.21)</td>
</tr>
<tr>
<td>Fried fish/fish sandwich</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusting for MI/CHF*</td>
<td>980</td>
<td>42 544</td>
<td>1.0 (referent)</td>
<td>1.12 (0.96–1.30)</td>
</tr>
<tr>
<td>No MI/CHF†</td>
<td>483</td>
<td>36 669</td>
<td>1.0 (referent)</td>
<td>1.14 (0.92–1.41)</td>
</tr>
<tr>
<td>Prevalent MI/CHF†</td>
<td>190</td>
<td>36 323</td>
<td>1.0 (referent)</td>
<td>0.98 (0.68–1.41)</td>
</tr>
</tbody>
</table>

Covariates as in Model 1, Table 2.

*Adjustment for preceding MI or CHF as time-varying covariates (546 prevalent cases, 840 incident cases).
†Excluding persons with prevalent MI or CHF and censoring after incident MI or CHF.
‡Evaluating only persons with prevalent MI or CHF at baseline.
§The few individuals consuming fried fish/fish sandwiches ≥5/wk (n = 67) were combined with the 1–4/wk group.
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might also influence risk. Frying can greatly alter a fish meal’s nutrient composition, increasing contents of n-6 fatty acids, trans-fatty acids, and oxidation products, particularly when oils are used repeatedly for frying.35–36 Adjustment for baseline coronary heart disease, left ventricular systolic function, blood pressure, treated hypertension, and C-reactive protein levels attenuated the higher AF risk seen with fried fish/fish sandwich intake, which suggests that these factors may in part confound or mediate the association. Further investigation is necessary to confirm these observations, determine if they are specific for certain kinds of fish or frying oils, and examine potential mechanisms and alternative explanations. Our findings suggest, however, that intake of fried fish or fish sandwiches is unlikely to reduce risk of AF.

Our analysis has several strengths. The prospective design reduces potential bias from recall differences. The population-based recruitment strategy enhances generalizability. Standardized assessment of a wide variety of participant characteristics increases the capacity to adjust for confounding. Close follow-up, annual ECGs, and review of all hospitalizations reduce potential for missed or misclassified outcomes.

There are also limitations to our findings. Fish intake was assessed at baseline, and consumption may have changed over time; this likely would cause underestimation of associations between fish intake and AF. Cases of paroxysmal AF may have been missed, particularly if asymptomatic. The possibility of residual confounding due to unmeasured or imprecisely measured factors cannot be excluded. The associations were observed in older individuals participating in a cohort study and may not be generalizable to other populations.

Our findings indicate that consumption of tuna and other broiled or baked fish, but not fried fish or fish sandwiches, is associated with lower incidence of AF among older adults. These results suggest that fish intake may influence the risk of this common cardiac arrhythmia. Confirmation of these findings in other studies and evaluation of potential mechanisms of effect, such as effects on blood pressure, left ventricular diastolic function, systemic inflammation, or direct antiarrhythmic effects, are indicated.

Acknowledgments

Research reported in this article was supported by contracts N01-HC-85079 through N01-HC-85086, N01-HC-35129, and N01-HC-15103 from the National Heart, Lung, and Blood Institute. Dr Mozaffarian was supported in part by a National Research Service Award Training Grant in Academic Nutrition (DK07703). For a full list of CHS investigators/institutions, see “About CHS-Principal Investigators and Study Sites” at http://chs-nhlbi.org.

References


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Circulation. 2004;110:368-373; originally published online July 19, 2004;
doi: 10.1161/01.CIR.0000138154.00779.A5
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

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