Comprehensive nationwide incidence and prevalence trends of atrial fibrillation in Finland

Mika Lehto,1,2 Jari Haukka,3 Aapo Aro,2 Olli Halminen,4,5 Jukka Putaala,5 Miika Linna,6,7 Pirjo Mustonen,7,8 Janne Kinnunen,5,9 Elis Kouki,6 Jussi Niiranen,2,9 Alex Luojus,8 Paula Tiili,5 Saga Itäinen-Strömberg,2 Juha Hartikainen,10 Juhani K E Airaksinen7 On behalf of the FinACAF study group

ABSTRACT

Objective Atrial fibrillation (AF) is a worldwide healthcare challenge owing to population ageing. In this study, we assessed the current trends in the incidence and prevalence of AF for the first time in an unselected, nationwide population.

Methods In the Finnish Anticoagulation in Atrial Fibrillation study, we gathered comprehensive data including all primary, secondary and tertiary healthcare visits and drug reimbursement from national healthcare registers to identify all patients with incident AF between 2004 and 2018 in Finland. Incident AF was defined as new-onset AF occurring after 2007. Time trends for the incidence and prevalence of AF were calculated and stratified by sex and age.

Results A total of 411 387 patients with AF diagnosis were documented in Finland during 2004–2018. In 2018, the incidence and prevalence of AF in the total Finnish population were 469/100 000 and 4.1%, respectively. The incidence of new-onset AF in the adult population (≥20 years) increased from 471/100 000 in 2007 to 604/100 000 in 2018, but the age-adjusted incidence remained stable. The prevalence of AF increased in the adult population from 2.5% to 5.2%, and was higher in men than in women (5.9% vs 4.6%, p<0.001). The incidence and prevalence of AF increased with age and were 3194/100 000 and 23.4% in patients older than 75 years.

Conclusions Based on comprehensive nationwide data including primary care, we observed an increasing incidence and prevalence of AF over time. This increase was strongly age-dependent with the age-standardised incidence remaining stable during 2007–2018.

Trial registration number NCT04645537.

INTRODUCTION

Atrial fibrillation (AF) is a chronic condition, and most patients require lifelong treatment, including rate or rhythm control for symptom relief and oral anticoagulation to reduce the risk of stroke.1 Both the incidence and prevalence of AF are strongly age-dependent, and with population ageing, the burden of AF is rapidly increasing worldwide.2-4

Due to its major public health implications, it is important to understand the characteristics of these patients and the current trends in the incidence and prevalence of AF. In earlier studies on the incidence and prevalence of AF, the target populations have ranged from regional populations and administrative registers to healthcare claim samples and used diverse methodologies in the capture of AF diagnosis. Most epidemiological studies have included patients from either primary care or hospital registers and have often focused only on certain age groups or regions. This has led to widely differing estimates of the incidence and prevalence of AF.3-10

This study is based on the Finnish Anticoagulation in Atrial Fibrillation (FinACAF) study, which included all Finnish patients with AF over a 15-year period until 2018. To the best of our knowledge, this is the first comprehensive, nationwide AF study based on all levels of health registry data, including primary, secondary and tertiary healthcare. In this study, we assessed the incidence and prevalence of AF and characterised the changes in these trends.
over time. Moreover, we evaluated sex-specific and age-specific differences in the incidence and prevalence of AF and described the characteristics of the average patient.

METHODS

The FinACAF study was a nationwide, retrospective, register-based cohort study that included all patients diagnosed with AF in Finland between 2004 and 2018. In Finland, all contacts in healthcare are mandatory to be registered in nationwide registers. Patients were identified from three national healthcare registers: hospitalisations and outpatient specialist visits from the Care Register of Healthcare (HILMO), primary healthcare visits from the Care Register of Healthcare (AvoHILMO) and drug prescriptions from the National Reimbursement Register maintained by the Social Insurance Institution (KELA). A list of the registers utilised in the study is presented in online supplemental table 1, and the design and methods have been reported in more detail. Figure 1 shows the frequencies of new-onset AF diagnosis by data source by year. Sources: hospitalisation: care register of Healthcare of hospitalisation and hospital outpatient care (HILMO), primary healthcare: (AvoHILMO) and reimbursement: national reimbursement register of prescriptions (Kela).

RESULTS

A total of 411,387 patients with the diagnosis of AF between 2004 and 2018 were documented. Table 1
Arrhythmias and sudden death

Table 1  Baseline characteristics of the individuals with new atrial fibrillation (AF) between 2012 and 2018, and characteristics of the cohort of AF patients alive on 31 December 2018

<table>
<thead>
<tr>
<th></th>
<th>Incident patients 2012–2018 (n=168,233)</th>
<th>Prevalent patients at the end of 2018 (n=226,847)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age mean (SD), median</td>
<td>74.1 (12.6), 74.8</td>
<td>74.7 (12.1), 75.5</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–64 years</td>
<td>37,169 (22.1)</td>
<td>41,791 (18.5)</td>
</tr>
<tr>
<td>65–74 years</td>
<td>47,972 (28.5)</td>
<td>64,886 (28.6)</td>
</tr>
<tr>
<td>≥75 years</td>
<td>83,092 (49.4)</td>
<td>120,008 (52.9)</td>
</tr>
<tr>
<td>Female sex</td>
<td>82,716 (49.2)</td>
<td>103,138 (45.5)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>131,392 (78.1)</td>
<td>193,438 (85.3)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>40,922 (24.3)</td>
<td>66,289 (29.2)</td>
</tr>
<tr>
<td>Ischaemic stroke or TIA</td>
<td>28,608 (17.0)</td>
<td>48,495 (21.4)</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>29,822 (17.7)</td>
<td>64,083 (28.2)</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>47,415 (28.2)</td>
<td>82,911 (36.5)</td>
</tr>
<tr>
<td>Hypercholesterolaemia</td>
<td>89,967 (53.5)</td>
<td>146,228 (64.5)</td>
</tr>
<tr>
<td>CHA2DS2-VASc score</td>
<td>3.59 (1.87)</td>
<td>4.01 (1.98)</td>
</tr>
</tbody>
</table>

Data are presented as n (%) or mean (SD). CHA2DS2-VASc, congestive heart failure, hypertension, age ≥75 years, age 65–74 years, diabetes mellitus, stroke, sex category (female), vascular disease; TIA, transient ischaemic attack.

provides the baseline characteristics of incident AF cases and the entire AF population at the end of 2018. Of the patients with new-onset AF, 49.2% were female, the median age was 74.8 years, and the most frequent comorbidity was hypertension (78%). The mean CHA2DS2-VASc score was 3.6±1.9.

Incidence of AF

In 2018, the incidence of AF was 604/100,000 among adults aged ≥20 years and 469/100,000 in the entire Finnish population. There was a steep increase in the incidence of AF after the age of 60 years in both men and women (figure 2, online supplemental figure 1). The incidence of AF in the adult population was higher in men than in women (640/100,000 vs 571/100,000, p<0.001 in 2018), and this difference was present in all age groups (figure 2, table 2). Among those aged ≥75 years, the incidence was 3194/100,000 in 2018.

Time trends in AF incidence

The raw incidence of new-onset AF increased from 471/100,000 in 2007 to 604/100,000 in 2018 in the adult population; however, the age-standardised incidence remained stable (figure 3, table 2). Inclusion of the primary care register increased the capture of AF cases, and this increase occurred predominantly in the patients aged ≥75 years. Before 2012, 99% of the new AF cases were captured from the hospital records, but in 2018, only 58% of the new-onset AF cases were derived from the hospital records (figure 1).

The IRR of new-onset AF showed a decrease from 2007 to 2018 in patients aged <65 years, but increased in those aged 65–74 and ≥75 years (Poisson regression model with calendar year, age groups, sex and hospital district as covariates) (figure 4). There were significant interactions between year and sex (p<0.001) and year and age (p<0.001), and when applying this in the model, the incidence of AF decreased by around 10% in both sexes in the age group <65 years. In the age group 65–74 years, AF incidence increased in women by 20%, but not in men. A marked increase of 30%–40% was detected in the age group ≥75 years in both sexes (figure 4). The corresponding information given as raw incidence rates of new-onset AF during 2007–2018 is provided in online supplemental figure 2.

Figure 2  The incidence of atrial fibrillation in men and women in relation to age in 2018.
Prevalence of AF

The prevalence of AF in the age group ≥20 years increased from 2.5% in 2007 to 5.2% in 2018 (p<0.001) (figure 5, online supplemental figure 2 and online supplemental table 2). At the end of the study period, the number of AF patients in Finland was 226,847, and the AF prevalence in the total Finnish population was 4.1%. The prevalence increased steeply in the elderly population, and was higher in men compared with women (5.9% vs 4.6%, p<0.001) in all age groups (figure 6, online supplemental figure 3). Among the elderly ≥75 years, the prevalence of AF was 23.4% in 2018.

Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>Men Population (100 000)</th>
<th>Rate Age standardised</th>
<th>Rate</th>
<th>Women Population (100 000)</th>
<th>Rate Age standardised</th>
<th>Rate</th>
<th>All Population (100 000)</th>
<th>Rate Age standardised</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>9527</td>
<td>19.21</td>
<td>496.0</td>
<td>323.4</td>
<td>9206</td>
<td>20.57</td>
<td>447.4</td>
<td>199.6</td>
<td>20.38</td>
</tr>
<tr>
<td>2008</td>
<td>10378</td>
<td>19.28</td>
<td>538.4</td>
<td>346.6</td>
<td>9814</td>
<td>20.62</td>
<td>476.0</td>
<td>211.6</td>
<td>20.52</td>
</tr>
<tr>
<td>2009</td>
<td>10361</td>
<td>19.33</td>
<td>535.9</td>
<td>341.7</td>
<td>9990</td>
<td>20.67</td>
<td>483.2</td>
<td>213.5</td>
<td>20.55</td>
</tr>
<tr>
<td>2010</td>
<td>10576</td>
<td>19.41</td>
<td>544.9</td>
<td>341.9</td>
<td>10302</td>
<td>20.73</td>
<td>496.9</td>
<td>219.2</td>
<td>20.88</td>
</tr>
<tr>
<td>2011</td>
<td>12184</td>
<td>19.49</td>
<td>625.2</td>
<td>386.2</td>
<td>11817</td>
<td>20.81</td>
<td>567.9</td>
<td>243.1</td>
<td>24.00</td>
</tr>
<tr>
<td>2012</td>
<td>12173</td>
<td>19.57</td>
<td>622.1</td>
<td>382.2</td>
<td>11786</td>
<td>20.87</td>
<td>564.6</td>
<td>241.2</td>
<td>23.96</td>
</tr>
<tr>
<td>2013</td>
<td>12193</td>
<td>19.64</td>
<td>620.7</td>
<td>377.8</td>
<td>11860</td>
<td>20.94</td>
<td>566.3</td>
<td>242.4</td>
<td>24.05</td>
</tr>
<tr>
<td>2014</td>
<td>11679</td>
<td>19.72</td>
<td>592.2</td>
<td>356.0</td>
<td>11590</td>
<td>21.01</td>
<td>551.6</td>
<td>234.5</td>
<td>23.26</td>
</tr>
<tr>
<td>2015</td>
<td>11745</td>
<td>19.79</td>
<td>593.5</td>
<td>351.0</td>
<td>11505</td>
<td>21.06</td>
<td>546.3</td>
<td>227.6</td>
<td>23.25</td>
</tr>
<tr>
<td>2016</td>
<td>12495</td>
<td>19.86</td>
<td>629.0</td>
<td>366.4</td>
<td>11911</td>
<td>21.10</td>
<td>564.5</td>
<td>231.4</td>
<td>24.40</td>
</tr>
<tr>
<td>2017</td>
<td>12478</td>
<td>19.91</td>
<td>626.7</td>
<td>360.7</td>
<td>12001</td>
<td>21.12</td>
<td>568.1</td>
<td>230.5</td>
<td>24.47</td>
</tr>
<tr>
<td>2018</td>
<td>12754</td>
<td>19.94</td>
<td>639.5</td>
<td>362.3</td>
<td>12063</td>
<td>21.14</td>
<td>570.7</td>
<td>228.4</td>
<td>24.81</td>
</tr>
</tbody>
</table>

Both raw and age-standardised rates. Age standardisation for European population.
DISCUSSION

In this comprehensive, nationwide study including data from hospitalisations, primary, secondary and tertiary outpatient visits, and drug reimbursements, the prevalence of AF more than doubled from 2007 to 2018 and reached 5.2% in the adult population. The incidence of new-onset AF also increased during the 12-year period, but when adjusted for the ageing population, the incidence of AF remained stable and the incidence of AF decreased in the working age population age. In all age groups, men were more likely to present with AF than women. With advancing age, AF increased exponentially, and among those aged ≥75 years, AF incidence was 3194/100 000 and prevalence was as high as 23.4%.

The reported incidence and prevalence of AF have varied owing to the diverse study populations and methods used to identify patients with AF.2-10 This study differs from previous reports in that we used hospital registers and comprehensive outpatient registers complemented by data from the drug reimbursement register to identify all patients with AF in Finland. However, since the diagnosis of AF depends on recording the arrhythmia with an ECG, many patients with paroxysmal AF or minimal symptoms may have remained undiagnosed.13

Only a few previous studies have investigated the AF incidence in the entire population of certain regions. Miyasaka et al reported an age-adjusted and sex-adjusted AF incidence of 3.68 per 1000 person-years in Olmsted County, USA, during the year 2000 in the adult population based on integrated medical records, including inpatient and outpatient contacts.6 In a more recent study from Sweden, based on a regional analysis of 75 800 inhabitants including primary care data, the incidence of AF was 4.0 per 1000 person-years in the entire population.13 Wilke et al observed an AF incidence of 4.4/1000 person-years in men and 3.9/1000 person-years in women, with an AF prevalence of 2.1% based on German health maintenance registers.14 In 2018, the incidence was slightly higher (4.69 per 1000 person-years) than in these reports in the entire Finnish population. When the analysis was restricted to the adult population (age ≥20 years), AF incidence was 6.40 in men and 5.71 in women per 1000 person-years in 2018 in our study.

The prevalence of AF has varied widely in previous studies depending on the age and population studied. The Dutch Rotterdam Study, a community-based prospective cohort study of adults aged >55 years, reported a prevalence of 6.0% in men and 5.1% in women.5 In our study, the figures were 12.6% and 9.5%, respectively. Another study from Italy focused on subjects aged ≥65 years in the participating regions using systematic and opportunistic AF screening, followed by clinical and ECG confirmation, found an AF prevalence of 7.3%.

In our study, the corresponding prevalence of AF in this age group was 15.3%. Friberg and Bergfeldt reported an AF prevalence of 2.9% in the adult (≥20 years) population in Sweden from 2005 to 2010.15 In a more recent study from Norway, the prevalence of AF was 3.4% in the adult population (≥18 years). However, both these Nordic studies were based only on hospital registers, which underestimates the true prevalence of AF diagnoses especially in older age groups. In the present FinACAF study, the prevalence of AF in the adult Finnish population was 5.2% in 2018.

Nevertheless, a direct comparison of these epidemiological studies is challenging and, to some extent, not useful. In line with previous studies, a continuous increase in the number of patients with AF was observed in this study.3 6 9 10 Importantly, this increase may be attributed to the ageing of population and longer life expectancy of AF patients. Half of the new AF patients were aged >75 years and had a mean CHA2DS2-VASc score of 3.6. The annual cohorts of new patients have increased slowly, but the total number of AF patients alive has increased...
more steeply owing to an ageing population, also in Finland (figures 1 and 5 and online supplemental table 2).

Improved general treatment of AF patients with an increased oral anticoagulant use, probably improves survival, especially in elderly patients. In recent years, blood pressure and other cardiovascular risk factor control have improved, and the overweight adult population has not increased in Finland, which may have also contributed to the unchanged age-standardised incidence of AF. Moreover, the increasing interest in AF screening and use of anticoagulation may have contributed to the growing number of patients. During the AF epidemic, our finding of unchanged age-standardised incidence and a decreasing incidence in the younger (<65 years) population is encouraging. However, silent AF is probably being increasingly discovered owing to an increased focus on screening.

The strength of this study was the comprehensive capture of diagnosed AF cases from all levels of healthcare delivery using reliable national registers directed by the Finnish law. As noted, all visits in healthcare are mandatory to be registered in nationwide registers in Finland. These registers have been found to be highly consistent, particularly in the detection of cardiovascular diseases. Elderly AF patients were included mostly from the primary care register; therefore, if only the hospital register data were available, significant erroneous decreases in both the raw and age-standardised incidences would have been observed. Furthermore, because AF is a chronic disease, its prevalence was established as a cumulative cohort of known cases in the population. This approach increases the reliability when the follow-up period of the study population is sufficiently long. In addition, reliable assessment of AF incidence requires a sufficiently long look back period with no previous history of AF. These elements, as well as the sufficient duration of the data collection period, are important for providing reliable and up-to-date information on AF epidemiology.

Our study had some limitations. Since the ICD-10 diagnostic code for AF at the time of the study did not differentiate between the subtypes of atrial arrhythmias, there was no distinction between AF and atrial flutter, or the type of AF (paroxysmal, persistent or permanent). Naturally, registers cannot catch asymptomatic and undiagnosed AF patients, but screening procedures to cover the whole population are not realistic. Furthermore, without ECG verification, there is always a possibility that the clinician has misclassified another arrhythmia as AF. Nevertheless, in Denmark and Sweden, in relatively comparable research environments, register studies have been shown to be highly reliable and accurate in identifying patients with AF when compared with ECG information.

CONCLUSIONS
In this nationwide study, using all available national register resources and having all Finnish residents as the background population, we found that both the incidence and prevalence of AF increased from 2007 to 2018. Importantly, this increase appears to be driven mostly by population ageing, and the age-standardised incidence of AF did not increase during this period. In 2018, the incidence of AF in the adult population was 604/100 000 and the prevalence of AF was 5.2%.

Author affiliations
1Department of Internal Medicine, Jorvi Hospital, Espoo, Finland
2Heart and Lung Center, Helsinki University Central Hospital, Helsinki, Finland
3Department of Public Health, University of Helsinki, Helsinki, Finland
4Department of Industrial Engineering and Management, Aalto University, Espoo, Finland
5Department of Neurology, Helsinki University Central Hospital, Helsinki, Finland
6University of Eastern Finland Faculty of Health Sciences, Kuopio, Finland
7TYKS Turku University Hospital, Turku, Finland
8University of Helsinki, Medical Faculty, Helsinki, Finland
9Florida State University College of Medicine, Tallahassee, Florida, USA
10Department of Medicine, Kuopio University Hospital, Kuopio, Finland

Contributors MLe, JHau, JP, MLi, PM and JKEA planned the work. MLe, JHar, OH, JP, MLi, JK, EK, AL, PT and SI-S had access to the data, and MLe, JHau, and OH contributed to the statistical analyses. MLe drafted the manuscript. All authors contributed to the design of the study, have critically revised the draft and have approved the final version of the submitted manuscript. MLe and JHar are responsible for the overall content as guarantors.

Funding This work was supported by the Arne Koskelo Foundation, Finnish Foundation for Cardiovascular Research, Yrjö Jahnsson Foundation, Helsinki and Uusimaa Hospital District Research Fund (FYH2019309) and Sigrid Jusélius Foundation.


Patient consent for publication Not applicable.

Ethics approval The study has been approved by the Ethics Committee of the Medical Faculty of Helsinki University, Helsinki Finland (nr. 15/2017).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available. Based on the contracts with the Finnish registries, the data are not available for sharing. Requests to access the dataset from qualified researchers trained in human subject confidentiality protocols may be sent to the Finnish national register holders.

Supplemental material This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and


Open Heart: first published as 10.1136/openhrt-2022-002140 on 22 November 2022. Downloaded from openheart.bmj.com on September 15, 2023 by guest. Protected by copyright.
responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iDs
Mika Lehto http://orcid.org/0000-0002-8691-5142
Olli Halminen http://orcid.org/0000-0001-9266-8435
Janne Kinnunen http://orcid.org/0000-0002-0592-3184

REFERENCES