To the Editor:

We completely agree with Dr Lang.1 Lingering misperceptions held by patients, physicians, and advanced practice providers continue to inhibit them from using safe and effective pharmacotherapy for tobacco dependence. There is also a misperception that we have conquered the tobacco epidemic. This is also not true, although we have made great progress. In the United States, we continue to have 30 to 35 million adults who use tobacco regularly and tobacco causes tremendous excess mortality beyond the diseases commonly associated with tobacco use such as cancer, cardiovascular disease, and chronic lung disease.2 In addition, the people who are disproportionately affected by tobacco-caused disease often have comorbid serious mental illness.3 Our article shows that these medications can be used safely in patients and with and underlying mental illness who also use tobacco (ClinicalTrials.gov Identifier: NCT01456936). Appropriate use of pharmacologic therapy for tobacco dependence is an important part of providing effective treatment for every person who uses tobacco whenever they contact the health care and mental health care systems.

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1. Lang AE. Changing the culture of tobacco dependence treatment among not only patients, but also prescribers. Mayo Clin Proc. 2021;96(9).


Racial Differences in the Prevalence of Diagnosed Atrial Fibrillation Among Hospitalized Patients

To the Editor: Atrial fibrillation (AF) will affect at least 12 million people in the United States by 2030. Atrial fibrillation is associated with an increased risk for stroke and death and contributes to substantial costs and resource use.1 Considerable efforts are devoted to optimize AF management and mitigate its negative sequelae. However, the literature suggests the presence of racial disparities in the management of AF in the United States. Recent studies showed that direct oral anticoagulant, pulmonary vein isolation, and left atrial appendage closure are less commonly used among patients of non-White race.2 There is a notion that a large proportion of this disparity may be related to the lower prevalence of AF among non-White US individuals.3,4 However, large-scale studies examining race-based differences in the prevalence of AF are lacking.

We used the National-Inpatient Sample (January 1-December 31, 2018) to identify hospitalization for 6 common conditions using the Clinical Classifications Software Refined. The Clinical Classifications Software Refined collapses diagnosis codes from the International Classification of Diseases, Tenth Revision into major disease categories and has been used in numerous studies.5 To ensure adequate power, we
limited this analysis to White, Black, or Hispanic patients. The 6 conditions included were selected from the top 20 causes of US hospitalizations to reflect various likelihoods of in-hospital rhythm monitoring: high likelihood (myocardial infarction and heart failure), intermediate likelihood (pulmonary embolism and stroke), and low likelihood (sepsis and chronic obstructive pulmonary disease).

We calculated the prevalence of AF among White, Hispanic, and Black patients in each of the 6 admission categories. Atrial fibrillation was identified using International Classification of Diseases, Tenth Revision, Clinical Modification codes (I48.0, I48.1, I48.11, I48.19, I48.2, I48.20, and I48.21). To adjust for differences in risk profile, we used a multilevel mixed-effects logistic regression model that included age, sex, hypertension, hyperlipidemia, diabetes, vascular disease, carotid stenosis, coronary disease, prior sternotomy, and smoking. The adjusted odds of AF were presented as odds ratios and 95% CIs. Analyses were performed using Stata, version 15.1 (StataCorp LLC), and SPSS, version 26 (IBM Corp). Because we used publicly available deidentified data, the study was exempt by the Institutional Review Board.

A total of 5,370,885 weighted hospitalizations were included. The prevalence of AF among Black and Hispanic patients was significantly lower than in White patients across all admission categories (Table). After risk adjustment, the odds of AF remained significantly lower in Black and Hispanic patients than in White patients (Table).

Prior studies using long-term prospective follow-up and/or surveillance of implantable cardiac devices suggested that racial differences exist in the prevalence of AF. However, to our knowledge, no large-scale studies have confirmed these findings. Our analysis of a nationwide cohort of more than 5 million patients hospitalized for various conditions revealed a lower prevalence of AF among Black and Hispanic patients compared with White patients. The reported findings in this letter should be interpreted in the context of the study’s design and the database used. The National-Inpatient-Sample contains inpatient data and hence is unable to assess differences in AF prevalence among nonhospitalized individuals. In theory, a large difference in hospitalization rates

<table>
<thead>
<tr>
<th>Hospitalization Diagnosis (total no; racial mix)</th>
<th>AF Prevalence</th>
<th>W</th>
<th>B</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial infarction (N=598,200; W=77.8%, B=12.3%, H=9.9%)</td>
<td>AF, %</td>
<td>21.3</td>
<td>13.0</td>
<td>15.1</td>
</tr>
<tr>
<td>OR (95% CI)</td>
<td>Ref</td>
<td>0.55 (0.52-0.58)</td>
<td>0.66 (0.62-0.70)</td>
<td></td>
</tr>
<tr>
<td>Adjusted OR</td>
<td>Ref</td>
<td>0.62 (0.60-0.70)</td>
<td>0.70 (0.66-0.80)</td>
<td></td>
</tr>
<tr>
<td>Congestive heart failure (N=1,059,980; W=70.4%, B=21%, H=8.6%)</td>
<td>AF, %</td>
<td>53.9</td>
<td>29.8</td>
<td>36.8</td>
</tr>
<tr>
<td>OR (95% CI)</td>
<td>Ref</td>
<td>0.36 (0.35-0.37)</td>
<td>0.49 (0.47-0.52)</td>
<td></td>
</tr>
<tr>
<td>Adjusted OR</td>
<td>Ref</td>
<td>0.50 (0.52-0.54)</td>
<td>0.61 (0.56-0.61)</td>
<td></td>
</tr>
<tr>
<td>Pulmonary embolism (N=699,355; W=77.5%, B=16.2%, H=6.3%)</td>
<td>AF, %</td>
<td>18.8</td>
<td>11.0</td>
<td>13.9</td>
</tr>
<tr>
<td>OR (95% CI)</td>
<td>Ref</td>
<td>0.53 (0.50-0.56)</td>
<td>0.69 (0.65-0.74)</td>
<td></td>
</tr>
<tr>
<td>Adjusted OR</td>
<td>Ref</td>
<td>0.58 (0.55-0.60)</td>
<td>0.70 (0.67-0.71)</td>
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</tr>
<tr>
<td>Cerebrovascular accident N=487,140; W=72.3%, B=18.3%, H=9.4%</td>
<td>AF, %</td>
<td>28.4</td>
<td>15.6</td>
<td>20.9</td>
</tr>
<tr>
<td>OR (95% CI)</td>
<td>Ref</td>
<td>0.46 (0.44-0.50)</td>
<td>0.66 (0.62-0.71)</td>
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</tr>
<tr>
<td>Adjusted OR</td>
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<td>0.60 (0.57-0.64)</td>
<td>0.80 (0.74-0.83)</td>
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<tr>
<td>Chronic obstructive lung disease (N=520,055; W=78.8%, B=14.9%, H=6.3%)</td>
<td>AF, %</td>
<td>20.4</td>
<td>12.4</td>
<td>15.2</td>
</tr>
<tr>
<td>OR (95% CI)</td>
<td>Ref</td>
<td>0.55 (0.52-0.60)</td>
<td>0.69 (0.64-0.75)</td>
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<td>Adjusted OR</td>
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<td>0.63 (0.58-0.70)</td>
<td></td>
</tr>
<tr>
<td>Septicemia (N=2,006,155; W=73.6%, B=14.2%, H=12.2%)</td>
<td>AF, %</td>
<td>24.4</td>
<td>13.3</td>
<td>13.4</td>
</tr>
<tr>
<td>OR (95% CI)</td>
<td>Ref</td>
<td>0.47 (0.45-0.49)</td>
<td>0.47 (0.45-0.50)</td>
<td></td>
</tr>
<tr>
<td>Adjusted OR</td>
<td>Ref</td>
<td>0.57 (0.55-0.60)</td>
<td>0.56 (0.50-0.60)</td>
<td></td>
</tr>
</tbody>
</table>

*AF, atrial fibrillation; B, Black; H, Hispanic; OR, odds ratio; Ref, reference; W, White.

**P<.01 for all.**

*OR adjusted for age, sex, smoking, diabetes mellitus, hypertension, hyperlipidemia, peripheral vascular disease, coronary artery disease, carotid stenosis, and prior sternotomy.*
across different races could neutralize the differences in AF prevalence in this study. However, this is highly unlikely for 2 reasons: (1) prior studies using granular rhythm detection methods in ambulatory patients showed similarly lower rates of AF among non-White patients, and (2) the incidence rate of hospitalizations for certain diseases (included in this analysis) is higher in non-White patients. For example, stroke and pulmonary embolism are more common in Black vs White patients, which makes "undersampling" of these patients due to the inclusion of inpatients admissions only unlikely.

These data emphasize the need for more research to better understand the pathophysiology of AF and its interaction with race. A comprehensive prospective study addressing the incidence and burden of AF among both ambulatory and hospitalized patients across various races is needed and could have important preventive, therapeutic, and policy-making implications.

In conclusion, in a large sample of hospitalizations for common cardiac and noncardiac conditions, Black and Hispanic patients had substantially lower crude and adjusted AF prevalences compared with White patients. Further studies are needed to examine potential biological, lifestyle, and socioeconomic factors that may explain these differences.

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