

ORIGINAL CONTRIBUTION

ONLINE FIRST

Fish Oil and Postoperative Atrial Fibrillation

The Omega-3 Fatty Acids for Prevention of Post-operative Atrial Fibrillation (OPERA) Randomized Trial

Dariusz Mozaffarian, MD, DrPH

Roberto Marchioli, MD

Alejandro Macchia, MD

Maria G. Silletta, MS

Paolo Ferrazzi, MD

Timothy J. Gardner, MD

Roberto Latini, MD

Peter Libby, MD

Federico Lombardi, MD

Patrick T. O'Gara, MD

Richard L. Page, MD

Luigi Tavazzi, MD

Gianni Tognoni, MD

for the OPERA Investigators

POSTOPERATIVE ATRIAL FIBRILLATION or flutter (AF) occurs in approximately 1 of 3 patients undergoing cardiac surgery, and rates of this complication remain unchanged, even with advances in surgical techniques, anesthetic procedures, and perioperative care.^{1,2} Postoperative AF can cause hemodynamic instability or symptoms requiring cardioversion or escalation of supportive therapies and also can cause renal and neurologic complications. Antiarrhythmic and anticoagulant drugs are often required, both in-hospital and after discharge, and can cause adverse effects including bleeding. Postoperative AF at discharge can cause palpitations, fatigue, and decreased exercise tolerance. Patients with postoperative AF also have higher long-term mortality,^{1,2} at least partly attributable to embolic stroke.³

Postoperative AF is also associated with greater intensive care unit stays, total hospital stays, and total hospital

Context Postoperative atrial fibrillation or flutter (AF) is one of the most common complications of cardiac surgery and significantly increases morbidity and health care utilization. A few small trials have evaluated whether long-chain n-3-polyunsaturated fatty acids (PUFAs) reduce postoperative AF, with mixed results.

Objective To determine whether perioperative n-3-PUFA supplementation reduces postoperative AF.

Design, Setting, and Patients The Omega-3 Fatty Acids for Prevention of Postoperative Atrial Fibrillation (OPERA) double-blind, placebo-controlled, randomized clinical trial. A total of 1516 patients scheduled for cardiac surgery in 28 centers in the United States, Italy, and Argentina were enrolled between August 2010 and June 2012. Inclusion criteria were broad; the main exclusions were regular use of fish oil or absence of sinus rhythm at enrollment.

Intervention Patients were randomized to receive fish oil (1-g capsules containing ≥ 840 mg n-3-PUFAs as ethyl esters) or placebo, with preoperative loading of 10 g over 3 to 5 days (or 8 g over 2 days) followed postoperatively by 2 g/d until hospital discharge or postoperative day 10, whichever came first.

Main Outcome Measure Occurrence of postoperative AF lasting longer than 30 seconds. Secondary end points were postoperative AF lasting longer than 1 hour, resulting in symptoms, or treated with cardioversion; postoperative AF excluding atrial flutter; time to first postoperative AF; number of AF episodes per patient; hospital utilization; and major adverse cardiovascular events, 30-day mortality, bleeding, and other adverse events.

Results At enrollment, mean age was 64 (SD, 13) years; 72.2% of patients were men, and 51.8% had planned valvular surgery. The primary end point occurred in 233 (30.7%) patients assigned to placebo and 227 (30.0%) assigned to n-3-PUFAs (odds ratio, 0.96 [95% CI, 0.77-1.20]; $P = .74$). None of the secondary end points were significantly different between the placebo and fish oil groups, including postoperative AF that was sustained, symptomatic, or treated (231 [30.5%] vs 224 [29.6%], $P = .70$) or number of postoperative AF episodes per patient (1 episode: 156 [20.6%] vs 157 [20.7%]; 2 episodes: 59 [7.8%] vs 49 [6.5%]; ≥ 3 episodes: 18 [2.4%] vs 21 [2.8%]) ($P = .73$). Supplementation with n-3-PUFAs was generally well tolerated, with no evidence for increased risk of bleeding or serious adverse events.

Conclusion In this large multinational trial among patients undergoing cardiac surgery, perioperative supplementation with n-3-PUFAs, compared with placebo, did not reduce the risk of postoperative AF.

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costs.⁴⁻⁶ Even with use of β -blockers and amiodarone, approximately 1 of 4 patients still develop postoperative AF, with inconsistent improvements in mortality or resource utilization.⁷ Hence, new therapies are needed to

Author Affiliations and the OPERA Investigators and Institutions are listed at the end of this article.

Corresponding Authors: Dariusz Mozaffarian, MD, DrPH, Harvard School of Public Health, 665 Huntington Ave, Bldg 2-319, Boston, MA 02115 (dmozaffa@hsph.harvard.edu) and Roberto Marchioli, MD, Consorzio Mario Negri Sud, Laboratory of Clinical Epidemiology of Cardiovascular Disease, Via Nazionale 8, Santa Maria Imbaro, CH 66030 Italy (marchioli@negrisud.it).

prevent postoperative AF and its associated morbidity and health care costs.

The accumulated evidence from observational studies and clinical trials suggests that habitual intake of fish or fish oil reduces risk of coronary death, possibly related to fewer primary ventricular arrhythmias.^{8,9} Experimental evidence supports direct and indirect antiarrhythmic effects of long-chain n-3 polyunsaturated fatty acids (n-3-PUFAs) in fish oil, especially in the setting of acute ischemia.⁸ Yet effects of n-3-PUFAs on atrial arrhythmias such as postoperative AF remain uncertain. In experimental studies and short-term clinical trials, n-3-PUFAs favorably influence several risk factors for AF.^{8,10-12} Only small trials of n-3-PUFA supplementation to prevent postoperative AF have been performed, with mixed results.¹³

We designed and implemented the Omega-3 Fatty Acids for Prevention of Post-operative Atrial Fibrillation (OPERA) trial to determine whether perioperative administration of oral n-3-PUFAs reduces postoperative AF in patients undergoing cardiac surgery.

METHODS

Study Design and Patients

The OPERA trial was an investigator-initiated, double-blind, placebo-controlled, randomized clinical trial conducted in 28 centers in the United States, Italy, and Argentina to test the primary hypothesis that perioperative n-3-PUFA supplementation reduces the occurrence of postoperative AF in 1516 patients undergoing cardiac surgery. The detailed methods have been published.¹⁴ The design was pragmatic to maximize practical application and generalizability to real-world patients and clinical care.

Inclusion criteria were broad (eTable 1, available at <http://www.jama.com>), including age 18 years or older, being scheduled for cardiac surgery on the following day or later, and presence of sinus rhythm on the screening electrocardiogram (ECG). Exclusions were absence of sinus rhythm at screening,

regular use of fish oil, known allergy or intolerance to fish oil or olive oil, being currently pregnant, existing or planned cardiac transplant or use of ventricular assist device, or being unable or unwilling to provide informed consent. Use of chronic or prophylactic antiarrhythmic drugs, history of prior AF, and planned AF ablation were not exclusions, given the similar or higher risk of postoperative AF in these patients and no known biologic interaction that might reduce efficacy of n-3-PUFAs in such patients.

The study was approved by the human subjects committees of all participating institutions and conducted according to international standards of Good Clinical Practice (FDA Title 21 part 312, International Conference on Harmonization guidelines). All patients provided written informed consent.

Intervention

Patients were block randomized to receive n-3-PUFAs; each 1-g capsule contained at least 840 mg of eicosapentaenoic acid (EPA) (approximately 465 mg) plus docosahexaenoic acid (DHA) (approximately 375 mg) as ethyl esters (Omacor; Pronova BioPharma, Norway) or matched placebo (olive oil) by means of computer-generated numbers, stratified by enrolling medical center and planned valve surgery (yes/no). Study drugs were prepared in identical-appearing capsules specially coated to minimize taste differences. All investigators, patients, and clinicians were blinded to treatment assignment.

Patients received a total preoperative loading dose of 10 g divided over 3 to 5 days (or 8 g divided over 2 days), including the morning of surgery.¹⁴ For each patient, the loading dose was divided over the maximum number of days possible, based on the dates of enrollment and planned surgery. Flexibility in the loading days included in the regimen maximized generalizability by allowing enrollment of most patients undergoing cardiac surgery, including those scheduled as early as the

next day. Following cardiac surgery, patients received 2 g/d until hospital discharge or postoperative day 10, whichever occurred sooner, at which time administrative censoring occurred for in-hospital follow-up.

The dosing was selected to balance potential efficacy vs patient intolerance and risk. Cohort studies suggest that n-3-PUFAs reduce risk of primary ventricular arrhythmias at low doses, eg, 250 to 500 mg/d of EPA plus DHA.⁸ Similar low dietary doses have been associated with lower incident AF in ambulatory adults,¹⁵ and, in 1 small open-label trial, a 10-g preoperative loading dose over 5 days followed by 2 g/d postoperatively reduced postoperative AF.¹⁶ Supplementation with n-3-PUFAs alters circulating and tissue levels of EPA and DHA within days.¹⁷ Because n-3-PUFAs persist in tissues for several days, a loading dose also provides some buffer in patients who might not tolerate oral medications for several days after surgery. Higher doses could increase patient dyspepsia as well potential concern among treating physicians for risks such as bleeding.

For patients unable to tolerate oral medications postoperatively, the study drug could be administered via polyvinyl chloride-free nasogastric or gastric tube if present for clinical indications or otherwise as soon as the patient was tolerating oral medications. Adherence was monitored by capsule count for outpatient loading and by hospital records for inpatient administration as well as by changes in plasma phospholipid n-3-PUFA levels (see "Covariates," below).

Centers were encouraged to use continuous electrocardiographic monitoring for at least 5 days post surgery. Twelve-lead ECGs were recommended daily and more frequently at the discretion of the treating physicians for symptoms or clinically suspected arrhythmia. Clinical data (eg, onset time, symptoms, treatments, duration) and confirmatory rhythm strips or 12-lead ECGs were collected for all postoperative arrhythmias of at least 30 seconds' duration, including postoperative AF

and other tachyarrhythmias (eTable 2). Data on at least the first 3 suspected episodes of postoperative AF were collected for each patient. All other treatments, including surgical and anesthetic procedures, medications including regular or prophylactic antiarrhythmic drugs, and treatment of arrhythmias remained entirely at the discretion of the physicians caring for the patient. Current best-practice guidelines for prevention of postoperative AF were strongly recommended to all centers.¹⁸

End Points

The primary end point was the occurrence of postoperative AF of at least 30 seconds' duration and documented by rhythm strip or 12-lead ECG (eTable 2). Secondary AF end points included postoperative AF that was sustained (>1 hour), symptomatic, or treated with pharmacological or electrical cardioversion; postoperative AF excluding atrial flutter; time to first postoperative AF; and the number of postoperative AF episodes per patient. The OPERA trial also evaluated the total number of in-hospital days in which any postoperative AF, including sustained postoperative AF, was present and the proportion of in-hospital days free of any postoperative AF. All potential episodes of postoperative AF and other tachyarrhythmias were reviewed and adjudicated by a centralized events committee of cardiac electrophysiologists. Additional end points included resource utilization, major adverse cardiovascular events, arterial thromboembolism, and 30-day mortality.

Safety Evaluation

Safety outcomes included adverse events and bleeding assessed by 24-hour chest tube output following surgery, total packed red blood cell transfusions, and composite bleeding indices (eTable 2). Potential adverse events were recorded and reported to the steering committee and the independent data and safety monitoring board (DSMB), as well as to the US Food and Drug Administration, European Medi-

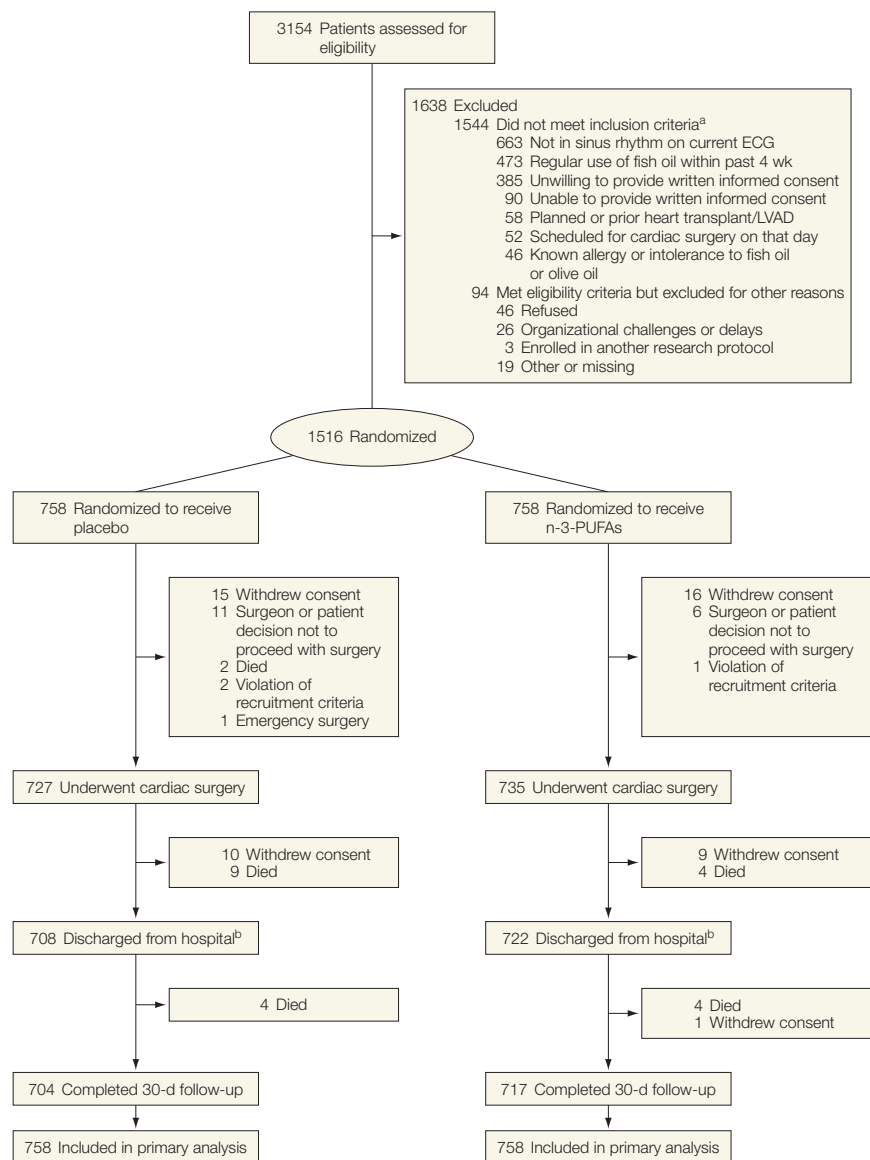
cines Agency, and Argentina National Administration of Drugs, Foods and Medical Devices. The steering committee monitored the progress of the trial, and the DSMB monitored both scientific integrity and patient safety throughout the trial and could recommend termination or other trial modifications at any time. In July 2011, the DSMB reviewed a detailed interim analysis pre-

pared by a biostatistician not affiliated with the trial and recommended study continuation.

Covariates

Standardized data were collected on demographics, risk factors, major comorbid conditions, past medical and surgical history, anthropometry, lifestyle habits, outpatient and inpa-

Figure 1. Screening, Randomization, and Follow-up



No patients were lost to follow-up. ECG indicates electrocardiogram; LVAD, left-ventricular assist device; n-3-PUFA, omega-3 polyunsaturated fatty acid.

^aPatients could be excluded based on more than 1 criterion; all are listed.

^bIncludes patients (102 placebo; 104 n-3-PUFA) censored at postoperative day 10 rather than discharged.

tient medications, and laboratory measures. Details of the surgical and anesthetic procedure were recorded. Daily follow-up and discharge information, including cardiac drug use and bleeding end points, was

recorded. In a subset of 523 patients from centers participating in biologic studies, samples of EDTA plasma were drawn at enrollment and on the morning of cardiac surgery, stored at -70°C , and shipped on dry ice to a central repository for long-term storage at -80°C . Levels of plasma phospholipid n-3-PUFAs (EPA plus docosapentaenoic acid [DPA] plus DHA) were measured as a percentage of total fatty acids at the Fred Hutchinson Cancer Research Center (Seattle, Washington) using established methods,¹⁹ with coefficients of variation of less than 3% for EPA, DPA, and DHA.

Table 1. Baseline Characteristics of the OPERA Participants, According to Treatment Assignment

Characteristic	No. (%)		P Value ^a
	Placebo (n = 758)	n-3-PUFAs (n = 758)	
Age, mean (SD), y	63.6 (12.4)	63.8 (12.6)	.75
Men	543 (71.6)	551 (72.7)	.65
Planned valve surgery ^b	389 (51.3)	396 (52.2)	.72
Current smoking	96 (13.0)	99 (13.5)	.78
Body mass index, mean (SD) ^c	28.4 (5.9)	28.1 (5.4)	.30
Waist circumference, mean (SD), cm	99.4 (13.5)	98.8 (14.1)	.16
Hypertension	563 (74.9)	572 (76.2)	.56
Dyslipidemia	477 (64.1)	460 (61.7)	.33
Diabetes mellitus	199 (26.3)	194 (25.7)	.78
Chronic obstructive pulmonary disease	90 (11.9)	80 (10.6)	.42
Chronic renal failure	52 (6.9)	44 (5.8)	.40
Coronary heart disease ^d	288 (38.0)	297 (39.2)	.64
Prior myocardial infarction	178 (23.6)	188 (25.0)	.55
Prior percutaneous coronary intervention	99 (13.1)	80 (10.6)	.13
Prior cardiac surgery	48 (6.3)	45 (5.9)	.75
Coronary bypass	18 (2.4)	17 (2.2)	.86
Valve surgery	27 (3.6)	23 (3.0)	.57
Other cardiac surgery	12 (1.6)	13 (1.7)	.84
Prior arrhythmias	99 (13.3)	92 (12.5)	.64
Atrial fibrillation	62 (8.4)	52 (7.1)	.35
Other supraventricular tachycardia	8 (1.1)	12 (1.6)	.40
Ventricular tachycardia or fibrillation	5 (0.7)	7 (0.9)	.51
Other	33 (4.5)	22 (3.0)	.14
Congestive heart failure	212 (28.0)	204 (27.0)	.66
NYHA class			
I	10 (1.3)	4 (0.5)	.16
II	104 (13.7)	100 (13.2)	
III	61 (8.1)	77 (10.2)	
IV	12 (1.6)	8 (1.1)	
Not available	25 (3.3)	15 (2.0)	
Ejection fraction, mean (SD), %	56.8 (11.3)	56.6 (11.4)	.67
Left atrial diameter, mean (SD), mm	42.2 (7.6)	42.1 (7.8)	.77
Prior implantable cardioverter-defibrillator	11 (1.5)	5 (0.7)	.13
Prior pacemaker	9 (1.2)	11 (1.5)	.54
Prior cardiac resynchronization therapy	0	1 (0.1)	.50
Prior AF ablation	6 (0.8)	6 (0.8)	>.99
EuroSCORE, median (IQR) ^e			
Logistic	3.6 (1.8-7.2)	3.7 (2.0-7.5)	.64
Additive	5.0 (3.0-7.0)	5.0 (3.0-7.0)	.68

Abbreviations: AF, atrial fibrillation; EuroSCORE, European System for Cardiac Operative Risk Evaluation; IQR, interquartile range; n-3-PUFA, omega-3 polyunsaturated fatty acid; NYHA, New York Heart Association; OPERA, Omega-3 Fatty Acids for Prevention of Post-operative Atrial Fibrillation.

^aDifferences between treatment groups were evaluated using unpaired *t* tests or Wilcoxon rank-sum tests, as appropriate, for continuous variables; and Pearson χ^2 (or Fisher exact tests for cells <10) for categorical variables.

^bOf the 756 patients who underwent valve surgery, 522 (69.0%) underwent aortic valve surgery, 195 (28.8%) mitral valve surgery, 30 (4.0%) aortic and mitral valve surgery, and 9 (1.2%) other valve surgery; see eTable 3.

^cCalculated as weight in kilograms divided by height in meters squared.

^dPrior myocardial infarction, coronary revascularization, or angina.

^eIncorporates 17 predictive factors about the patient, comorbid conditions, and the planned operation to calculate the risk of 30-day postoperative mortality.^{20,21} The EuroScore can be calculated using either a logistic or additive model, with higher scores indicating higher risk. The logistic model (theoretical range, 0-100) provides a score that is directly equivalent to the predicted 30-day mortality (percent). The additive model (theoretical range, 0-39) is a simplified version that approximates the predicted 30-day mortality. Values for the 17 individual components of these scores were also well balanced between treatment groups (eTable 4).

Statistical Analysis

All analyses were prespecified prior to closing of the study database. The main analysis was by intention-to-treat, including all patients according to treatment assigned at randomization. The primary end point was evaluated using Pearson χ^2 (for 2 groups, equivalent to binomial test of proportions). Logistic regression was used to determine the odds ratio and 95% CI and for secondary multivariate analyses and tests of interaction. Survival analyses and the log-rank test were used for incident postoperative AF and major adverse cardiovascular events, arterial thromboembolism, and mortality. In all analyses, missing values were not imputed, and only observed values were used. All patients who withdrew or died were included in all analyses until their date of death or withdrawal. A sensitivity analysis considered all patients who died, withdrew, or were otherwise lost to follow-up before hospital discharge or postoperative day 10, whichever came first, as having had postoperative AF.

Planned enrollment of 1516 patients provided 90% power to detect a 25% reduction in postoperative AF with 2-tailed $\alpha = .05$, based on an estimated 30% event rate in controls and 5% dropout. The control event rate was estimated from prior studies of postoperative AF,^{1,2} and the 25% reduction as a reasonable minimum clinically meaningful risk reduction that was also con-

siderably more conservative than in earlier studies.¹⁶

Secondary multivariable analyses were prespecified, adjusted for age, sex, country, type of cardiac surgery, use of perioperative antiarrhythmic drugs, and any baseline characteristics that were statistically different between treatment groups at $P \leq .15$. In addition to intention-to-treat analyses, we also secondarily evaluated the surgical population (the subset of patients who were enrolled without protocol violation, received at least 1 dose of study drug, and underwent cardiac surgery) and the adherent (on-treatment) population (the subset of the surgical population who took $\geq 80\%$ of their loading dose [or $\geq 75\%$ for patients who received study drug loading over 2 days] and also $\geq 80\%$ of all assigned study capsules over the course of the study until the onset of the primary end point or the end of assigned treatment, whichever occurred first).

We hypothesized stronger efficacy of treatment in 3 prespecified subgroups: those with lower habitual consumption of oily fish (< 2 vs ≥ 2 servings/wk), lower plasma phospholipid n-3-PUFA levels at enrollment ($< 4\%$ vs $\geq 4\%$, also evaluated continuously using semiparametric restricted cubic splines), and greater number of actual study drug loading days (0 to 5 actual days, evaluated ordinally). Interaction by these subgroups was evaluated at 2-tailed $\alpha = .05$. Other subgroup analyses (eAppendix), also prespecified but considered exploratory (ie, no hypothesized direction of interaction) and based on lower statistical power to detect interaction, were evaluated at 2-tailed $\alpha = .10$. Analyses were performed using Stata version 12.1 (College Station, Texas).

RESULTS

Between August 2010 and June 2012, 1516 patients were enrolled (FIGURE 1). Formal screening logs were maintained, and 48% of all screened patients and 94% of all eligible patients were enrolled. Ineligible patients were most often excluded because they were

Table 2. Baseline Medication Use of the OPERA Participants, According to Treatment Assignment

Medication	No. (%)		P Value ^a
	Placebo (n = 758)	n-3-PUFAs (n = 758)	
β -Blocker	433 (57.2)	444 (58.6)	.57
Statin	427 (56.3)	436 (57.5)	.64
ACE inhibitor	274 (36.2)	284 (37.5)	.59
Angiotensin II receptor blocker	103 (13.6)	114 (15.0)	.42
Calcium channel blocker	122 (16.1)	132 (17.4)	.49
Loop diuretics	168 (22.2)	190 (25.1)	.19
Aldosterone antagonists	37 (4.9)	28 (3.7)	.25
Digitalis	2 (0.3)	14 (1.9)	.004
Antiplatelets or anticoagulants	473 (62.4)	455 (60.0)	.34
Antiplatelets	407 (53.7)	389 (51.3)	.36
Aspirin	396 (52.2)	378 (49.9)	.36
Clopidogrel	53 (7.0)	62 (8.2)	.38
Ticlopidine	5 (0.7)	4 (0.5)	>.99
Other	5 (0.7)	4 (0.5)	>.99
Anticoagulants	129 (17.0)	121 (16.0)	.58
Warfarin	24 (3.2)	17 (2.2)	.27
Heparin	105 (13.9)	103 (13.6)	.88
Other	1 (0.1)	1 (0.1)	>.99
Antiarrhythmics			
Amiodarone	28 (3.7)	30 (4.0)	.78
Other ^b	12 (1.6)	14 (1.9)	.69

Abbreviations: ACE, angiotensin-converting enzyme; OPERA, Omega-3 Fatty Acids for Prevention of Post-operative Atrial Fibrillation.

^aDifferences between treatment groups were evaluated using Pearson χ^2 (or Fisher exact tests for cells < 10).

^bIncluding flecainide, propafenone, quinidine, disopyramide, or sotalol.

not in sinus rhythm (40.5%), were taking fish oil (28.9%), or were unwilling to provide informed consent (23.5%). At baseline, mean age was 64 (SD, 13) years; 1094 patients (72.2%) were men, and cardiovascular risk factors were common (TABLE 1 and TABLE 2). Valve surgery was planned in 785 patients (51.8%); of the 756 who underwent valve surgery, 522 (69.0%) underwent aortic valve surgery, 195 (25.8%) mitral valve surgery, 30 (4.0%) aortic and mitral valve surgery, and 9 (1.2%) other valve surgery. The median logistic EuroSCORE (European System for Cardiac Operative Risk Evaluation)^{20,21} value was 3.7 (interquartile range [IQR], 1.9-7.4). The treatment groups had evenly matched characteristics.

Following randomization and study drug loading, 96.4% of patients underwent cardiac surgery. Details of the surgical procedure and postoperative medications are reported in eTable 3. Postoperative medications were simi-

lar by treatment group and included β -blockers in 76.9% of patients overall and amiodarone in 36.9% after cardiac surgery.

The primary end point occurred in 233 patients (30.7%) in the placebo group and 227 (30.0%) in the n-3-PUFA group ($P = .74$). None of the secondary postoperative AF end points or other arrhythmias were significantly different by treatment group (TABLE 3 and FIGURE 2). In-hospital major adverse cardiovascular events occurred in 20 patients (2.6%) in the placebo group and in 13 (1.7%) in the n-3-PUFA group ($P = .18$). At 30 days, 15 patients (2.0%) in the placebo group and 8 (1.1%) in the n-3-PUFA group had died ($P = .14$). Incidence of the secondary end points of arterial thromboembolism and arterial thromboembolism or death was significantly lower in the n-3-PUFA group ($P = .047$ and $P = .01$, respectively). The total number of days in the intensive care unit or coronary care unit, of te-

lemetry monitoring, or of total hospital stay did not differ significantly between groups.

Most postoperative AF events occurred between postoperative days 1 to 4, peaking on day 2 (eFigure). Among all 661 episodes, 353 lasted less than 1 day (median duration, 3.3 hours [IQR, 1.2-7.7 hours]), and 308 lasted 1 day or longer (median duration, 1.0 day

[IQR, 1.0-3.0 days]). There were no significant differences in duration by treatment (Wilcoxon rank-sum $P = .25$). Thirty-two patients in the placebo group and 30 in the n-3-PUFA group were discharged with persistent postoperative AF.

In sensitivity analyses defining all patients who died or withdrew consent as having had postoperative AF,

266 patients (35.1%) in the placebo group and 250 (33.0%) in the n-3-PUFA group developed postoperative AF ($P = .39$). Findings were similar in multivariable analyses adjusted for age, sex, country, type of cardiac surgery, use of perioperative antiarrhythmic drugs, and baseline characteristics differing between groups (eAppendix).

Table 3. Primary and Secondary Study Outcomes in OPERA, According to Treatment Assignment.

Outcome	No. (%)		OR or HR (95% CI) ^a	P Value ^b
	Placebo (n = 758)	n-3-PUFAs (n = 758)		
Any first postoperative AF, primary end point ^c	233 (30.7)	227 (30.0)	0.96 (0.77-1.20)	.74
Postoperative AF, secondary end points				
Sustained, symptomatic, or treated postoperative AF ^d	231 (30.5)	224 (29.6)	0.96 (0.77-1.19)	.70
Postoperative AF excluding flutter ^e	220 (29.0)	217 (28.6)	0.98 (0.79-1.23)	.87
No. of postoperative AF episodes				
1	156 (20.6)	157 (20.7)	NA	.73
2	59 (7.8)	49 (6.5)		
≥3	18 (2.4)	21 (2.8)		
Total in-hospital days with any postoperative AF, mean (SD) ^f	2.75 (2.1)	2.84 (2.1)	NA	.58
Proportion of in-hospital days free of any postoperative AF, %	89.0	88.7	NA	.88
Other arrhythmias				
Other supraventricular tachycardia	6 (0.8)	11 (1.5)	1.85 (0.68-5.02)	.33
Ventricular tachycardia or fibrillation	9 (1.2)	5 (0.7)	0.55 (0.18-1.66)	.42
Other end points				
MACEs, in-hospital ^g	20 (2.6)	13 (1.7)	0.62 (0.31-1.25)	.18
Myocardial infarction	10 (1.3)	10 (1.3)	0.99 (0.41-2.39)	>.99
Stroke	8 (1.1)	4 (0.5)	0.45 (0.13-1.51)	.18
Cardiovascular death	3 (0.4)	0 (0.0)	NA	.08
Arterial thromboembolism, 30-d	13 (1.7)	5 (0.7)	0.37 (0.13-1.03)	.047
Arterial thromboembolism or death, 30-d	27 (3.6)	13 (1.7)	0.44 (0.24-0.86)	.01
Total mortality, 30-d	15 (2.0)	8 (1.1)	0.53 (0.23-1.26)	.14
Cardiac arrhythmic	0 (0.0)	1 (0.1)	NC ^h	.32
Cardiac nonarrhythmic	2 (0.3)	0 (0.0)	NC ^h	.16
Vascular	3 (0.4)	0 (0.0)	NC ^h	.08
Noncardiovascular	10 (1.3)	7 (0.9)	0.70 (0.27-1.84)	.47
Resource utilization, median (IQR), d				
Total ICU/CCU stay	2 (1-3)	2 (1-3)	NA	.38
Total telemetry monitoring	6 (5-7)	6 (5-7)	NA	.39
Total hospital stay	7 (5-8)	7 (5-9)	NA	.48

Abbreviations: AF, atrial fibrillation; HR, hazard ratio; ICU/CCU, intensive care unit/coronary care unit; IQR, interquartile range; MACEs, major adverse cardiac events (myocardial infarction, stroke, or cardiovascular death); NA, not applicable; NC, not calculable; n-3-PUFA, omega-3 polyunsaturated fatty acid; OPERA, Omega-3 Fatty Acids for Prevention of Post-operative Atrial Fibrillation; OR, odds ratio.

^aAll analyses were based on intention-to-treat. Values are ORs estimated using logistic regression for postoperative AF and other arrhythmias and HRs estimated using Cox proportional hazards for other end points such as MACEs.

^bDetermined using Pearson χ^2 (or Fisher exact tests for cells <10) for the primary postoperative AF end point, the first 2 secondary postoperative AF end points, and other tachyarrhythmias; Poisson regression for the total number of postoperative AF events per patient and the total number of in-hospital days with 1 or more episodes of postoperative AF; the Wilcoxon rank-sum test for the proportion of in-hospital days free of any postoperative AF and days of resource utilization; and the log-rank test for MACEs, arterial thromboembolism, and mortality end points.

^cThe median duration of the first postoperative AF episode was 0.92 (IQR, 0.17-1.0) days in the placebo group and 1.0 (0.17-1.0) days in the n-3-PUFA group (Wilcoxon rank-sum $P = .62$).

^dA total of 661 postoperative AF episodes occurred in 460 patients. Among these episodes, 8.9% were associated with dyspnea, chest pain, or hypotension requiring escalation of therapy; 76.7% were treated with electrical or pharmacological cardioversion (predominantly amiodarone); 87.4% lasted longer than 1 hour; and 97.9% met 1 or more of these criteria.

^eExcluding atrial flutter and supraventricular tachycardia with some but not all characteristics consistent with AF.

^fAmong the 460 patients with postoperative AF. Among all 1516 patients, the corresponding values were 0.8 (1.7) days in the placebo group and 0.8 (1.7) days in the n-3-PUFA group ($P = .93$).

^gSee eTable 2 for detailed definitions of all events. Analyses of individual MACEs components include all subtypes of events occurring in any patient.

^hNot reliably calculable, given few numbers of events.

Effects of n-3-PUFAs on the primary end point did not significantly differ among most prespecified subgroups (FIGURE 3). Potential interaction (prespecified $\alpha = .10$) was observed only by type of cardiac surgery ($P = .06$ for interaction), with patients undergoing valve surgery having a trend toward lower risk of postoperative AF with n-3-PUFA treatment. In post hoc analyses, risk of postoperative AF with n-3-PUFA treatment was similar whether valve surgery was aortic or mitral (eAppendix).

In the predefined surgical population (underwent surgery, received at least 1 dose of study drug), 233 of 723 patients (32.2%) in the placebo group and 225 of 728 (30.9%) in the n-3-PUFA group developed postoperative AF ($P = .60$). In the further subset of adherent patients (taking $\geq 80\%$ of assigned study drug), which included 591 of 723 patients (81.7%) assigned to placebo and 596 of 728 patients (81.9%) assigned to n-3-PUFAs, 186 (31.5%) and 178 (29.9%) patients, respectively, developed postoperative AF ($P = .55$).

From the time of enrollment to the morning of cardiac surgery, plasma phospholipid n-3-PUFA concentrations increased approximately 40% in the n-3-PUFA group, from 4.65% (SD, 1.44%) to 6.40% (SD, 1.70%) of total fatty acids, whereas they remained unchanged in the placebo group (4.65% [SD, 1.43%] to 4.78% [SD, 1.43%]) ($P < .001$ for change in fatty acid levels by treatment group). Stratified by actual study drug loading days, phospholipid n-3-PUFA concentrations in the treatment group increased by 0.47% of total fatty acids at day 1, by 1.11% at day 2, by 1.91% at day 3, by 2.55% at day 4, and by 2.30% at day 5. Effects of n-3-PUFA treatment on postoperative AF, however, were not significantly different by loading days (Figure 3).

Compared with patients in the placebo group, those in the n-3-PUFA group received significantly fewer packed red blood cell transfusions, including during surgery ($P = .002$), af-

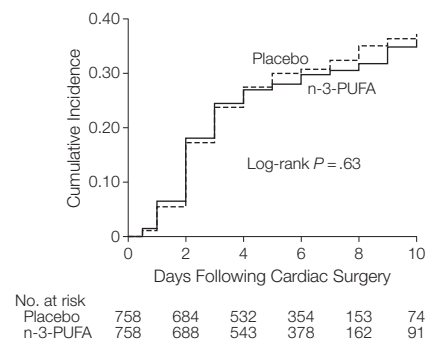
ter surgery ($P = .008$), and overall ($P < .001$) (eTable 5). Other bleeding indices did not significantly differ by treatment. Minor adverse events commonly seen with fish oil, such as gastrointestinal upset, burping, and fish oil taste, occurred more commonly in the n-3-PUFA group. Adverse events requiring discontinuation of study drug and other serious adverse events were similar between groups (eTable 6).

COMMENT

This large, multinational, double-blind, placebo-controlled randomized clinical trial found no evidence that perioperative n-3-PUFA supplementation reduced postoperative AF. Results were similar for various secondary end points, among different patient subgroups, and in various sensitivity analyses. Major strengths of OPERA include its large size and large numbers of events, which achieved anticipated statistical power. The broad inclusion criteria and multinational enrollment support the generalizability of our findings.

In controlled trials lasting weeks to months, n-3-PUFA supplementation favorably influences several physiological pathways related to AF, including blood pressure, systemic vascular resistance, heart rate, inflammation, endothelial function, left ventricular diastolic function, myocardial efficiency of oxygen use, and possibly vagal tone.⁸ Our design cannot exclude potential benefits of much longer durations (eg, weeks to years) of n-3 PUFA supplementation for altering systemic physiology and risk of AF in other clinical contexts. Such prolonged durations of therapy would be impractical as a common preventive measure for most patients scheduled to undergo cardiac surgery. Based on the known benefits of n-3-PUFAs on cardiovascular risk factors and physiologic pathways, a more promising strategy may be long-term consumption to reduce the primary incidence of AF among ambulatory elderly adults with hypertension or other risk factors¹⁵;

Figure 2. Kaplan-Meier Incidence of Postoperative Atrial Fibrillation, According to Treatment Group



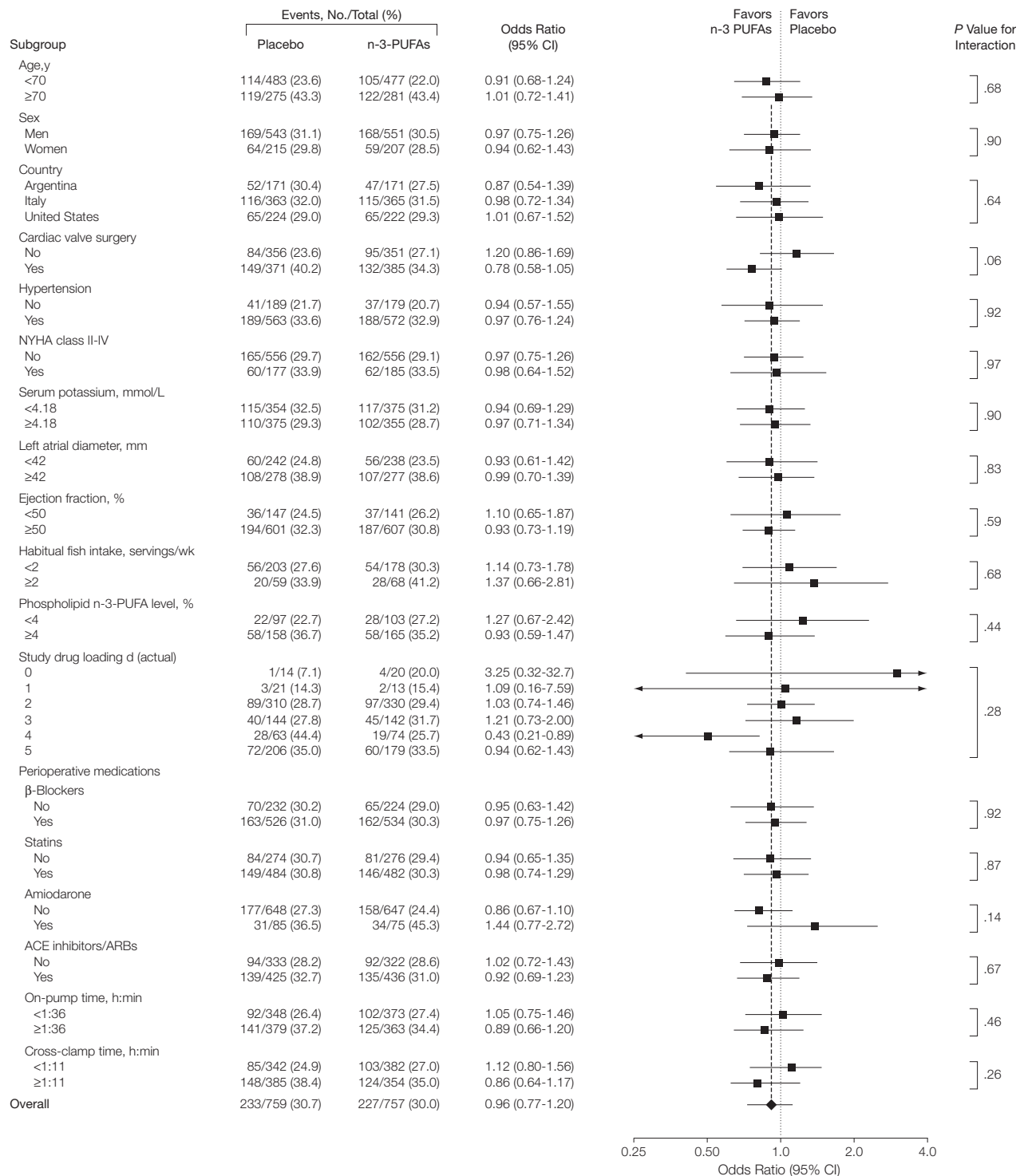
Hazard ratio, 0.96 (95% CI, 0.80-1.15). n-3-PUFA indicates omega-3 polyunsaturated fatty acid.

such an approach should be tested in appropriately designed and powered clinical trials.

Subgroup analyses did not detect any difference in efficacy depending on baseline fish consumption or circulating n-3-PUFA levels. Observational studies of fish consumption and coronary heart disease death in generally healthy populations suggest that some dietary n-3-PUFAs (approximately 250 mg/d of EPA plus DHA, or about 1-2 fish servings/wk) are better than none but that greater consumption may not substantially alter risk further.²² Our findings do not support such a dose-response relationship for postoperative AF. Findings were also similar in other subgroups, except for a suggestion of greater efficacy among patients undergoing valve surgery. Based on the multiple subgroups explored, this finding most plausibly results from chance and should be interpreted cautiously until evaluated prospectively in future studies.

Experimental studies suggest that n-3-PUFAs have antiarrhythmic actions.^{23,24} Our findings provide no evidence that short-term n-3-PUFA supplementation provides clinically relevant antiarrhythmic effects in the acute setting of cardiac surgery. Further, there is no consistent evidence that n-3-PUFAs are effective antiarrhythmic agents in the context of established

Figure 3. Efficacy of Omega-3-PUFAs to Prevent Postoperative Atrial Fibrillation, According to Prespecified Baseline Characteristics



All characteristics are at enrollment except for cardiac valve surgery (based on actual surgery performed), study drug loading days, perioperative medication use (defined as use at enrollment, on the morning after cardiac surgery, or both), on-pump time, and cross-clamp time. Only patients with complete data on the relevant stratifying variable were included in each subgroup analysis. Logistic regression was used to determine the odds ratio and 95% CI for the effect of treatment in each subgroup. The statistical significance of potential interaction was quantified using the Wald test for a multiplicative interaction term (treatment × stratifying variable). ACE indicates angiotensin-converting enzyme; ARB, angiotensin II receptor blocker; n-3-PUFA, omega-3 polyunsaturated fatty acid; NYHA, New York Heart Association.

cardiac arrhythmias, such as in patients with prior ventricular arrhythmias and implantable cardio defibrillators or with prior established chronic or paroxysmal AF.²⁵⁻³¹ Early clinical trials demonstrated that long-term intake of fish³² or fish oil^{33,34} reduced the risk of cardiac death in patients with recent myocardial infarction, and the overall evidence from subsequent experiments, observational studies, and clinical trials continues to point toward a reduction in cardiac death as the principal cardiovascular benefit of long-term n-3-PUFA intake.^{8,9}

Prior smaller trials found mixed effects of perioperative n-3-PUFAs on postoperative AF.^{16,35-40} Two studies reported a reduction in postoperative AF^{16,38} but were small (<40 events each) and also open-label, ie, neither placebo-controlled nor double-blind. Five other small placebo-controlled trials found no significant effects of n-3-PUFAs on postoperative AF,^{35-37,39,40} but the small numbers of events in each study (range, 24-91 events each) limited statistical power and made it difficult to draw strong conclusions about absence of effects. The OPERA trial, comprising more patients and AF events than all of these prior trials combined, provides the most definitive answer to this important research question. The variation in findings of prior small trials and especially studies without placebo control highlights the importance of conducting large, appropriately powered, placebo-controlled trials such as the present study.

Many drugs have been tested but failed to prevent postoperative AF; others, such as β -blockers and amiodarone, only partly reduce risk.² The effects of cardiac surgery on neurohormonal, oxidative, and inflammatory activation and atrial remodeling may simply be too great to be countered by most drugs, including n-3-PUFAs. Postoperative AF remains an intractable and enigmatic complication of surgery. Our findings and those of prior studies highlight the need for meticulous investigation of the underlying physiological, structural, and molecu-

lar underpinnings of postoperative AF to allow novel targeted preventive and therapeutic interventions.

The secondary end points of arterial thromboembolism and arterial thromboembolism or death occurred less frequently in the n-3-PUFA group. However, numbers of events were small, and these findings should be viewed with caution until confirmed in future studies. Supplementation with n-3-PUFAs was well tolerated in this large and heterogeneous population of patients undergoing cardiac surgery, and there was no evidence that n-3-PUFA supplementation was unsafe.

Although there have been theoretical concerns that n-3-PUFAs could aggravate bleeding, no increased hemorrhagic risk was seen across a variety of indices. Patients in the n-3-PUFA group required significantly fewer transfusions; this finding may be attributable to chance, but it further supports absence of increased bleeding risk. These results confirm and extend the findings of prior smaller trials that found no evidence that n-3-PUFA supplementation increased clinical bleeding following cardiac surgery,^{16,35-39} surgical arterial endarterectomy,^{41,42} or coronary angioplasty.⁴³ More than half of the patients in OPERA were taking aspirin or other anticoagulants before cardiac surgery, similar to other trials in which n-3-PUFAs were combined with aspirin or warfarin following cardiac surgery without any excess clinical bleeding.⁴⁴

This study has limitations that should be considered. Current best-practice guidelines for preventing postoperative AF were recommended to all centers, which could have reduced the influence of any additional therapy on risk of postoperative AF. As would be reflected in clinical practice, patients were identified and assigned to receive n-3-PUFAs over varying durations ranging from 2 to 5 days prior to surgery. Shorter durations could have been less effective. Subgroup analyses, however, did not detect significantly greater risk reduction with greater numbers of days of preoperative n-3-PUFAs, providing little evidence that longer dura-

tions of loading make a difference, at least up to 5 days. The dose of n-3-PUFAs may have been too low to produce a benefit, and we did not have available data on achieved myocardial levels of n-3-PUFAs. Yet circulating n-3-PUFAs have systemic effects that could reduce risk of AF,⁸ and phospholipid n-3-PUFA levels increased by an average of 40% by the time of surgery, providing novel evidence that even short-term supplementation significantly influences circulating levels. Adherence with study drug was high but not perfect. Our analysis restricted to adherent patients, however, was consistent with the main findings.

In summary, perioperative n-3-PUFA supplementation did not reduce postoperative AF in this large, adequately powered, placebo-controlled, randomized multinational trial.

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Author Affiliations: Division of Cardiovascular Medicine (Drs Mozaffarian, Libby, and O'Gara) and Channing Division of Network Medicine (Dr Mozaffarian), Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, and Departments of Epidemiology and Nutrition, Harvard School of Public Health (Dr Mozaffarian), Boston, Massachusetts; Department of Clinical Pharmacology and Epidemiology, Consorzio Mario Negri Sud, Santa Maria Imbaro, Italy (Drs Marchioli and Tognoni and Ms Silletta); GESICA Foundation, Buenos Aires, Argentina (Dr Macchia); Ospedali Riuniti di Bergamo, Bergamo, Italy (Dr Ferrazzi); The Center for Heart and Vascular Health, Christiana Care Health System, Newark, Delaware (Dr Gardner); Department of Cardiovascular Research, Istituto di Ricerche Farmacologiche Mario Negri, Milan, Italy (Dr Latini); Department of Health Sciences, University of Milan, Milan, Italy (Dr Lombardi); Department of Medicine, University of Wisconsin School of Medicine & Public Health, Madison (Dr Page); and GVM Hospitals of Care and Research, Villa Maria Cecilia Hospital, Cotignola, Italy (Dr Tavazzi).

Author Contributions: Drs Mozaffarian and Marchioli had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Drs Mozaffarian and Marchioli contributed equally to all aspects of this manuscript, including serving as co-principal investigators of OPERA.

Study concept and design: Mozaffarian, Marchioli, Ferrazzi, Libby, Lombardi, O'Gara, Tavazzi.

Acquisition of data: Mozaffarian, Marchioli, Silletta, Ferrazzi, Tavazzi.

Analysis and interpretation of data: Mozaffarian, Marchioli, Silletta, Gardner, Latini, Libby, Lombardi, O'Gara, Page, Tavazzi, Tognoni.

Drafting of the manuscript: Mozaffarian, Marchioli. **Critical revision of the manuscript for important intellectual content:** Mozaffarian, Marchioli, Silletta, Ferrazzi, Gardner, Latini, Libby, Lombardi, O'Gara, Page, Tavazzi, Tognoni.

Statistical analysis: Mozaffarian, Marchioli.

Obtained funding: Mozaffarian, Marchioli, Tavazzi. **Administrative, technical, or material support:** Mozaffarian.

Study supervision: Mozaffarian, Marchioli, Silletta, Gardner, Lombardi, Tognoni.

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OPERA Investigators and Institutions: Steering Committee: Roberto Marchioli, MD (cochair) (Consorzio Mario Negri Sud, Santa Maria Imbaro, Italy), Dariush Mozaffarian, MD, DrPH (cochair) (Brigham and Women's Hospital, Boston, Massachusetts), Timothy J. Gardner, MD (Christiana Care Health System, Newark, Delaware), Paolo Ferrazzi, MD (Ospedali Riuniti di Bergamo, Bergamo, Italy), Patrick T. O'Gara, MD (Brigham and Women's Hospital, Boston, Massachusetts), Alejandro Macchia, MD (GESICA Foundation, Buenos Aires, Argentina), Massimo Santini, MD (Ospedale San Filippo Neri, Rome, Italy), Luigi Tavazzi, MD (Villa Maria Cecilia Hospital, Cotignola, Italy), Gianni Tognoni, MD (Consorzio Mario Negri Sud, Santa Maria Imbaro, Italy), and the cochairs of the Events and Biologic Studies Committees. **Events Committee:** Richard L. Page, MD (cochair) (University of Wisconsin, Madison), Federico Lombardi, MD (cochair) (University of Milan, Milan, Italy), Christine M. Albert, MD, MPH (Brigham and Women's Hospital, Boston, Massachusetts), Aldo P. Maggioni, MD (Centro Studi Associazione Nazionale Medici Cardiologi Ospedalieri, Florence, Italy), Katherine T. Murray, MD (Vanderbilt University School of Medicine, Nashville, Tennessee). **Biologic Studies Committee:** Roberto Latini, MD (cochair) (Istituto di Ricerche Farmacologiche Mario Negri, Milan, Italy), Peter Libby, MD (cochair) (Brigham and Women's Hospital, Boston, Massachusetts), Bill Harris, PhD (Sanford School of Medicine, Sioux Falls, South Dakota), Jeffrey E. Saffitz, MD, PhD (Harvard Medical School, Boston), David Siscovick, MD, MPH (University of Washington, Seattle), Phyllis Stein, PhD (Washington University School of Medicine, St Louis, Missouri), Domenico Corradi, MD (University of Parma, Parma, Italy), Serge Masson, MD (Istituto di Ricerche Farmacologiche Mario Negri, Milan, Italy). **Biomarker and Cognitive Decline Ancillary Study:** Nancy J. Brown, MD, E. Wesley Ely, MD, MPH, James C. Jackson, PhD, Ayumi Shintani, PhD, MPH, Ginger L. Milne, PhD (Vanderbilt University Medical School, Nashville, Tennessee), Xiaoling Song, PhD (Fred Hutchinson Cancer Research Center, Seattle, Washington), Frank W. Sellke, MD (Brown Medical School and Rhode Island Hospital, Providence). **Main Data Coordinating Center, Consorzio Mario Negri Sud, Santa Maria Imbaro, Italy:** Maria G. Silletta, MS, Raffaella Pioggiarella, PharmD, Lorenzo Marfisi, MEng. **US Clinical Coordinating Center, Harvard School of Public Health, Boston, Massachusetts:** Sarah L. King, BSN, Kristen E. Mills, MS, Adeemy Ogunleye, MD, Namasha H. Schelling, BS, ALM, Jason Wu, PhD. **Italy Centers: Ospedali Riuniti di Bergamo, Bergamo (197 patients enrolled):** Paolo Ferrazzi, MD (center principal investigator [PI]),

Caterina Simon, MD, Maria Iascone, BS, PhD; *Ospedale S. Andrea-Università La Sapienza, Roma (126 patients enrolled):* Riccardo Sinatra, MD (center PI), Umberto Benedetto, MD, PhD; *Ospedali Riuniti and University of Trieste, Trieste (105 patients enrolled):* Lorella Dreas, MD (center PI), Aneta Aleksova, MD, MS; *Department of Surgical Sciences, Division of Cardiac Surgery, University of Torino, Torino (101 patients enrolled):* Mauro Rinaldi, MD (center PI), Stefano Salizzoni, MD, Giovanni Marchetto, MD; *GVM Care & Research—E.S. Health Science Foundation, Cotignola (62 patients enrolled):* Mauro Lamarra, MD (center PI), Marco Pagliaro, MD, Maria Cristina Jori, MD, Luca Dozza, MSB, Simone Calvi, MD; *Azienda Ospedaliera Ordine Mauriziano di Torino, Ospedale Mauriziano Umberto I, Torino (30 patients enrolled):* Riccardo Casabona, MD (center PI), Edoardo Zingarelli, MD, Roberto Flocco, MD; *Unit of Cardiac Surgery, Humanitas Clinical and Research Center, Rozzano (29 patients enrolled):* Alessandro Eusebio, MD (center PI), Giuseppe Raffa, MD, Giuseppe Tarelli, MD; *Centro Cardiologico Monzino I.R.C.C.S. Milano (24 patients enrolled):* Alessandro Parolari, MD, PhD (center PI), Laura Cavallotti, MD, Veronica Miyasoe-dova, MD, PhD, Federica Laguzzi, BS; *GVM Care & Research—E.S. Health Science Foundation, Lecce (19 patients enrolled):* Renato Gregorini, MD (center PI), Federica Mangia, MD; *Fondazione I.R.C.C.S. Policlinico S. Matteo, Pavia (15 patients enrolled):* Fabrizio Gazzoli, MD (center PI), Eliana Raviola, MD, Mario Viganò, MD; *Azienda Ospedaliero—Universitaria Santa Maria della Misericordia, Udine (12 patients enrolled):* Ugolino Livi, MD (center PI), Esmeralda Pompei, MD; *Ospedale San Bortolo, Vicenza (5 patients enrolled):* Loris Salvador, MD (center PI), Nicola Lamascese, MD, Massimo Bilotta, MD; *Niguarda Ca' Granda Hospital, Department of Cardiac Surgery, Milan (3 patients enrolled):* Luigi Martinelli, MD (center PI), Aldo Cannata, MD. **US Centers: Vanderbilt University, Nashville, Tennessee (99 patients enrolled):** Nancy J. Brown, MD (center PI), John Byrne, MD, Marzia Leacche, MD, Michael R. Petracek, MD, Stephen K. Ball, MD; *University of Texas Southwestern Medical Center Dallas (74 patients enrolled):* Michael E. Jessen, MD (center PI), Mary Weyant, RN, BSN; *Washington University, St Louis, Missouri (66 patients enrolled):* Ralph J. Damiano Jr, MD (center PI); *Rhode Island Hospital, Providence (61 patients enrolled):* Frank W. Sellke, MD (center PI), Arun K. Singh, MD, Mary Jane McDonald, RN, MS; *Brigham and Women's Hospital, Boston, Massachusetts (54 patients enrolled):* R. Morton Bolman III, MD (center PI), Debra A. Conboy, RN, BSN, Anne Burgess, RN, MSHI, BSN; *Emory Healthcare, Atlanta, Georgia (45 patients enrolled):* John D. Puskas, MD (center PI); *Sanford Health, Sanford University of South Dakota Medical Center, Sioux Falls (31 patients enrolled):* John Vander-Woude Jr, MD (center PI), Maria C. Bell, MD (center PI); *University of Arizona and Tucson Medical Center, Tucson (9 patients enrolled):* Gulshan Sethi, MD (center PI); *State University of New York Downstate, Brooklyn (7 patients enrolled):* Daniel C. Lee, MD (center PI). **Argentina Centers: Fundación Favaloro, Buenos Aires (180 patients enrolled):** Roberto René Favaloro, MD (center PI), Alejandro Rubén Hershson, MD, Julio César Figal, MD; *Hospital Italiano, Buenos Aires (59 patients enrolled):* Alberto Domenech, MD (center PI), Marcelo Halac, MD; *Hospital Español, Buenos Aires (44 patients enrolled):* Liliana Noemi Nicolosi, MD (center PI), Claudio Gabriel Morós, MD, María del Carmen Rubio, MD, Richard Fuentes Suárez, MD; *Instituto de Cardiología de Corrientes, Corrientes (33 patients enrolled):* Horacio Cacheda, MD (center PI), Juan Pablo Casal, MD; *Clinica y Maternidad de Suizo, Buenos Aires (23 patients enrolled):* Juan Carlos Medrano, MD (center PI), María Carla Cucurell, MD, Florencia Scattini, MD; *Instituto Fundación de Lucha contra las Enfermedades Neurológicas en la Infancia,*

Buenos Aires (3 patients enrolled): Carlos Nojek, MD (center PI), Mariano Camporrotondo, MD.

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Online-Only Material: The eAppendix, eTables 1-6, and the eFigure are available at <http://www.jama.com>.

Additional Contributions: Data and Safety Monitoring Board: David M. Herrington, MD, MHS (chair) (Wake Forest University School of Medicine, Winston-Salem, North Carolina), Maria Mori Brooks, PhD (University of Pittsburgh, Pittsburgh, Pennsylvania), Raffaele De Caterina, MD, PhD (Università degli Studi "G. d'Annunzio," Chieti, Italy), Marc Gillinov, MD (Cleveland Clinic Main Campus, Cleveland, Ohio), Luigi Padeletti, MD (University of Florence, Florence, Italy), Fabio Pellegrini, MS (Consorzio Mario Negri Sud, Santa Maria Imbaro, Italy), Barbra Bluestone Rothschild, MD (The University of North Carolina at Chapel Hill), Fernando Rubinstein, MD, MPH (IECS—Instituto de Efectividad Clínica y Sanitaria, Buenos Aires, Argentina). **Biomarker and Cognitive Decline Ancillary Study:** Pho Q. Diep, BS, Junitta B. Guzman, MS (Fred Hutchinson Cancer Research Center, Seattle, Washington). **Main Data Coordinating Center, Consorzio Mario Negri Sud, Santa Maria Imbaro, Italy:** Laura Palmarini, PharmD, Stefania Sacchetti, PharmD, Anna V. Flaminio, Rosamaria Marfisi, MS, Marco Scarano, MS. **US Clinical Coordinating Center, Harvard School of Public Health, Boston, Massachusetts:** Ashkan Afshin, MD, MPH, Hongyan Huang, MS, PhD, Fadar Otite, MD, MS. **Italy Centers: Ospedali Riuniti di Bergamo, Bergamo:** Marilisa Ambrosio, BS, Annarita Lincasso, BS, Laura Pezzoli, BS; *Ospedali Riuniti and University of Trieste, Trieste:* Marco Anzini, MD, Cosimo Carriere, MD, Rita Belfiore, MD; *Department of Surgical Sciences, Division of Cardiac Surgery, University of Torino:* Guglielmo Fortunato, MD, Augusto Pellegrini, MD, Eliana Raviola, MD, Vincenzo Reale, MD, Paolo Sorrentino, MD; *GVM Care & Research—E.S. Health Science Foundation, Cotignola:* Giulia Schiavina, MSB, Monica Negrosanti, BS; *Azienda Ospedaliera Ordine Mauriziano di Torino, Ospedale Mauriziano Umberto I, Torino:* Giacomo Ravenni, MD; *Centro Cardiologico Monzino, I.R.C.C.S. Milano:* Franco Moro, Marta Brambilla, PhD, Cristina Nava, MD, PhD, Monica Girolì, BS, Andrea Duprati, MD, Marco Gennari, MD, Dennis Ezra Puma Cusiuhuman, MD; *GVM Care & Research—E.S. Health Science Foundation, Lecce:* Barbara Spagnolo, PhD, Michela Francia, MS, Maurizio Stanca, MS; *Fondazione I.R.C.C.S. Policlinico S. Matteo, Pavia:* Marco Paris, MD, Daniele Berwick, MD, Bruno Lusona, MD, Nicoletta Castiglione, MD; *Azienda Ospedaliero—Universitaria Santa Maria della Misericordia, Udine:* Marzia De Biasio, MD, Cristian Daffarra, MD; **US Centers: Vanderbilt University, Nashville, Tennessee:** Rashid Ahmad, MD, Carol A. Meisch, RN, BSN, CCRP, Simon Maltais, MD, Jorge Balaguer, MD; *Washington University, St Louis, Missouri:* Tamara Donahue, RN, BSN; *Emory Healthcare, Atlanta, Georgia:* Robert A. Guyton, MD, Vinod Thourani, MD, Michael Halkos, MD, Omar Lattouf, MD, Kim T. Baio, MSN, Samatha R. Levine, RN, Zachary E. Pitts, RN; *Sanford Health, Sanford University of South Dakota Medical Center, Sioux Falls:* Kathy Janssen, Marilyn Ruhlman, RN, BSN, PA-C, CCRP; *University of Arizona and Tucson Medical Center, Tucson:* Sarah Sharp, BS; *State University of New York Downstate, Brooklyn:* Kristy Pang, BS, RN. **Argentina Centers: Fundación Favaloro, Buenos Aires:** Matías Nicolás Mungo, SC, Ada Liz Servián, RN; *Hospital Italiano, Buenos Aires:* Roberto Battellini, MD, Ricardo Marenchino, MD, Vadim Kotowicz, MD, Vicente Cesáreo, MD, Ricardo Sán-

chez, MD, Veronica Romero, SC, Silvia Avila, SC; *Hospital Espanol, Buenos Aires*: Fabian Donnini, MD, Leticia Biancospino, BS; *Instituto de Cardiologia de Corrientes, Corrientes*: Romina Laurino, MD, Rodolfo Portalea, RN.

REFERENCES

- Hogue CW Jr, Creswell LL, Guterman DD, Fleisher LA; American College of Chest Physicians. Epidemiology, mechanisms, and risks: American College of Chest Physicians guidelines for the prevention and management of postoperative atrial fibrillation after cardiac surgery. *Chest*. 2005;128(2)(suppl):9S-16S.
- Mitchell LB; CCS Atrial Fibrillation Guidelines Committee. Canadian Cardiovascular Society atrial fibrillation guidelines 2010: prevention and treatment of atrial fibrillation following cardiac surgery. *Can J Cardiol*. 2011;27(1):91-97.
- Mariscalco G, Klersy C, Zanobini M, et al. Atrial fibrillation after isolated coronary surgery affects late survival. *Circulation*. 2008;118(16):1612-1618.
- Mathew JP, Parks R, Savino JS, et al; MultiCenter Study of Perioperative Ischemia Research Group. Atrial fibrillation following coronary artery bypass graft surgery: predictors, outcomes, and resource utilization. *JAMA*. 1996;276(4):300-306.
- Auer J, Weber T, Berent R, Ng CK, Lamm G, Eber B. Postoperative atrial fibrillation independently predicts prolongation of hospital stay after cardiac surgery. *J Cardiovasc Surg (Torino)*. 2005;46(6):583-588.
- Hravnak M, Hoffman LA, Saul MI, Zullo TG, Whitman GR. Resource utilization related to atrial fibrillation after coronary artery bypass grafting. *Am J Crit Care*. 2002;11(3):228-238.
- Burgess DC, Kilborn MJ, Keech AC. Interventions for prevention of post-operative atrial fibrillation and its complications after cardiac surgery: a meta-analysis. *Eur Heart J*. 2006;27(23):2846-2857.
- Mozaffarian D, Wu JH. Omega-3 fatty acids and cardiovascular disease: effects on risk factors, molecular pathways, and clinical events. *J Am Coll Cardiol*. 2011;58(20):2047-2067.
- Rizos EC, Ntzani EE, Bika E, Kostapanos MS, Elisaf MS. Association between omega-3 fatty acid supplementation and risk of major cardiovascular disease events: a systematic review and meta-analysis. *JAMA*. 2012;308(10):1024-1033.
- Jahangiri A, Leifert WR, Patten GS, McMurchie EJ. Termination of asynchronous contractile activity in rat atrial myocytes by n-3 polyunsaturated fatty acids. *Mol Cell Biochem*. 2000;206(1-2):33-41.
- Kumar S, Sutherland F, Rosso R, et al. Effects of chronic omega-3 polyunsaturated fatty acid supplementation on human atrial electrophysiology. *Heart Rhythm*. 2011;8(4):562-568.
- Kumar S, Sutherland F, Teh AW, et al. Effects of chronic omega-3 polyunsaturated fatty acid supplementation on human pulmonary vein and left atrial electrophysiology in paroxysmal atrial fibrillation. *Am J Cardiol*. 2011;108(4):531-535.
- Khawaja O, Gaziano JM, Djoussé L. A meta-analysis of omega-3 fatty acids and incidence of atrial fibrillation. *J Am Coll Nutr*. 2012;31(1):4-13.
- Mozaffarian D, Marchioli R, Gardner T, et al. The ω -3 Fatty Acids for Prevention of Post-operative Atrial Fibrillation (OPERA) trial—rationale and design. *Am Heart J*. 2011;162(1):56-63, e3.
- Mozaffarian D, Psaty BM, Rimm EB, et al. Fish intake and risk of incident atrial fibrillation. *Circulation*. 2004;110(4):368-373.
- Calò L, Bianconi L, Colivicchi F, et al. N-3 Fatty acids for the prevention of atrial fibrillation after coronary artery bypass surgery: a randomized, controlled trial. *J Am Coll Cardiol*. 2005;45(10):1723-1728.
- Harris WS. Effects of n-3 fatty acids on human lipoprotein metabolism. In: Frolich JC, von Schacky C, eds. *Fish, Fish Oil, and Human Health*. Gernering, Germany: Zuckschwerdt-Verlag; 1992:88-97.
- Camm AJ, Kirchhof P, Lip GY, et al; European Heart Rhythm Association; European Association for Cardio-Thoracic Surgery. Guidelines for the management of atrial fibrillation: the Task Force for the Management of Atrial Fibrillation of the European Society of Cardiology (ESC). *Eur Heart J*. 2010;31(19):2369-2429.
- Wu JH, Lemaitre RN, King IB, et al. Association of plasma phospholipid long-chain ω -3 fatty acids with incident atrial fibrillation in older adults: the Cardiovascular Health Study. *Circulation*. 2012;125(9):1084-1093.
- Nashef SA, Roques F, Michel P, Gauducheau E, Lemeshow S, Salamon R. European System for Cardiac Operative Risk Evaluation (EuroSCORE). *Eur J Cardiothorac Surg*. 1999;16(1):9-13.
- Roques F, Michel P, Goldstone AR, Nashef SA. The logistic EuroSCORE. *Eur Heart J*. 2003;24(9):881-882.
- Mozaffarian D, Rimm EB. Fish intake, contaminants, and human health: evaluating the risks and the benefits. *JAMA*. 2006;296(15):1885-1899.
- McLennan PL. Myocardial membrane fatty acids and the antiarrhythmic actions of dietary fish oil in animal models. *Lipids*. 2001;36(suppl):S111-S114.
- Leaf A, Kang JX, Xiao YF, Billman GE. Clinical prevention of sudden cardiac death by n-3 polyunsaturated fatty acids and mechanism of prevention of arrhythmias by n-3 fish oils. *Circulation*. 2003;107(21):2646-2652.
- Brouwer IA, Raitt MH, Dullemeijer C, et al. Effect of fish oil on ventricular tachyarrhythmia in three studies in patients with implantable cardioverter defibrillators. *Eur Heart J*. 2009;30(7):820-826.
- Kowey PR, Reiffel JA, Ellenbogen KA, Naccarelli GV, Pratt CM. Efficacy and safety of prescription omega-3 fatty acids for the prevention of recurrent symptomatic atrial fibrillation: a randomized controlled trial. *JAMA*. 2010;304(21):2363-2372.
- Nodari S, Triggiani M, Campia U, et al. n-3 polyunsaturated fatty acids in the prevention of atrial fibrillation recurrences after electrical cardioversion: a prospective, randomized study. *Circulation*. 2011;124(10):1100-1106.
- Bianconi L, Calò L, Mennuni M, et al. n-3 polyunsaturated fatty acids for the prevention of arrhythmia recurrence after electrical cardioversion of chronic persistent atrial fibrillation: a randomized, double-blind, multicentre study. *Europace*. 2011;13(2):174-181.
- Ozaydın M, Erdoğan D, Tayyar S, et al. N-3 polyunsaturated fatty acids administration does not reduce the recurrence rates of atrial fibrillation and inflammation after electrical cardioversion: a prospective randomized study. *Anadolu Kardiyol Derg*. 2011;11(4):305-309.
- Kumar S, Sutherland F, Morton JB, et al. Long-term omega-3 polyunsaturated fatty acid supplementation reduces the recurrence of persistent atrial fibrillation after electrical cardioversion. *Heart Rhythm*. 2012;9(4):483-491.
- Finzi AA, Latini R, Barlera S, et al. Effects of n-3 polyunsaturated fatty acids on malignant ventricular arrhythmias in patients with chronic heart failure and implantable cardioverter-defibrillators: a substudy of the Gruppo Italiano per lo Studio della Sopravvivenza nell'Insufficienza Cardiaca (GISSI-HF) trial. *Am Heart J*. 2011;161(2):338-343, e1.
- Burr ML, Fehily AM, Gilbert JF, et al. Effects of changes in fat, fish, and fibre intakes on death and myocardial reinfarction: Diet And Reinfarction Trial (DART). *Lancet*. 1989;2(8666):757-761.
- Gruppo Italiano per lo Studio della Sopravvivenza nell'Infarto Miocardico. Dietary supplementation with n-3 polyunsaturated fatty acids and vitamin E after myocardial infarction: results of the GISSI-Prevenzione trial. *Lancet*. 1999;354(9177):447-455.
- Marchioli R, Barzi F, Bomba E, et al; GISSI-Prevenzione Investigators. Early protection against sudden death by n-3 polyunsaturated fatty acids after myocardial infarction: time-course analysis of the results of the Gruppo Italiano per lo Studio della Sopravvivenza nell'Infarto Miocardico (GISSI)-Prevenzione. *Circulation*. 2002;105(16):1897-1903.
- Heidt MC, Vician M, Stracke SK, et al. Beneficial effects of intravenously administered n-3 fatty acids for the prevention of atrial fibrillation after coronary artery bypass surgery: a prospective randomized study. *Thorac Cardiovasc Surg*. 2009;57(5):276-280.
- Saravanan P, Bridgewater B, West AL, O'Neill SC, Calder PC, Davidson NC. Omega-3 fatty acid supplementation does not reduce risk of atrial fibrillation after coronary artery bypass surgery: a randomized, double-blind, placebo-controlled clinical trial. *Circ Arrhythm Electrophysiol*. 2010;3(1):46-53.
- Heidarsdóttir R, Arnar DO, Skuladóttir GV, et al. Does treatment with n-3 polyunsaturated fatty acids prevent atrial fibrillation after open heart surgery? *Europace*. 2010;12(3):356-363.
- Sorice M, Tritto FP, Sordelli C, Gregorio R, Piazza L. N-3 polyunsaturated fatty acids reduces post-operative atrial fibrillation incidence in patients undergoing "on-pump" coronary artery bypass graft surgery. *Monaldi Arch Chest Dis*. 2011;76(2):93-98.
- Farquharson AL, Metcalf RG, Sanders P, et al. Effect of dietary fish oil on atrial fibrillation after cardiac surgery. *Am J Cardiol*. 2011;108(6):851-856.
- Sandesara CM, Chung MK, Van Wagoner DR, et al. A randomized, placebo-controlled trial of omega-3 fatty acids for inhibition of supraventricular arrhythmias after cardiac surgery: the FISH trial. *J Am Heart Assoc*. 2012;1:e000547.
- Thies F, Garry JM, Yaqoob P, et al. Association of n-3 polyunsaturated fatty acids with stability of atherosclerotic plaques: a randomised controlled trial. *Lancet*. 2003;361(9356):477-485.
- Rapp JH, Connor WE, Lin DS, Porter JM. Dietary eicosapentaenoic acid and docosahexaenoic acid from fish oil: their incorporation into advanced human atherosclerotic plaques. *Arterioscler Thromb*. 1991;11(4):903-911.
- Reis GJ, Boucher TM, Sipperly ME, et al. Randomised trial of fish oil for prevention of restenosis after coronary angioplasty. *Lancet*. 1989;2(8656):177-181.
- Eritsland J, Arnesen H, Seljeflot I, Kierulf P. Long-term effects of n-3 polyunsaturated fatty acids on haemostatic variables and bleeding episodes in patients with coronary artery disease. *Blood Coagul Fibrinolysis*. 1995;6(1):17-22.