**Association between angiotensin-converting enzyme insertion/deletion gene polymorphism and atrial fibrillation: a meta-analysis**

**Tong Liu**, **Panagiotis Korantzopoulos**, **Gang Xu**, **Michael Shehata**, **Dong Li**, and **Xunzhang Wang**

**1Department of Cardiology, Tianjin Institute of Cardiology, Second Hospital of Tianjin Medical University, Tianjin 300211, People’s Republic of China; 2Department of Cardiology, University Hospital of Ioannina, 45001 Ioannina, Greece; and 3Heart Rhythm Center, The Heart Institute, Cedars-Sinai Health System, Los Angeles, CA 90048, USA**

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### Aims

Recent observations have raised concerns regarding the activation of the renin–angiotensin system and the development of atrial fibrillation (AF). Some initial studies indicated an association between an angiotensin-converting enzyme insertion/deletion (ACE I/D) polymorphism and AF, however, the results have been inconsistent. Our aim was to perform a meta-analysis of relevant studies to assess the validity of this association.

### Methods and results

PubMed, Cochrane clinical trials database, and EMBASE were searched through July 2009, and a manual search was also performed. Of the 68 initially identified studies, 18 case–control studies with 7577 patients were finally analysed.

No statistically significant associations were found between the ACE I/D polymorphism and AF risk in the genetic additive model and dominant model, whereas a significant association was observed in the recessive model. A significant heterogeneity between individual studies was evident in all three models. Subgroup analyses showed a strong association between the ACE I/D polymorphism and hypertensive AF without significant heterogeneity.

### Conclusion

Our meta-analysis suggests that there is insufficient evidence to demonstrate an association between ACE I/D polymorphism and AF risk. However, there seems to be a significant association between ACE I/D gene polymorphic variation and AF in patients with hypertension. Additional studies are warranted to further explore this association in ethnically diverse populations and varied cardiovascular substrates.

### Keywords

Angiotensin-converting enzyme • Gene polymorphism • Atrial fibrillation • Arrhythmias • Meta-analysis

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**Introduction**

Atrial fibrillation (AF) is a rapidly evolving epidemic representing a multifactorial, dynamic disorder with serious health consequences. Despite contemporary achievements in the pharmacological and non-pharmacological treatment of AF, its management remains a difficult task. Recently, the role of the renin–angiotensin system (RAS) in AF has been intensively investigated.

The human angiotensin-converting enzyme (ACE) gene is located in chromosome 17q23.3. In the intron 16 of this gene, a polymorphism consisting of an insertion (I) or a deletion (D) of a 287 bp Alu repeat sequence has been identified, which results in three genotypes: homozygous D/D, I/I, and heterozygous I/D. Previous reports of an insertion/deletion (I/D) polymorphism within the ACE gene have been associated with cardiovascular disease, including essential hypertension, myocardial infarction, dilated cardiomyopathy, and left ventricular hypertrophy.

It seems that the ACE I/D polymorphism accounts for approximately half of the observed variance in ACE levels. Individuals who are homozygous for the D allele have the highest levels of the enzyme, those who are homozygous for the I allele have the lowest, and heterozygous individuals have an intermediate level.

The ACE I/D polymorphism represents a candidate gene for association studies in AF. However, previous reports have...
shown inconsistent and even contradictory results. We therefore conducted a comprehensive meta-analysis of all available data regarding the association between the ACE I/D gene polymorphism and AF risk. We sought to examine the strength of genetic association, to determine the between-study heterogeneity, and to explore the reasons for heterogeneity through predefined sensitivity and subgroup analyses.

**Methods**

Meta-analyses of observational studies present particular challenges because of inherent biases and differences in study designs. Consequently, we performed this analysis according to the guidelines of the Meta-analysis of Observational Studies in Epidemiology Group (MOOSE).

**Inclusion criteria**

We restricted our meta-analysis to case-control or cohort studies which fulfilled the following inclusion criteria: (i) examined the association between the ACE I/D gene polymorphism and AF; (ii) the generally accepted criteria for AF, usually based on patient’s history, serial electrocardiography (ECG), and/or ambulatory ECG monitoring; (iii) cases of AF and control subjects without AF were examined; (iv) genotype or allele frequencies were reported in both cases and controls, and (v) validated genotyping methods were used. We included both published and unpublished studies without language restriction. In studies with overlapping patients or controls, the most recent study with the greatest number of subjects was included in the meta-analysis. Attempts were made to contact the corresponding authors if there were incomplete published data.

**Search strategies**

We carefully searched PubMed (January 1966 to July 2009), EMBASE (January 1980 to July 2009), the Cochrane Controlled Trials Register (Cochrane Library Issue 2, 2009), and Chinese National Knowledge Infrastructure (CNKI) (January 1980 to July 2009) databases to identify relevant studies. We used the following keywords: ‘ACE’, ‘angiotensin-converting enzyme’, ‘polymorphism’, and ‘atrial fibrillation’. Titles and abstracts as well as the reference lists of all the identified reports were examined by two independent investigators (T.L. and G.X.) in order to include potentially relevant studies. The two investigators agreed on the inclusion/exclusion status in 94% of the reviewed studies. Discrepancies were resolved by discussion or consensus with a third reviewer (G.L.). Additionally, a manual search was conducted using articles on this topic, bibliographies of original papers, and abstracts of the scientific sessions of the American College of Cardiology, the American Heart Association, the European Heart Rhythm Association, the European Society of Cardiology, the Heart Rhythm Society during the past 5 years.

**Data extraction**

In order to control for potential bias and improve the reliability, two independent investigators (T.L. and G.X.) performed data extraction using a standard data extraction form to determine eligibility for inclusion and to obtain data via a standardized protocol. Discrepancies were resolved by consensus with a third reviewer (G.L.). The extracted data elements of this review included: (i) publication details: first author’s family name, publication year; (ii) study design; (iii) characteristics of the studied population: country of origin, ethnic information, sample size, mean age, gender distribution, definition, characteristics and numbers of cases and controls, matching; (iv) genotyping method used; and (v) genotype distribution and frequencies of the alleles among cases and controls for the ACE I/D polymorphism. For the studies that had more than one control group, we selected the most matched controls for the case group. In the study from Wang et al. which reported two different matching case and control groups, we extracted related data separately for different subgroup analyses (Table 1).

**Statistical analysis**

The strength of association between the ACE I/D gene polymorphism and AF was estimated using odds ratios (OR), with the corresponding 95% confidence intervals (95% CI). For the ACE I/D polymorphism, we first estimated the risk of the variant genotype D/D compared with the wild-type I/I homozygote (additive model) and then evaluated the risks of D/D vs. (I/D + I/I) (recessive model) and (D/D + I/D) vs. I/I (dominant model). Heterogeneity was examined using the standard χ² test. Since this test has poor power in the case of few analysed studies, we considered the presence of significant heterogeneity at the 10% level of significance and values of χ² exceeding 56% as an indicator of significant heterogeneity. If the χ² test for heterogeneity was significant, a pooled effect was calculated with a random-effects model which was used to take into account the within-study and between-study variance, otherwise, with a fixed-effects model. Pearson’s χ² test was used to determine whether the observed frequencies of genotypes in control group conformed to the Hardy-Weinberg equilibrium (HWE). Studies with controls that violated HWE (P < 0.05) were subjected to a sensitivity analysis. Sensitivity analyses were also performed by excluding four studies with a small number of cases (n < 50) or those two were presented as preliminary abstracts to check the consistency of the overall effect estimate. Subgroup analyses were performed for populations of differing ethnicity, different AF co-morbidities (i.e. lone AF, AF with hypertension, AF with heart failure), and different sources of controls (hospital-based or population-based) to investigate the possible origin of heterogeneity. Egger’s regression asymmetry tests were performed to examine publication bias.

All analyses were performed using SPSS 11.5 Statistical Package Program for Windows (SPSS Inc., Chicago, IL, USA) and Review Manager version 4.2 (Revman, The Cochrane Collaboration, Oxford, UK). All the tests were two-sided and the significant P-value <0.05.

**Results**

**Eligible studies**

Sixty-eight records were identified by the primary literature search. However, after screening the titles and abstracts, 41 studies were excluded secondarily as they were review articles or irrelevant to the current analysis. We retrieved the 27 remaining relevant manuscripts for detailed review. Among these, five studies were excluded due to duplicate publications, two additionally had incomplete data on genotyping frequency and we did not receive any response from the corresponding authors after requesting extra information, and an additional two were excluded due to the absence of a control group. Consequently, the remaining 18 case-control studies which examined the association between the ACE I/D gene polymorphism and AF were finally included (Figure 1). The main characteristics of these studies are shown in Table 1. The total number of subjects enrolled in the 18 studies was 7577, comprising 2188 patients and
<table>
<thead>
<tr>
<th>Author (ref. no.)</th>
<th>Year</th>
<th>Country</th>
<th>Ethnicity</th>
<th>Cases</th>
<th>Controls</th>
<th>Case/control (n)</th>
<th>Case/control, mean age (years)</th>
<th>Case/control, men (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yamashita et al.</td>
<td>1997</td>
<td>Japan</td>
<td>East Asian</td>
<td>Lone AF</td>
<td>Healthy volunteers</td>
<td>77/83</td>
<td>65/64</td>
<td>71.4/NA</td>
</tr>
<tr>
<td>Ogimoto et al.</td>
<td>2002</td>
<td>Japan</td>
<td>East Asian</td>
<td>HCM patients with AF</td>
<td>Healthy volunteers</td>
<td>26/112</td>
<td>66/62</td>
<td>85/73</td>
</tr>
<tr>
<td>Gensini et al.</td>
<td>2003</td>
<td>Italy</td>
<td>Caucasian</td>
<td>Documented AF lasting &gt;24 h (lone AF 20%)</td>
<td>Healthy volunteers</td>
<td>148/210</td>
<td>67/65</td>
<td>62.2/59.0</td>
</tr>
<tr>
<td>Wang et al.</td>
<td>2003</td>
<td>China</td>
<td>East Asian</td>
<td>Lone AF</td>
<td>Healthy subjects</td>
<td>53/50</td>
<td>43/41</td>
<td>71.7/64.0</td>
</tr>
<tr>
<td>Wang et al.</td>
<td>2003</td>
<td>China</td>
<td>East Asian</td>
<td>Hypertensive patients with AF</td>
<td>Hypertensive patients without AF</td>
<td>32/38</td>
<td>45/41</td>
<td>65.6/52.6</td>
</tr>
<tr>
<td>Tsai et al.</td>
<td>2004</td>
<td>China (Taiwan)</td>
<td>East Asian</td>
<td>Non-familial structural AF</td>
<td>Matched controls with structural heart disease</td>
<td>250/250</td>
<td>68/66</td>
<td>58/58</td>
</tr>
<tr>
<td>Asselbergs et al.</td>
<td>2006</td>
<td>Netherlands</td>
<td>Caucasian</td>
<td>AF subjects within a general population</td>
<td>Age- and gender-matched controls</td>
<td>97/97</td>
<td>60/59</td>
<td>56.7/56.7</td>
</tr>
<tr>
<td>Bedi et al.</td>
<td>2006</td>
<td>USA</td>
<td>Caucasian</td>
<td>Non-familial AF with CHF</td>
<td>CHF patients without AF</td>
<td>51/289</td>
<td>63/56</td>
<td>87/70</td>
</tr>
<tr>
<td>Fatini et al.</td>
<td>2007</td>
<td>Italy</td>
<td>Caucasian</td>
<td>Non-valvular AF (lone AF 20%)</td>
<td>Healthy subjects</td>
<td>510/520</td>
<td>71/70</td>
<td>61.2/62.7</td>
</tr>
<tr>
<td>Chen et al.</td>
<td>2007</td>
<td>China</td>
<td>East Asian</td>
<td>Persistent AF hospitalized for EC</td>
<td>Hospitalized patients without AF</td>
<td>40/36</td>
<td>59/57</td>
<td>77.5/72.2</td>
</tr>
<tr>
<td>Chang et al.</td>
<td>2007</td>
<td>China</td>
<td>East Asian</td>
<td>Hospitalized non-familial AF</td>
<td>Hospitalized matched controls without AF</td>
<td>189/194</td>
<td>56/56</td>
<td>63.5/61.9</td>
</tr>
<tr>
<td>Tziakas et al.</td>
<td>2007</td>
<td>Greece</td>
<td>Caucasian</td>
<td>Hypertensive patients with AF</td>
<td>Matched hypertensive patients without AF</td>
<td>158/174</td>
<td>71/71</td>
<td>45.6/50.6</td>
</tr>
<tr>
<td>Tsai et al.</td>
<td>2008</td>
<td>China (Taiwan)</td>
<td>East Asian</td>
<td>Non-familial documented AF</td>
<td>Patients without documented or history of AF</td>
<td>227/1009</td>
<td>68/62</td>
<td>52.9/50.6</td>
</tr>
<tr>
<td>Wei et al.</td>
<td>2008</td>
<td>China</td>
<td>East Asian</td>
<td>Documented structural AF</td>
<td>Patients without AF (63.5%) and healthy subjects</td>
<td>55/63</td>
<td>70/64</td>
<td>56.4/55.6</td>
</tr>
<tr>
<td>Darrieux et al.</td>
<td>2008</td>
<td>Brazil</td>
<td>South American</td>
<td>Lone AF</td>
<td>Individuals from general population without AF and structural heart disease</td>
<td>64/1576</td>
<td>44/45</td>
<td>75.0/45.4</td>
</tr>
<tr>
<td>Huang et al.</td>
<td>2009</td>
<td>China</td>
<td>East Asian</td>
<td>AF patients with hypertensive disease</td>
<td>Hypertensive disease patients without AF</td>
<td>97/529</td>
<td>73/71</td>
<td>67.0/62.6</td>
</tr>
<tr>
<td>Yang et al.</td>
<td>2009</td>
<td>China</td>
<td>East Asian</td>
<td>Non-familial AF</td>
<td>Hospitalized patients without AF</td>
<td>20/30</td>
<td>77/77</td>
<td>80.0/83.3</td>
</tr>
<tr>
<td>Dana et al.</td>
<td>2009</td>
<td>Romania</td>
<td>Caucasian</td>
<td>Heart failure patients with permanent AF</td>
<td>Heart failure patients without AF</td>
<td>25/11</td>
<td>71 (total)</td>
<td>55.5 (total)</td>
</tr>
<tr>
<td>Watanabe et al.</td>
<td>2009</td>
<td>USA</td>
<td>Caucasian</td>
<td>Paroxysmal lone AF</td>
<td>Healthy subjects</td>
<td>69/118</td>
<td>38/27</td>
<td>72/39</td>
</tr>
</tbody>
</table>

AF, atrial fibrillation; HCM, hypertrophy cardiomyopathy; CHF, congestive heart failure; EC, electrical cardioversion.
5389 controls. The average age ranged from 38 to 77 years in the case groups and from 27 to 77 years in the control groups. The prevalence of male gender varied from 45.6 to 87% in the case groups and from 39 to 83.3% in the control groups. Ten studies examined East Asian populations, seven examined Caucasian subjects, and the

Table 2 Distribution of genotype and allele frequencies in individual studies

<table>
<thead>
<tr>
<th>Author (ref. no.)</th>
<th>Cases</th>
<th>Controls</th>
<th>HWE in control, P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D/D</td>
<td>I/D</td>
<td>I/I</td>
</tr>
<tr>
<td>D, deletion; I, insertion; HWE, Hardy–Weinberg equilibrium.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1 Flow diagram of the trial selection process.
remaining one enrolled South American subjects. Of the 18 studies, 16 were published as full manuscripts and 2 in abstract form. The HWE test that was performed in the control group of each study revealed that four of them violated the HWE (Table 2). The distribution of the genotype in these studies is listed in Table 2.

**Results of meta-analysis**

Among the 18 studies analysed, the association between the D/D genotype compared with I/I genotype and AF risk showed no significance utilizing the random-effects model (OR = 1.31, 95% CI: 0.92–1.87, Z = 1.50, P = 0.13) (Figure 2). Additionally, no significant association was demonstrated in the dominant model (OR = 1.09, 95% CI: 0.82–1.43, Z = 0.58, P = 0.56) (Figure 3). However, this association was significant in the recessive model (OR = 1.36, 95% CI: 1.07–1.74, Z = 2.49, P = 0.01) (Figure 4). Significant heterogeneity was present in all three models [additive genetic model (P < 0.0001, I² = 77.6%), recessive model (P < 0.0001, I² = 65.8%), and dominant model (P < 0.0001, I² = 76.2%)].

**Sensitivity and subgroup analyses**

We subsequently performed sensitivity and subgroup analyses to investigate the origin of this heterogeneity. After removing four studies which included a small number of cases (n ≤ 50) and two studies which were presented as abstracts, no significant difference from main analysis was noted. Moreover, exclusion of studies having controls that were not in HWE did not alter the results of the main meta-analysis.

Subgroup analysis stratified by ethnicity of populations (Table 3) showed significant association between the ACE I/D polymorphism and AF risk [additive genetic model: D/D vs. I/I].
and AF in the recessive model (random-effects OR = 1.64, 95% CI: 1.19–2.26 for dominant model) without significant heterogeneity between the studies. In patients with heart failure, a significant association was demonstrated in the recessive model for D allele without heterogeneity (fixed-effects OR = 1.79, 95% CI: 1.03–3.14). In lone AF patients or other composite groups of AF, the random-effects pooled OR were not significant in the three gene models and also had significant heterogeneity.

Finally, the subgroup analysis classified by different sources of controls showed that in studies with hospital-based controls, the relationship between the ACE I/D polymorphic variant and AF was evident only under the recessive model (random-effects OR = 1.43, 95% CI: 1.05–1.94) which was similar to the main analysis. In the studies that enrolled...

**Figure 3** Forest plots of OR with 95% CI for the association between the ACE I/D gene polymorphism and AF risk [dominant genetic model: (D/D + I/D) vs. I/I].
population-based controls, the ACE I/D polymorphism was not associated with AF. There was also significant heterogeneity noted in both the analyses (Table 3).

Egger’s regression asymmetry tests showed no evidence of publication bias in all three genetic models (additive: $P = 0.34$; recessive: $P = 0.16$; and dominant: $P = 0.61$).

**Discussion**

This comprehensive meta-analysis indicates that there is insufficient evidence to draw clear conclusions on the potential association between the ACE I/D polymorphism and AF risk. Moreover, a significant heterogeneity was evident across studies. On the other hand, the subgroup analysis demonstrated that there was a significant association between ACE I/D gene polymorphic variation and AF risk in patients with hypertension (in all three genetic models). Of note, no heterogeneity was observed across these studies.

Recent evidence indicates that activation of the RAS plays an important role in the development and perpetuation of AF. ACE expression is elevated in atrial biopsies of patients with AF and angiotensin II (Ang II) concentrations are increased in the rapid ventricular pacing-induced congestive heart failure model of AF. We have previously demonstrated that ACE-inhibitors (ACEIs), angiotensin-receptor blockers (ARBs), and angiotensin-(1–7) prevent atrial electrical and structural remodelling and reduce AF vulnerability in chronic rapid atrial pacing in canines. Recent clinical evidence also suggests that RAS inhibition with ACEIs and/or ARBs may suppress AF in patients with systolic left ventricular dysfunction and left ventricular hypertrophy. Angiotensin II is a
potent promoter of interstitial fibrosis triggering the mitogen-activated protein kinase pathway, which is responsible for the proliferation of fibroblasts and hypertrophy of cardiomyocytes. Theoretically, the DD genetic variant may increase ACE activity and consequently promote Ang II production and atrial fibrosis, causing atrial structural remodelling and promoting development of AF. However, studies that have examined the association between the ACE I/D polymorphism and AF showed inconsistent, even contradictory results. Our present meta-analysis demonstrated no conclusive association between the ACE I/D polymorphism and the risk of AF, possibly due to the significant heterogeneity between different individual studies.

When between-study variation cannot be explained by chance, exploration of the reasons for heterogeneity rather than derivation of a single summary estimate emerges as the main goal of a meta-analysis. The heterogeneity test in our analysis showed that there were significant differences between individual studies. Subsequently, sensitivity and subgroup analyses were performed in order to investigate the underlying causes. Our sensitivity analysis showed that even after excluding studies with a small number of cases (n < 50), studies presented as abstracts, or having controls violating the HWE, the results of the main meta-analysis do not change.

Alternatively, the subgroup analysis showed some interesting results. First, although the ethnic background does not seem to have obvious influence on the heterogeneity of our analysis, white subjects have a significant association between the ACE I/D polymorphism and AF under the recessive model, whereas no significant association was found in all the three genetic models for Eastern Asian populations. In addition, our analysis indicated that there was a strong relationship between the ACE I/D polymorphism and hypertensive AF without significant heterogeneity in all the three genetic models. Finally, we demonstrated that differing sources of controls were not the cause of heterogeneity in our meta-analysis. Such possible sources of heterogeneity in our analysis may include differences in the underlying cardiovascular substrates, different sample selection, ethnic differences, or to varied methods of genotyping.

It is prudent to acknowledge that several potential limitations are apparent. We did not receive a response from the corresponding author of two studies and therefore we did not acquire the data on genotyping frequency necessary for analysis. These articles were excluded from our meta-analysis. Only published studies were included in the meta-analysis and thus we cannot exclude the possibility of publication bias, although the results of statistical tests showed that publication bias is unlikely. Additionally, our analysis is based on observational studies and unadjusted estimates and may be subject to the potential biases of such studies. The interactions between gene–gene and gene–environment could not be included in our meta-analysis due to a lack of relative data. Finally, we have to acknowledge that meta-analysis represents a retrospective research tool that is subject to the methodological deficiencies of the included studies. Therefore, our results should be interpreted cautiously.

### Table 3 Odds ratios and heterogeneity tests for the ACE I/D gene polymorphism and risk of atrial fibrillation in different subgroup populations

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Additive model, D/D vs. I/I [OR (95% CI); Ph]</th>
<th>Dominant model, (D/D + I/D) vs. I/I [OR (95% CI); Ph]</th>
<th>Recessive model, D/D vs. (I/D + I/I) [OR (95% CI); Ph]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1.31 (0.92–1.87); &lt; 0.0001</td>
<td>1.09 (0.82–1.43); &lt; 0.0001</td>
<td>1.36 (1.07–1.74)*; &lt; 0.0001</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Asian</td>
<td>1.20 (0.79–1.83); 0.0006</td>
<td>1.01 (0.73–1.40); 0.0002</td>
<td>1.25 (0.92–1.72); 0.03</td>
</tr>
<tr>
<td>Caucasian</td>
<td>1.71 (0.97–3.01); 0.0001</td>
<td>1.35 (0.85–2.14); 0.0007</td>
<td>1.62 (1.13–2.34)*; 0.004</td>
</tr>
<tr>
<td>South American</td>
<td>0.59 (0.29–1.18); NA</td>
<td>0.58 (0.32–1.03); NA</td>
<td>0.88 (0.50–1.54); NA</td>
</tr>
<tr>
<td>AF groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone AF</td>
<td>0.78 (0.50–1.20); 0.54</td>
<td>0.85 (0.61–1.20); 0.39</td>
<td>0.84 (0.59–1.21); 0.59</td>
</tr>
<tr>
<td>AF with hypertension</td>
<td>2.76 (1.81–4.22)*; 0.24</td>
<td>1.64 (1.19–2.26)*; 0.51</td>
<td>2.27 (1.59–3.25)*; 0.20</td>
</tr>
<tr>
<td>AF with heart failure</td>
<td>1.10 (0.54–0.23); 0.80</td>
<td>0.71 (0.37–1.37); 0.88</td>
<td>1.79 (1.03–3.14)*; 0.46</td>
</tr>
<tr>
<td>Other AF</td>
<td>1.33 (0.84–2.24)*; &lt; 0.0001</td>
<td>1.10 (0.72–1.69); &lt; 0.0001</td>
<td>1.36 (0.99–1.89); 0.0003</td>
</tr>
<tr>
<td>Source of controls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>1.31 (0.86–1.99); &lt; 0.0001</td>
<td>1.02 (0.73–1.43); &lt; 0.0001</td>
<td>1.43 (1.05–1.94)*; 0.005</td>
</tr>
<tr>
<td>Population</td>
<td>1.32 (0.68–2.56); &lt; 0.0001</td>
<td>1.19 (0.73–1.95); &lt; 0.0001</td>
<td>1.25 (0.81–1.94); 0.0003</td>
</tr>
</tbody>
</table>

ACE, angiotensin-converting enzyme; D, deletion; I, insertion; n, number of studies involved; OR, odds ratio; CI, confidence interval; Ph, P-value of the χ² test for heterogeneity between the studies; NA, not available; AF, atrial fibrillation.

*In the study from Wang et al. which reported two different matching case and control groups, we extracted related data separately. Therefore, there are 19 data sets in the subgroup analysis of AF groups and source of controls.

*Other AF includes data from studies with mixed AF groups or those in which co-morbidities were not clearly defined.

*P-value calculated by Q-test for OR was < 0.05.
whereas significant heterogeneity was evident across the individual studies. The subgroup analysis indicated that there is a significant association between ACE I/D gene polymorphic variation and AF risk in patients with hypertension. Further larger, well-designed studies are needed to elucidate this potential association, examining subjects with different ethnic backgrounds and diverse cardiovascular substrates.

**Acknowledgments**

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**References**