Supplementary material for Johansson C, et al.Characterization of patients with atrial fibrillation not treated with oral anticoagulants. *Scand J Prim Health Care* 2014;32:226–31.

Supplementary Appendix 1. Table of definitions used in the present study.

Condition	Definition
Risk factors for embolism:	
Congestive heart failure	ICD-10 diagnosis of congestive heart failure or LVEF ≤ 40% or an at least moderately decreased left ventricular systolic function
Hypertension	ICD-10 diagnosis of hypertension or receiving antihypertensive treatment
Diabetes mellitus	ICD-10 diagnosis of diabetes mellitus or diagnosis of diabetes mellitus stated in the medical record
Previous stroke	ICD-10 diagnosis of stroke or diagnosis of stroke stated in the medical record
Previous TIA	ICD-10 diagnosis of TIA or diagnosis of TIA stated in the medical record
Previous arterial embolism	ICD-10 diagnosis of arterial embolism or diagnosis of arterial embolism stated in the medical record
Vascular disease	Previous myocardial infarction, objectively verified peripheral arterial disease (verified by appropriate imaging or treated with revascularization or amputation), complex aortic plaque or previous surgery for an arterial aneurysm
Presence of a mechanical or biological heart valve	Evidence of presence of a mechanical or biological heart valve stated in the medical record
Chronic venous thromboembolism	Chronic venous thromboembolism stated in the medical record
Risk factors for bleeding:	
Uncontrolled hypertension	Persistent hypertension with a systolic blood pressure > 180 mm Hg or a diastolic blood pressure > 100 mm Hg
Renal failure[a]	S-creatinine ≥ 200 μmol/l, dialysis dependency or previous renal transplantation
Liver failure[a]	Chronic liver disease such as hepatitis, liver cirrhosis or a malignant liver disease, or having a S-total bilirubin > 50 μmol/l in combination with S-ALAT > 4.5 μkat/l or S-ASAT > 1.8 μkat/l or S-ALP > 5.4 μkat/l for women and S-ALAT > 6.6 μkat/l or S-ASAT > 2.25 μkat/l or S-ALP > 5.4 μkat/l for men
Thrombocytopenia[a]	Platelet count less than 100×10^9/l
Anemia[a]	Haemoglobin value of less than 90 g/l
History of gastrointestinal bleeding	Diagnosis of gastrointestinal bleeding stated in the medical record
Recent gastrointestinal bleeding	Gastrointestinal bleeding during the three months preceding 31st December 2010
High risk of falls	ICD-10 diagnosis of repeated falls (R29.6) or when high risk of falls was noted as the reason for not recommending OAC treatment
Inability to comply with INR monitoring	Active alcohol abuse or having previously discontinued OAC treatment due to labile INR or when other reasons for inability to comply with INR monitoring were present (e.g. dementia or severe psychiatric disease with no home care services)
Predisposition for bleeding	Thrombocytopenia, anaemia, previous intracerebral or intracranial bleeding, recent or previous gastrointestinal bleeding, bleeding disorders, or other reasons for an increased risk of bleeding such as history of generalized seizures during the past two years
Other reasons for predisposition for bleeding	Recurrent haemoptysis during the last year, documented high risk of falls, generalized seizures during the past two years, recurrent macroscopic haematuria during the last year, patient with recurrent bladder cancer and previous macroscopic haematuria, chronic thrombocytopenia, aortic dissection, anaemia (B-Hb <50 g/l) during previous warfarin treatment where the bleeding source was not identified, recurrent epistaxis, menorrhagia, previous severe pancreatic bleeding, previous extracranial vertebral artery bleeding or previous vitreous haemorrhage during treatment with low molecular weight heparin where the patient also was affected by diabetic retinopathy
Active alcohol abuse	Active alcohol abuse stated in the medical records
Bleeding disorders	Diagnosis of bleeding disorder stated in the medical record
Other factors:	
Dementia or other types of cognitive dysfunction such as severe psychiatric disease	Diagnosis of dementia, cognitive dysfunction, or a severe psychiatric disease stated in the medical record
Unsuitable for warfarin treatment	Patient having declined treatment with warfarin or having had previous adverse effects other than bleeding on warfarin, labile INR during previous warfarin treatment, or inability to comply with INR monitoring

Note: [a] = The biochemical tests for assessing anaemia, thrombocytopenia, renal failure, and liver failure considered were the last analysed before 31st December 2010.

Supplementary Appendix 2. Types of AF.

Type of AF	Definition
Isolated episode of AF	Only one ECG-documented episode of AF and all the subsequent ECGs showed sinus rhythm, with or without an identifiable reversible cause. The individual had never been subjected to cardioversion
Paroxysmal AF	More than one ECG-documented episode of AF, the last ECG showed sinus rhythm, and the individual had never been subjected to cardioversion
Permanent AF	The last ECG showed AF and the individual was not planned to undergo cardioversion
Persistent AF	The individual had been subjected to cardioversion or was planned to undergo cardioversion after December 31, 2010 and did not fulfil the criteria for permanent AF