

AHA SCIENTIFIC STATEMENT

Caffeine and Cardiovascular Disease: A Scientific Statement From the American Heart Association

Gregory M. Marcus, MD, MAS, FAHA, Chair; Frank B. Hu, MD, MPH, PhD, FAHA, Vice Chair; Rob M. van Dam, PhD; Marilyn C. Cornelis, PhD; Thomas A. Dewland, MD; JungHee Kang, PhD, MPH, RN; Susanna C. Larsson, PhD; Robert L. Page II, PharmD, MSPH, FAHA; Niyati Parekh, PhD, FAHA; on behalf of the American Heart Association Council on Lifestyle and Cardiometabolic Health; Council on Clinical Cardiology; and Stroke Council

ABSTRACT: Caffeine is one of the most commonly consumed drugs in the world. It is found in various naturally occurring substances and can be ingested in a synthetically derived pure form. The majority of human subject-based research is observational and has focused on beverages and foods that contain caffeine. The relationships between caffeine and cardiovascular risk factors and diseases are complex, exhibiting heterogeneity depending on the nature of the caffeine consumed and individual-level propensities. Acute versus chronic caffeine-associated cardiovascular effects are often different. Most studies suggest an inverse J-shaped relationship between consumption of naturally occurring caffeinated products and blood pressure. Data on relationships between caffeine and diabetes are not consistently, but habitual coffee consumption has been associated with a lower risk of incident type 2 diabetes. Whereas no clear relationship between caffeine and blood lipids is evident, unfiltered coffee raises low-density lipoprotein cholesterol. Caffeine, studied primarily in the context of coffee, has been shown either to have no relationship or to be associated with a lower risk of coronary artery disease and heart failure. Randomized controlled trial data among regular caffeinated coffee drinkers showed that caffeinated coffee decreases the risk of atrial fibrillation occurrence but increases the frequency of premature ventricular contractions. Data are fairly consistent that moderate caffeine consumption, again studied primarily in the setting of coffee consumption, was associated with a lower risk of stroke. Data on high doses of caffeine such as that found in energy drinks are limited and generally suggest cardiovascular harm.

Key Words: AHA Scientific Statements ■ arrhythmias, cardiac ■ caffeine ■ cardiology ■ coffee ■ heart failure ■ hypertension ■ myocardial infarction

Caffeine is one of the most commonly consumed drugs in the world. The science evaluating the effects of caffeine on human health must be considered in the context of several complicating factors. First, although caffeine is available by prescription in a pure form, it is most commonly consumed within foods or beverages, often making distinguishing effects inherent to caffeine from those of the constituents in which it travels difficult if not impossible. Indeed, because much of the related literature focuses on coffee (the most commonly consumed beverage in the United States¹), much of this scientific statement is dedicated to describing literature pertinent to cardiovascular health that can be attributed to coffee rather than caffeine per se. Second, caffeine affects multiple organs and, even within the cardiovascular system, has myriad effects. Third, individuals can

metabolize caffeine at different rates, depending on both inherited genetic variants and prior patterns of exposure. Last, investigators have used various study designs to understand its health effects, each with their own pros and cons worthy of careful consideration. The majority of studies have used observational study designs prone to unmeasured and residual confounding, with a few but growing number of randomized controlled trials to provide more definitive evidence.

MECHANISMS AND PHARMACOLOGY

With use dating as far back as 2737 BC, caffeine is the world's most popular stimulant and psychoactive substance. Today, >60 different plant species, including cacao beans and tea leaves, naturally contain caffeine in varying

degrees; however, caffeine can also be found in many over-the-counter, prescription, and other commercially available food products (Table 1).² Caffeine is a methylxanthine derivative with alkaloid properties that can be administered orally, intravenously, topically, or rectally. As a result of its 100% oral bioavailability and high hydrophilicity, caffeine rapidly undergoes dissolution and is absorbed on consumption, reaching peak concentrations in 1 hour (Table 2).^{3,4} Because of its minimal first-pass metabolism, caffeine exhibits a linear pharmacokinetic profile, meaning increasing doses result in proportionate increases in caffeine blood levels. In addition, caffeine is lipophilic enough to cross all biological membranes, including the blood-brain and placental barriers. Although caffeine does not accumulate in tissues or organs, high concentrations of caffeine (up to 80%) can be found in the brain.³

As shown in Figure 1, caffeine is extensively metabolized by hepatic cytochrome P450 (CYP) isoenzymes CYP1A2 and CYP2C9, leading to oxidative N-demethylation and resulting in paraxanthine (80%), theobromine (11%), and theophylline (4%), each of which has biological activity similar to that of caffeine. The primary route of elimination for caffeine and its metabolites is by the kidneys through urine excretion. Only a small percentage (<3%) of caffeine is excreted unchanged from the body; most of the caffeine molecules are reabsorbed back into the bloodstream by the renal tubules. Moreover, caffeine elimination is dose dependent and follows the Michaelis-Lenten kinetics, meaning that at low to moderate caffeine concentrations, caffeine exhibits first-order kinetics, but at higher concentrations, it follows zero-order kinetics. Hence, at higher concentrations, the decline of caffeine concentrations occurs over longer periods of time. Ultimately, caffeine and its metabolites are excreted primarily in the urine as uric acid and minimally through sweat and feces.^{3,5,6}

Food consumption, particularly meals high in fat or fiber, can delay the onset of caffeine and reduce the peak concentration in the blood by slowing gastric emptying. In addition, different types and volumes of food consumed and the composition of the caffeine delivery matrix (eg, infused coffees or teas, energy bars or gels, and sodas or energy drinks) can affect the rate of caffeine absorption and bioaccessibility. For example, compared with tea and coffee, caffeine absorption from soft drinks occurs at a slower rate.³ The composition of energy drinks such as through the presence of ingredients such as taurine increases the solubility, absorption, and onset of action of caffeine.⁷

Caffeine has different biochemical targets and several mechanisms through which it exerts its effects: (1) antagonism of adenosine receptors, (2) inhibition of the phosphodiesterase enzyme, (3) calcium release from intracellular stores, and (4) antagonism of GABA_A receptors. Table 3 summarizes the pharmacological effects based on its target tissues.^{3,5,6}

Table 1. Concentrations of Caffeine in Commercial Food Products, Over-the-Counter/Supplement Medications, and Prescription Medications

Example	Caffeine content
Commercial food products	
Coffee, caffeinated	
Regular, brewed, nonspecialty	9.4–20.6 mg/fluid oz
Specialty coffees, all	7.9–15.8 mg/fluid oz
Cappuccino	9.3–15.8 mg/fluid oz
Café au lait or latte	9.3–11.9 mg/fluid oz
Mocha or other flavored syrup	10.6 mg/fluid oz
Ready to drink, bottles or cans	4.1–9.5 mg/fluid oz
Coffee, decaffeinated	
All types, including regular, brewed, specialty, brand or brand not specified, ready to drink, bottles, or cans	0.25 mg/fluid oz
Colas/soft drinks	
All types, caffeinated, regular or diet, including flavors	3.0–5.8 mg/fluid oz
Citrus, all types, caffeinated	4.6–5.9 mg/fluid oz
Other, all types, regular or diet	1.9–6.9 mg/fluid oz
Tea	
Black, all types, brewed, caffeinated, brand or no brand specific	5.9 mg/fluid oz
Green, all types, brewed, caffeinated, brand or no brand specified	3.1 mg/fluid oz
White, all types, brewed, caffeinated, brand or no brand specified	1.9 mg/fluid oz
Energy drinks	
Drinks, all types, bottles or cans, diet or regular	3.4–20.5 mg/fluid oz
Shots, all types	40.0–69.0 mg/fluid oz
Chocolate	
Chocolate milk, prepared from powered mix	0.3–1.5 mg/fluid oz
Cocoa, restaurant/coffee house/homemade	0.8–1.6 mg/fluid oz
Over-the-counter/supplements	
Alka-Seltzer Hangover Relief	130 mg/2 tablets
Bayer Back and Body	70 mg/2 capsules
Excedrin Migraine	130 mg/2 gel-tabs
Excedrin Tension Headache	130 mg/2 capsules
Midol Complete	120 mg/2 capsules
Hydroxycut Hardcore	265 mg/2 capsules
NoDoz	200 mg/1 capsules
Vivarin	200 mg/1 tablet
Prescription medications	
Butalbital/aspirin/caffeine	40 mg/capsule
Orphenadrine citrate/aspirin/caffeine	30 mg/capsule (standard tablets) 60 mg/capsule (forte or extra strength)

Although much of the evidence on caffeine derives from studies of coffee consumption, coffee contains numerous bioactive compounds beyond caffeine, including chlorogenic acids, diterpenes, trigonelline, and

Table 2. Summary of the Pharmacokinetics of Caffeine

Pharmacokinetic properties	Comments
Absorption	
Oral	20% through stomach, 80% through GI tract (99%–100% bioavailability)
Rectal	Highly variable; topical caffeine has high skin permeability because of its small molecule size
Topical	Absorption rate of 2.24 µg·cm ⁻¹ ·h ⁻¹ in which hair follicles shunt into bloodstream within 5 min
Onset	After 30–45 min, passes into bloodstream; after 1–2 h with topical formulations Peak concentrations reached in 1 h (which can be delayed by food)
Distribution	
Protein binding	10%–30% bound to plasma proteins (eg, albumin)
Volume of distribution	0.7 L/kg
Tissue distribution	Crosses blood-brain barrier and the placental barrier Actively passes into the brain (80%), breastmilk, and placenta
Metabolism	
Hepatic metabolism	Metabolized extensively by CYP1A2 and CYP2C9 through demethylation into active metabolites: theobromine, theophylline, and paraxanthine
Half-life	2–12 h (4–5 h in healthy adults)
Factors affecting metabolism	Smoking cigarettes induces CYP1A2 through polycyclic aromatic hydrocarbons and thus increases metabolism while decreasing the half-life of caffeine; pregnancy reduces CYP1A2, leading to slower metabolism and a longer half-life
Elimination	
Kidney	Primary route of elimination is through urine; 98% of caffeine and metabolites are reabsorbed in the renal tubules and affected by renal blood flow and urine output
Feces, sweat, saliva	These modes of elimination are not significant forms or effective because only a small percentage is eliminated

CYP indicates cytochrome P450 isoenzyme; and GI, gastrointestinal.



melanoidins. In large cohort studies, inverse associations between coffee intake and risk of type 2 diabetes and cardiovascular disease have also been observed for decaffeinated coffee, supporting a role for noncaffeine components.^{8,9} Experimental studies conducted in animals and humans suggest that the bioactive compounds in coffee have antioxidant and anti-inflammatory properties and may improve insulin sensitivity, endothelial function, and glucose metabolism, partly through effects on the gut microbiota.¹⁰

GENETICS

The estimated heritability of caffeine consumption and symptoms of caffeine tolerance, toxicity, and withdrawal ranges from 30% to >50%.^{11,12} Genetics also underlie the wide interindividual variation in the activity of CYP1A2, itself responsible for >95% of caffeine metabolism.^{13–15} The most successful approach to identify specific genetic factors has been population-based genome-wide association studies of dietary caffeine (coffee, tea, total caffeine) consumption and plasma levels of caffeine metabolites. The strongest and most replicated single-nucleotide polymorphisms map to the biologically plausible genes *CYP1A2* and *AHR*.^{16–22} Those with genetic variants associated with lower plasma caffeine metabolites also generally consume more caffeine, attributed to the fact that individuals with these variants would need

more caffeine for the same psychostimulant effects.^{15,19,23} These and multiple other single-nucleotide polymorphisms in various genetic regions have been associated with other behavioral patterns related to caffeine consumption, including preferences for black coffee (without added creamers) and decaffeinated coffee. Specific single-nucleotide polymorphisms and their relative contribution to caffeine behaviors and metabolism vary by populations because of differences in allele frequencies, as well as social or cultural factors and concomitant behaviors or medications affecting these traits.¹¹

RELATIONSHIPS WITH CARDIOVASCULAR RISK FACTORS

Blood Pressure

Relationships between caffeine and blood pressure are complex, and the chronicity of use may result in divergent effects. For example, men with hypertension experienced a >1.5-fold increase in both systolic and diastolic blood pressures after the consumption of 250 mg caffeine compared with individuals with optimal blood pressure.²⁴ In contrast, a mendelian randomization analysis using data derived from the UK Biobank, the International Consortium for Blood Pressure Research, and the UK Blood Pressure Study revealed significantly lower systolic and diastolic blood pressures among those with genetic

Downloaded from <http://ahajournals.org> by on July 25, 2026

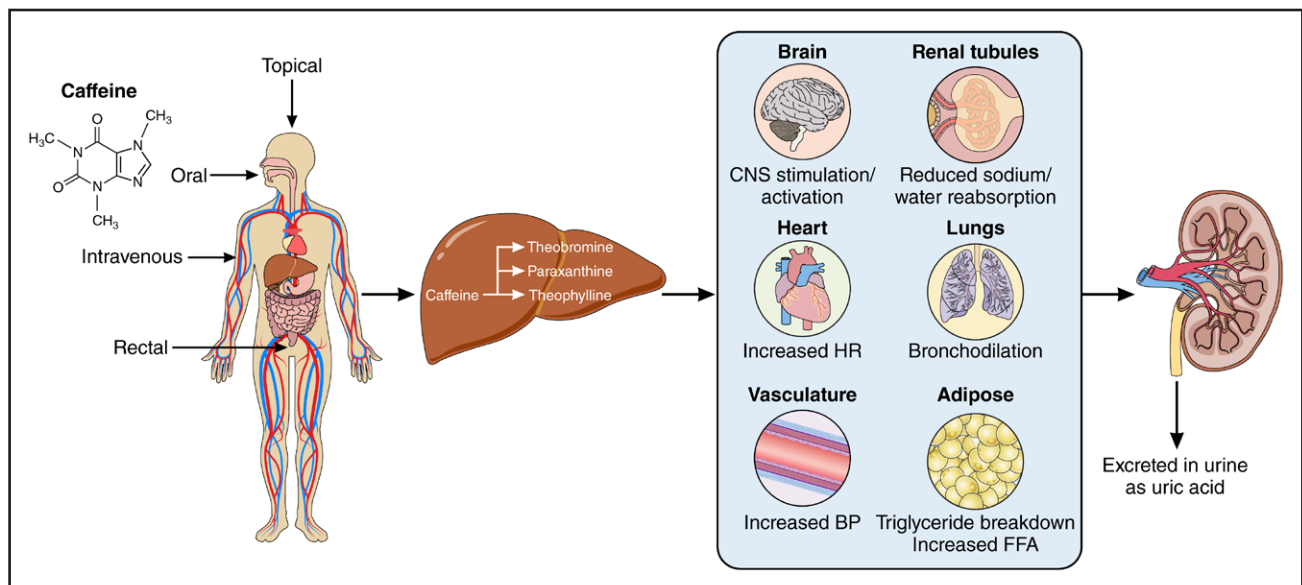


Figure 1. Summary of the metabolism of caffeine and its immediate effects on tissues.

BP indicates blood pressure; CNS, central nervous system; FFA, free fatty acids; and HR, heart rate.

variants expected to correspond to regular caffeine intake.²⁵ Indeed, prospective cohort studies with long-term follow-up have revealed an inverse J-shaped association of habitual coffee consumption with the risk of hypertension, demonstrating an increased risk with intake of 1 to 3 cups/d but a trend toward a decreased risk with higher consumption.²⁶ The long-term effects of habitual caffeine consumption on blood pressure remain unclear and are likely minimal, although the risk may increase with high intake, particularly among individuals with severe hypertension or heightened sensitivity, because regular use can lead to tolerance.²⁷

Consumption of energy drinks containing high concentrations of caffeine has been shown to result in significant increases in both systolic and diastolic blood pressures in healthy adults.²⁸ In contrast, green coffee bean extract has been shown to decrease both systolic and diastolic blood pressures in adults, particularly among individuals with elevated baseline levels.²⁹ These contrasting outcomes may be attributed to differences in caffeine concentration and the presence of other bioactive compounds such as taurine in energy drinks and chlorogenic acid in coffee with opposing effects on blood pressure.^{28,29}

Consuming energy drinks before exercise has been shown to elevate submaximal systolic blood pressure in healthy individuals, and this effect may pose a greater risk for those with hypertension.³⁰ Furthermore, findings from a recent double-blind, randomized, placebo-controlled trial indicated that habitual pre-exercise consumption of a moderate daily doses (1.9 ± 0.34 mg/kg) of a caffeine-based supplement attenuated exercise-induced reductions in blood pressure in young women.³¹

Diabetes

Although mechanistic studies suggest that caffeine may reduce insulin sensitivity in the short term, the majority of studies examining caffeine and diabetes risk have focused on coffee consumption and reveal predominantly salutary effects. Habitual coffee consumption has been consistently associated with a lower risk of type 2 diabetes in observational cohort studies, revealing significant dose-dependent reductions in disease risk. A review of 28 prospective cohort studies noted a 20% and 30% decreased risk of type 2 diabetes among people who, on average, consumed 3.5 and 5 cups/d, respectively.⁸ The European Prospective Investigation Into Cancer and Nutrition demonstrated a 27% lower risk of type 2 diabetes among 69 532 women who consumed ≥ 3 cups of coffee compared with those who did not consume coffee.³² In another large cohort consisting of both sexes, associations were in a similar direction for higher total coffee consumption and for caffeine intakes of 126 to 400 mg/d.³³ It is important to note that these findings may be more specific to coffee than to caffeine: In the Health Professionals and Nurses' Health Study of more than 100 000 women, coffee consumption was associated with reduced incidence of type 2 diabetes, regardless of caffeine content.³⁴

Although observational cohort studies consistently report strong inverse associations with type 2 diabetes, data from (predominantly acute) clinical trials are inconsistent.^{8,35} In a review including 8 clinical trials ($n=247$), results were analyzed 1 to 3 hours after coffee intake and over 2 to 16 weeks.³⁵ Although improvements in blood glucose was observed for the long term, there

Table 3. Summary of the Pharmacology of Caffeine by Mechanism of Action

Mechanism of action	Comment
Antagonism of adenosine receptors	Blocks adenosine A1 and A2 _A receptors nonselectively, thus antagonizes and inhibits adenosine stimulation of the receptors Observed with typical levels of caffeine consumption Binding of adenosine to the receptors in the central nervous systems will promote drowsiness
Inhibition of phosphodiesterase	Minimal at normal levels of consumption but is more commonly observed at higher doses At higher doses, caffeine will inhibit phosphodiesterase activity, preventing the breakdown of cAMP and leading to accumulation and increased duration and effects of cAMP action High cAMP levels activate the hormone-sensitive lipase in the adipose tissue, which is required for lipolysis, thus promoting lipolysis, which causes the release of fatty acids and glycerol
Calcium release	Occurs at very high, nonphysiological concentrations (beyond average consumption) Causes the release of stored calcium from cellular sarcoplasmic reticulum and translocation of calcium, resulting in a decrease in intracellular calcium accumulation Affects neurotransmission because synaptic transmission depends on calcium influx into nerve endings In muscle tissue, restricts calcium uptake and storage by the sarcoplasmic reticulum; this action results in an increase in the strength and endurance of cardiac and skeletal muscles
Antagonism of GABA _A receptors	Not common; occurs only at toxic levels Weak binding affinity to the benzodiazepine receptors and weak antagonistic effects on the GABA _A receptors Changes and opposes the effects of benzodiazepines
Other peripheral effects	Blocks adenosine receptors in myocardial pacemaker cells, thus removing the braking effect of adenosine, leading to activation of cAMP and increased HR Stimulates the central sympathetic nervous system, thus increasing peripheral vasoconstriction and BP Inhibits sodium and water reabsorption in the renal tubules, thereby increasing urine output and possible dehydration Relaxes smooth muscle in bronchioles, opening airways, while also stimulating GI and colonic smooth muscle cells, thus promoting bowel movements, all of which is contributed by actin depolymerization Increases gastric acid secretion in the stomach by stimulating gastrin release and H ₂ receptors, which can worsen ulcers Triggers the breakdown of triglycerides and release of free fatty acids, thus altering lipid metabolism Enhances muscle contraction strength by increasing calcium ion release from the sarcoplasmic reticulum, which can enhance athletic performance

BP indicates blood pressure; GI, gastrointestinal; H2, histamine type 2 receptor; and HR, heart rate.

was a suggestion of acute detrimental effects immediately after caffeinated coffee consumption. Similarly, in a study of 45 Japanese participants with overweight, no improvement in glucose tolerance was reported after 8 weeks of 5 daily cups of caffeinated or decaffeinated coffee compared with water, but a small reduction was observed after 16 weeks.³⁶ Among 100 volunteers, daily randomization to caffeinated coffee versus caffeine avoidance failed to reveal any differences in mean daily glucose.^{37,38}

The mechanisms underlying these observations may also be linked to constituents in coffee, unrelated to caffeine. Coffee contains chlorogenic acid, a polyphenol that improves glucose metabolism,³⁹ and 2 micronutrients, magnesium and chromium, both linked to insulin sensitivity and lower blood glucose concentrations.

Lipids

Consumption of unfiltered coffee raises serum cholesterol concentrations as a result of the coffee component cafestol.⁴⁰ In double-blind, placebo-controlled, randomized trials, cafestol capsules,⁴⁰ but not caffeine

capsules,⁴¹ increased low-density lipoprotein cholesterol concentrations. Cafestol is present in unfiltered coffee, including French press, Greek/Turkish, and Scandinavian boiled coffee, and to a lesser extent in espresso-based and Moka coffee.⁴⁰ However, cafestol is not present in substantial amounts in paper-filtered or instant coffee. Indeed, high consumption of unfiltered coffee consistently increased serum cholesterol in randomized trials, whereas consumption of filtered coffee did not.⁴² Espresso-based coffee contains a smaller amount of cafestol than unfiltered coffee⁴⁰ and has been associated with modestly higher serum cholesterol concentrations.⁴³

RELATIONSHIPS WITH CARDIOVASCULAR DISEASES

Arrhythmias

Observational studies and related meta-analyses have generally demonstrated that caffeine and caffeinated coffee consumption is associated with either no difference in risk or a lower risk for atrial fibrillation (AF), particularly in regular and moderate amounts (eg, 1–7 times a week and 1–3 cups of caffeinated coffee per day).^{44,45}

Downloaded from <http://ahajournals.org> by on July 25, 2026

Mendelian randomization studies similarly reveal no anticipated heightened risk of AF.^{46,47} Among patients with AF who consumed at least 1 cup of caffeinated coffee at some point in the past 5 years scheduled for elective cardioversion, randomization to consume at least 1 cup of caffeinated coffee per day compared with avoidance of coffee and caffeine led to a statistically significant 39% reduced risk of recurrent AF.⁴⁸ Substantially fewer studies have focused on caffeinated tea and AF, with some suggestion that green tea consumers may experience a lower odds of AF.⁴⁹ It is important to note that multiple case reports and small case series have described acute episodes of AF in otherwise low-risk individuals (including young healthy people in their 20s) shortly after consuming caffeinated energy drinks.⁵⁰ On the whole, these data have resulted in a Class 3 recommendation in the updated American College of Cardiology/American Heart Association/Heart Rhythm Society guidelines (albeit written before the randomized controlled trial data), admonishing clinicians to avoid recommending against caffeine consumption in order to reduce the risk of AF.⁵¹

Even fewer studies have focused on supraventricular tachycardia, comprising atrioventricular nodal reentrant tachycardia, atrioventricular reciprocating tachycardia, and atrial tachycardia, with the evidence favoring a reduced risk among caffeine consumers.⁴⁶

Studies have generally revealed no relationship between caffeine when consumed in amounts found in natural substances such as coffee and tea and premature atrial contractions,⁵² including a randomized controlled case-crossover study of caffeinated coffee examining premature atrial contraction frequency as the primary outcome.³⁸ In contrast, although several observational studies have failed to demonstrate a relationship between caffeinated beverages and premature ventricular contraction frequency, randomized trials have shown that caffeine, even when ingested in beverages in amounts commonly consumed in the general population, can increase premature ventricular contractions.^{38,53}

Caffeinated coffee has been associated with a lower risk of ventricular tachycardia in a large cohort study.⁴⁶ However, extremely high doses of caffeine, such as when consumed in capsule or powder form in amounts >10 times that found in a typical cup of coffee, have been reported to result in ventricular fibrillation and sudden death in multiple individual case reports.^{54,55}

Although bradyarrhythmias result in substantial morbidity, often require pacemaker implantation, and may have lethal consequences, relationships between either short-term use or long-term consumption of caffeine and such outcomes have not been rigorously examined.

Potential antiarrhythmic mechanisms of caffeine include vagolytic effects that may be especially relevant to AF, diuretic effects that may related to lowering of blood pressure, blockage of adenosine receptors, and anti-inflammatory effects.^{56–60}

Coronary Artery Disease

The results of early epidemiological studies raised the concern that coffee consumption may increase the risk of coronary artery disease (CAD). However, more rigorous prospective studies conducted in recent decades did not confirm these results.⁹ In a meta-analysis of 30 prospective cohort studies, consumption up to 6 cups of coffee per day was not associated with a higher risk of CAD. Furthermore, light (median, 1.5 cups/d) and moderate (median, 3.5 cups/d) coffee consumption was associated with an ≈10% lower CAD risk.⁹ Similarly, a recent analysis in the UK Biobank showed that consumption of up to 5 cups of coffee per day was associated with a lower risk than nonconsumption, with the lowest risk for 2 to 3 daily cups.⁵⁶ Modest decaffeinated coffee consumption was also associated with a lower CAD risk in prospective cohorts.^{56,61} Moreover, genetic predisposition to higher blood caffeine levels was not associated with CAD risk and did not modify the association between coffee consumption and CAD risk.⁶² These findings suggest that caffeine intake within the commonly consumed range does not affect the risk of CAD but that other coffee components may slightly reduce CAD risk. Consistent with results for generally healthy populations, coffee consumption was not associated with a higher risk of cardiovascular diseases or mortality in individuals with a history of myocardial infarction.⁵⁸

Heart Failure

Caffeine has various potential physiological effects that could influence heart failure risk. Although caffeine-induced changes in sympathetic tone, vascular resistance, and inotropy have been hypothesized, these effects are largely speculative and have not been rigorously studied, especially in the setting of chronic caffeine ingestion. Similarly, the association between caffeine and heart failure has not been evaluated in a randomized fashion.

Examination of the relationship between chronic caffeine consumption and heart failure risk has thus far been limited to large observational cohort studies. These studies were conceived to quantify the association between various exposures and cardiovascular outcomes; none were specifically designed to study the association between caffeine ingestion and heart failure risk. In addition, such investigations typically relied on administrative coding to identify heart failure outcomes, often limiting differentiation between heart failure with a reduced and heart failure with preserved ejection fraction. Last, most studies have focused primarily on coffee consumption, not overall caffeine ingestion.

Although an early observational study suggested an increased risk of heart failure with consumption of ≥5 cups of coffee per day,⁶⁴ multiple subsequent cohort studies, including the Physician's Health Study,⁶⁵ Swedish Mammography Cohort,⁶⁶ UK Biobank,⁶⁷ Framingham

Heart Study,⁶⁸ Cardiovascular Health Study,⁶⁸ and Atherosclerosis Risk in Communities study,⁶⁸ have observed either no risk or a moderately lower risk of heart failure with chronic coffee consumption. In several studies, the association between coffee consumption and heart failure was not linear; after combining data from multiple cohorts, a meta-analysis has demonstrated a J-shaped curve with less heart failure observed with low to moderate coffee consumption.⁶⁹ The lowest heart failure risk was observed for ≈ 4 cups of coffee per day. Cohort-specific analyses that estimated overall daily caffeine consumption by combining all dietary sources (including tea) have similarly demonstrated a lower heart failure risk with higher daily caffeine intake.⁶⁸ Consistent with these results, an analysis of participants in the CARDIA study (Coronary Artery Risk Development in Young Adults) revealed that low to moderate daily coffee consumption from early adulthood to middle age was associated with better left ventricular systolic and diastolic function in midlife, whereas high daily coffee consumption (>4 cups/d) was associated with worse left ventricular function.⁷⁰

Stroke

Evidence indicates a nuanced relationship between caffeine and caffeine-containing beverages and the risk of stroke. Mendelian randomization studies have found no causal link between plasma caffeine concentrations⁷¹ or caffeine intake.⁷² In contrast, observational cohort studies have generally found a lower risk of total and ischemic stroke among coffee drinkers compared with nondrinkers or those with low intake.⁷³ A dose-response meta-analysis of 20 cohort studies revealed a U-shaped association between coffee consumption and the risk of stroke, with the lowest risk observed at moderate coffee consumption (3–4 cups/d), corresponding to a 21% risk reduction.⁷³ In terms of coffee type, an inverse association was found for caffeinated coffee (based on 5 studies), whereas no significant association was observed for decaffeinated coffee (based on 3 studies).⁷³ However, a more recent analysis based on the UK Biobank showed that consumption of 4 or 5 or more cups of ground, instant, and decaffeinated coffee was associated with a lower risk of incident ischemic stroke.⁵⁶ Evidence from cohort studies also indicates a modest inverse association between tea consumption and stroke risk, with similar association for black and green tea.⁷⁴

CLINICAL AND PUBLIC HEALTH IMPLICATIONS

The convergence of evidence from large cohort studies and small randomized controlled trials supports the conclusion that moderate caffeine or coffee consumption (up to 400 mg/d caffeine or ≈ 3 –5 cups of coffee at 8 oz per cup) is safe for most adults and is associated with

lower risk of cardiovascular disease, including coronary heart disease, stroke, heart failure, and AF, as well as hypertension and type 2 diabetes. Indeed, large prospective cohort studies with long-term follow-up consistently demonstrate modest inverse associations between habitual coffee consumption and all-cause mortality across diverse populations. These associations are typically non-linear, with the lowest mortality risk observed at moderate levels of intake (2–4 cups/d), and are generally robust after adjustment for smoking and other lifestyle factors.⁷⁵ Similar inverse associations have been reported for both caffeinated and decaffeinated coffee, supporting the contribution of noncaffeine bioactive components.

The conclusions of this scientific statement are largely consistent with those from previous authoritative reviews^{57,76} and the 2015 Dietary Guidelines Advisory Committee report.⁷⁷ According to this evidence, habitual moderate coffee consumption can be part of a healthy lifestyle. Although coffee is the main source of caffeine for most adults, tea, coffee, chocolate, and energy drinks also contribute to overall caffeine intake. Acute effects of caffeine can include transient increases in blood pressure, blood sugar, and alertness, as well as palpitations or sleep disruption in some individuals. Individual differences in genetic variation in caffeine metabolism partially explain the variability in caffeine tolerance and clinical response, although there is insufficient evidence to demonstrate that they modify the effects of habitual coffee consumption on chronic diseases or mortality. Large amounts of added sugar, flavored syrups, and dairy products can substantially increase caloric intake and counteract potential health benefits associated with coffee itself. Last, as alluded to throughout this scientific statement, limitations of various study designs used should be considered in the interpretation of these results. For example, “healthy user bias” may be especially operative among research participants who consume substances such as caffeinated coffee in moderation.

CONCLUSIONS AND RESEARCH NEEDS

Caffeine has heterogeneous effects that can meaningfully affect cardiovascular risk factors and cardiovascular diseases themselves (Figure 2). Many studies suggest potential protective effects, but these often come from studies of coffee as a beverage rather than caffeine per se in what are usually observational cohort studies. Several areas of future research are worth pursuing, made all the more important given the near ubiquity of caffeine consumption among the general public. This includes more research using the randomized controlled trial design such as crossover or pragmatic trials whenever feasible. Research priorities include disentangling caffeine from other components of the beverages such as polyphenols, assessing individual differences in response, and examining dose-response and thresholds

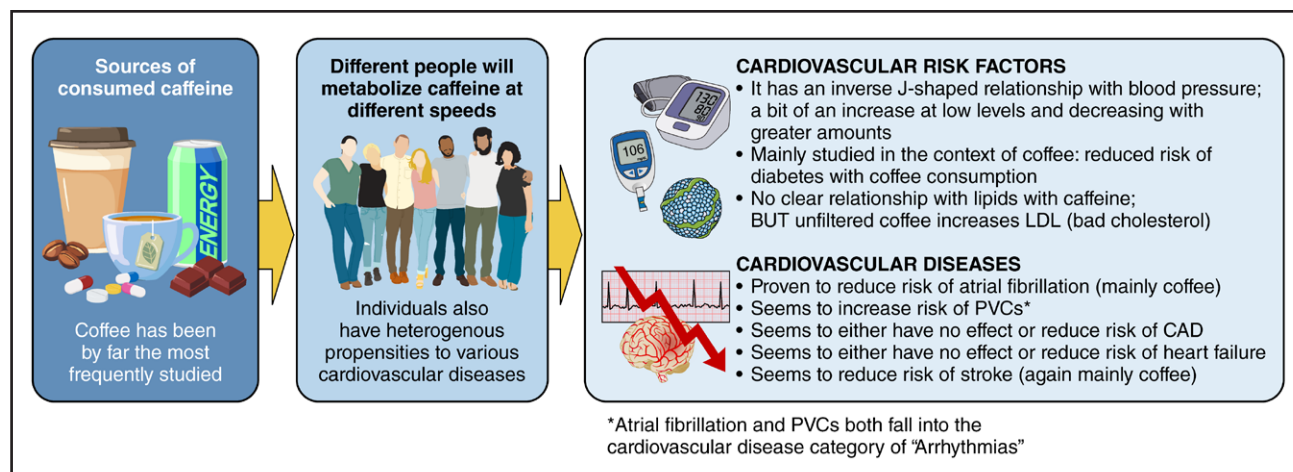


Figure 2. Relationships between caffeine, cardiovascular risk factors, and cardiovascular diseases.

CAD indicates coronary artery disease; LDL, low-density lipoprotein; and PVC, premature ventricular contraction.

in individuals with hypertension and other cardiovascular diseases. Because there is already substantial evidence of heterogeneous effects within individuals that may be genetically determined, elucidating those relationships will help the general public, health care professionals, and patients to tailor caffeine to individual risks and goals of care, improving risk stratification and personalization of recommendations. Potential health benefits that have been observed among individuals consuming caffeine that occurs in natural substances should not be extrapolated to synthetic products or high-dose caffeine. Indeed, although data on energy drinks are limited, available studies generally suggest cardiovascular harm. Last, in terms of applications of the potential beneficial effects of coffee intake, it is worth studying whether introducing or initiating regular coffee consumption among current abstainers yields positive cardiovascular health benefits.

personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This statement was approved by the American Heart Association Science Advisory and Coordinating Committee on March 27, 2026, and the American Heart Association Executive Committee on May 28, 2026. A copy of the document is available at <https://professional.heart.org/statements> by using either "Search for Guidelines & Statements" or the "Browse by Topic" area. To purchase additional reprints, call 215-356-2721 or email Meredith.Edelman@wolterskluwer.com

The American Heart Association requests that this document be cited as follows: Marcus GM, Hu FB, van Dam RM, Cornelis MC, Dewland TA, Kang J, Larsson SC, Page RL II, Parekh N, on behalf of the American Heart Association Council on Lifestyle and Cardiometabolic Health; Council on Clinical Cardiology; and Stroke Council. Caffeine and cardiovascular disease: a scientific statement from the American Heart Association. *Circulation*. 2026;154:e•••–e•••.

doi: 10.1161/CIR.0000000000001454

The expert peer review of AHA-commissioned documents (eg, scientific statements, clinical practice guidelines, systematic reviews) is conducted by the AHA Office of Science Operations. For more on AHA statements and guidelines development, visit <https://professional.heart.org/statements>. Select the "Guidelines & Statements" drop-down menu, then click "Publication Development"

Permissions: Multiple copies, modification, alteration, enhancement, and distribution of this document are not permitted without the express permission of the American Heart Association. Instructions for obtaining permission are located at <https://www.heart.org/permissions>. A link to the "Copyright Permissions Request Form" appears in the second paragraph (<https://www.heart.org/en/about-us/statements-and-policies/copyright-request-form>).

ARTICLE INFORMATION

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a

Disclosures

Writing Group Disclosures

Writing group member	Employment	Research grant	Other research support	Speakers' bureau/ honoraria	Expert witness	Ownership interest	Consultant/advisory board	Other
Gregory M. Marcus	University of California, San Francisco	None	None	None	None	None	None	None
Frank B. Hu	Harvard T.H. Chan School of Public Health	Analysis Group†	None	None	None	None	None	None
Marilyn C. Cornelis	Northwestern University Feinberg School of Medicine	None	None	None	None	None	Institute for the Advancement of Food and Nutrition Sciences: Caffeine Working Group (unpaid)*	None

(Continued)

Writing Group Disclosures (Continued)

Writing group member	Employment	Research grant	Other research support	Speakers' bureau/ honoraria	Expert witness	Ownership interest	Consultant/advisory board	Other
Thomas A. Dewland	University of California, San Francisco	None	None	None	None	None	Boston Scientific Corp (consulting fees)†	None
JungHee Kang	University of Kentucky College of Nursing	None	None	None	None	None	None	None
Susanna C. Larsson	Uppsala University, Department of Surgical Sciences (Sweden)	None	None	None	None	None	None	None
Robert L. Page II	University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences	None	None	None	None	None	None	None
Niyati Parekh	New York University, School of Global Public Health	None	None	None	None	None	None	None
Rob M. Van Dam	George Washington University, Milken Institute School of Public Health	None	None	None	None	None	None	None

This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit. A relationship is considered to be "significant" if (a) the person receives \$5000 or more during any 12-month period, or 5% or more of the person's gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns \$5000 or more of the fair market value of the entity. A relationship is considered to be "modest" if it is less than "significant" under the preceding definition.

*Modest.
†Significant.

Reviewer Disclosures

Reviewer	Employment	Research grant	Other research support	Speakers' bureau/ honoraria	Expert witness	Ownership interest	Consultant/ advisory board	Other
Christopher D. Black	University of Oklahoma	None	None	None	None	None	None	None
Christina Byrne	Copenhagen University Hospital–Rigshospitalet (Denmark)	None	None	None	None	None	None	None
Mohamad H. Khattab	Yale University School of Medicine	None	None	None	None	None	None	None
Peter M. Kistler	Baker Heart & Diabetes Institute (Australia)	None	None	None	None	None	None	None
Christopher X. Wong	University of Adelaide (Australia)	National Health and Medical Research Council of Australia (investigator grant)†	None	None	None	None	None	None

This table represents the relationships of reviewers that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all reviewers are required to complete and submit. A relationship is considered to be "significant" if (a) the person receives \$5000 or more during any 12-month period, or 5% or more of the person's gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns \$5000 or more of the fair market value of the entity. A relationship is considered to be "modest" if it is less than "significant" under the preceding definition.

†Significant.

REFERENCES

1. Lofthfield E, Freedman ND, Dodd KW, Vogtmann E, Xiao Q, Sinha R, Graubard BI. Coffee drinking is widespread in the United States, but usual intake varies by key demographic and lifestyle factors. *J Nutr*. 2016;146:1762–1768. doi: 10.3945/jn.116.233940

2. Mitchell DC, Knight CA, Hockenberry J, Teplansky R, Hartman TJ. Beverage caffeine intakes in the U.S. *Food Chem Toxicol*. 2014;63:136–142. doi: 10.1016/j.fct.2013.10.042

3. Reddy VS, Shiva S, Manikantan S, Ramakrishna S. Pharmacology of caffeine and its effects on the human body. *Eur J Med Chem Rep*. 2024;10:100138. doi: 10.1016/j.ejmcr.2024.100138

4. US Food and Drug Administration. Spilling the beans: how much caffeine is too much? 2024. Accessed October 3, 2025. <https://www.fda.gov/consumers/consumer-updates/spilling-beans-how-much-caffeine-too-much>

5. Nehlig A. Interindividual differences in caffeine metabolism and factors driving caffeine consumption. *Pharmacol Rev*. 2018;70:384–411. doi: 10.1124/pr.117.014407

6. Evans J, Richards JR, Battisti AS. Caffeine. *StatPearls*; 2026.

7. Melones-Pena N, Gomez-Gomez B, Gracia-Lor E. How much consumed caffeine is actually absorbed? Bioaccessibility and bioavailability in energy drinks, infusions and soft drinks. *Food Chem*. 2025;492:145626. doi: 10.1016/j.foodchem.2025.145626

8. Ding M, Bhupathiraju SN, Chen M, van Dam RM, Hu FB. Caffeinated and decaffeinated coffee consumption and risk of type 2 diabetes: a systematic review and a dose-response meta-analysis. *Diabetes Care*. 2014;37:569–586. doi: 10.2337/dc13-1203

9. Ding M, Bhupathiraju SN, Satija A, van Dam RM, Hu FB. Long-term coffee consumption and risk of cardiovascular disease: a systematic review and a dose-response meta-analysis of prospective cohort studies. *Circulation*. 2014;129:643–659. doi: 10.1161/CIRCULATIONAHA.113.005925

10. Manghi P, Bhosle A, Wang K, Marconi R, Selma-Royo M, Ricci L, Asnicar F, Golzato D, Ma W, Hang D, et al. Coffee consumption is associated with intestinal *Lawsonibacter asaccharolyticus* abundance and prevalence across multiple cohorts. *Nat Microbiol*. 2024;9:3120–3134. doi: 10.1038/s41564-024-01858-9

11. Yang A, Palmer AA, de Wit H. Genetics of caffeine consumption and responses to caffeine. *Psychopharmacology (Berl)*. 2010;211:245–257. doi: 10.1007/s00213-010-1900-1
12. Czajkowski N, Kendler KS, Torvik FA, Ystrom E, Rosenström T, Gillespie NA, Reichborn-Kjennerud T. Caffeine consumption, toxicity, tolerance and withdrawal; shared genetic influences with normative personality and personality disorder traits. *Exp Clin Psychopharmacol*. 2021;29:650–658. doi: 10.1037/pha0000429
13. Gunes A, Dahl ML. Variation in CYP1A2 activity and its clinical implications: influence of environmental factors and genetic polymorphisms. *Pharmacogenomics*. 2008;9:625–637. doi: 10.2217/14622416.9.5.625
14. Rasmussen BB, Brix TH, Kyvik KO, Brosten K. The interindividual differences in the 3-demethylation of caffeine alias CYP1A2 is determined by both genetic and environmental factors. *Pharmacogenetics*. 2002;12:473–478. doi: 10.1097/00008571-200208000-00008
15. Matthaei J, Tzvetkov MV, Strube J, Seht D, Sachse-Seebach C, Hjelmborg JB, Möller S, Halekoh U, Hofmann U, Schwab M, et al. Heritability of caffeine metabolism: environmental effects masking genetic effects on CYP1A2 activity but not on NAT2. *Clin Pharmacol Ther*. 2016;100:606–616. doi: 10.1002/cpt.444
16. Cornelis MC, Monda KL, Yu K, Paynter N, Azzato EM, Bennett SN, Berndt SI, Boerwinkle E, Chanock S, Chatterjee N, et al. Genome-wide meta-analysis identifies regions on 7p21 (AHR) and 15q24 (CYP1A2) as determinants of habitual caffeine consumption. *PLoS Genet*. 2011;7:e1002033. doi: 10.1371/journal.pgen.1002033
17. Zhong VW, Kuang A, Danning RD, Kraft P, van Dam RM, Chasman DI, Cornelis MC. A genome-wide association study of bitter and sweet beverage consumption. *Hum Mol Genet*. 2019;28:2449–2457. doi: 10.1093/hmg/ddz061
18. Cornelis MC, Byrne EM, Esko T, Nalls MA, Ganna A, Paynter N, Monda KL, Amin N, Fischer K, Renstrom F, et al; Coffee and Caffeine Genetics Consortium; International Parkinson's Disease Genomics Consortium (IP-DGC); North American Brain Expression Consortium (NABEC); UK Brain Expression Consortium (UKBE). Genome-wide meta-analysis identifies six novel loci associated with habitual coffee consumption. *Mol Psychiatry*. 2015;20:647–656. doi: 10.1038/mp.2014.107
19. Cornelis MC, Kacprowski T, Menni C, Gustafsson S, Pivn E, Adamski J, Artati A, Eap CB, Ehret G, Friedrich N, et al; Swiss Kidney Project on Genes in Hypertension (SKIPOGH) Team. Genome-wide association study of caffeine metabolites provides new insights to caffeine metabolism and dietary caffeine-consumption behavior. *Hum Mol Genet*. 2016;25:5472–5482. doi: 10.1093/hmg/ddw334
20. Nakagawa-Senda H, Hachiya T, Shimizu A, Hosono S, Oze I, Watanabe M, Matsuo K, Ito H, Hara M, Nishida Y, et al. A genome-wide association study in the Japanese population identifies the 12q24 locus for habitual coffee consumption: the J-MICC study. *Sci Rep*. 2018;8:1493. doi: 10.1038/s41598-018-19914-w
21. Matoba N, Akiyama M, Ishigaki K, Kanai M, Takahashi A, Momozawa Y, Ikegawa S, Ikeda M, Iwata N, Hirata M, et al. GWAS of 165,084 Japanese individuals identified nine loci associated with dietary habits. *Nat Hum Behav*. 2020;4:308–316. doi: 10.1038/s41562-019-0805-1
22. Thorpe HHA, Fontanillas P, Pham BK, Meredith JJ, Jennings MV, Courchesne-Krak NS, Vilar-Ribó L, Bianchi SB, Mutz J, Elson SL, et al; 23andMe Research Team. Genome-wide association studies of coffee intake in UK/US participants of European ancestry uncover cohort-specific genetic associations. *Neuropsychopharmacology*. 2024;49:1609–1618. doi: 10.1038/s41386-024-01870-x
23. Woolf B, Cronjé HT, Zagkos L, Larsson SC, Gill D, Burgess S. Comparison of caffeine consumption behavior with plasma caffeine levels as exposure measures in drug-target mendelian randomization. *Am J Epidemiol*. 2024;193:1776–1784. doi: 10.1093/aje/kwae143
24. Hartley TR, Sung BH, Pincomb GA, Whitsett TL, Wilson MF, Lavallo WR. Hypertension risk status and effect of caffeine on blood pressure. *Hypertension*. 2000;36:137–141. doi: 10.1161/01.hyp.36.1.137
25. Zhong J, Huang S, Dong S, Zheng W, Tong S. Intake of coffee and blood pressure: a mendelian randomized study. *Nutr Metab Cardiovasc Dis*. 2025;36:104273. doi: 10.1016/j.numecd.2025.104273
26. Zhang Z, Hu G, Caballero B, Appel L, Chen L. Habitual coffee consumption and risk of hypertension: a systematic review and meta-analysis of prospective observational studies. *Am J Clin Nutr*. 2011;93:1212–1219. doi: 10.3945/ajcn.110.004044
27. Kujawska A, Kujawski S, Hajec W, Skierkowska N, Kwiatkowska M, Husejko J, Newton JL, Simoes JA, Zalewski P, Kędziora-Kornatowska K. Coffee consumption and blood pressure: results of the second wave of the Cognition of Older People, Education, Recreational Activities, Nutrition, Comorbidities, and Functional Capacity Studies (COPERNICUS). *Nutrients*. 2021;13:3372. doi: 10.3390/nu13103372
28. Gualberto PIB, Benvindo VV, Wacławsky G, Deresz LF. Acute effects of energy drink consumption on cardiovascular parameters in healthy adults: a systematic review and meta-analysis of randomized clinical trials. *Nutr Rev*. 2024;82:1028–1045. doi: 10.1093/nutri/nuad112
29. Samavat S, Ashtary-Larky D, Naeini F, Nazarian B, Kashkooli S, Clark CCT, Bagheri R, Asbaghi O, Babaali M, Goudarzi MA, et al. The effects of green coffee bean extract on blood pressure and heart rate: a systematic review and dose-response meta-analysis of randomized controlled trials. *Diabetes Metab Syndr*. 2024;18:103120. doi: 10.1016/j.dsx.2024.103120
30. Grinberg N, Benkhedda K, Barber J, Krahn AD, La Vieille S. Effects of caffeinated energy drinks on cardiovascular responses during exercise in healthy adults: a systematic review and meta-analysis of randomized controlled trials. *Appl Physiol Nutr Metab*. 2022;47:618–631. doi: 10.1139/apnm-2021-0807
31. West KS, Helwig NJ, Schwager LE, Hart TW, Zucker AC, Venenga JS, Flores M, Jenkins NDM. Habitual preexercise caffeine supplementation prevents exercise training-induced attenuation of exercising systolic blood pressure and double product. *J Appl Physiol (1985)*. 2025;138:358–365. doi: 10.1152/jappphysiol.00874.2024
32. Sartorelli DS, Fagherazzi G, Balkau B, Touillaud MS, Boutron-Ruault MC, de Launay-Guilain B, Clavel-Chapelon F. Differential effects of coffee on the risk of type 2 diabetes according to meal consumption in a French cohort of women: the E3N/EPIC cohort study. *Am J Clin Nutr*. 2010;91:1002–1012. doi: 10.3945/ajcn.2009.28741
33. Floegel A, Pischon T, Bergmann MM, Teucher B, Kaaks R, Boeing H. Coffee consumption and risk of chronic disease in the European Prospective Investigation Into Cancer and Nutrition (EPIC)-Germany study. *Am J Clin Nutr*. 2012;95:901–908. doi: 10.3945/ajcn.111.023648
34. Bhupathiraju SN, Pan A, Malik VS, Manson JE, Willett WC, van Dam RM, Hu FB. Caffeinated and caffeine-free beverages and risk of type 2 diabetes. *Am J Clin Nutr*. 2013;97:155–166. doi: 10.3945/ajcn.112.048603
35. Reis CEG, Dórea JG, da Costa THM. Effects of coffee consumption on glucose metabolism: a systematic review of clinical trials. *J Tradit Complement Med*. 2019;9:184–191. doi: 10.1016/j.jtcme.2018.01.001
36. Ohnaka K, Ikeda M, Maki T, Okada T, Shimazoe T, Adachi M, Nomura M, Takayanagi R, Kono S. Effects of 16-week consumption of caffeinated and decaffeinated instant coffee on glucose metabolism in a randomized controlled trial. *J Nutr Metab*. 2012;2012:207426. doi: 10.1155/2012/207426
37. Marcus GM. Coffee's effects on cardiac arrhythmias, physical activity, sleep and serum glucose: insights from the Coffee and Real-time Atrial and Ventricular Ectopy trial. *Clin Transl Med*. 2023;13:e1348. doi: 10.1002/ctm2.1348
38. Marcus GM, Rosenthal DG, Nah G, Vittinghoff E, Fang C, Ogomori K, Joyce S, Yilmaz D, Yang V, Kessedjian T, et al. Acute effects of coffee consumption on health among ambulatory adults. *N Engl J Med*. 2023;388:1092–1100. doi: 10.1056/NEJMoa2204737
39. van Dam RM. Coffee consumption and risk of type 2 diabetes, cardiovascular diseases, and cancer. *Appl Physiol Nutr Metab*. 2008;33:1269–1283. doi: 10.1139/H08-120
40. Urgert R, Katan MB. The cholesterol-raising factor from coffee beans. *J R Soc Med*. 1996;89:618–623. doi: 10.1177/014107689608901107
41. Bak AA, Grobbee DE. Caffeine, blood pressure, and serum lipids. *Am J Clin Nutr*. 1991;53:971–975. doi: 10.1093/ajcn/53.4.971
42. Schoeneck M, Iggman D. The effects of foods on LDL cholesterol levels: a systematic review of the accumulated evidence from systematic reviews and meta-analyses of randomized controlled trials. *Nutr Metab Cardiovasc Dis*. 2021;31:1325–1338. doi: 10.1016/j.numecd.2020.12.032
43. Cornelis MC, van Dam RM. Habitual coffee and tea consumption and cardiometabolic biomarkers in the UK Biobank: the role of beverage types and genetic variation. *J Nutr*. 2020;150:2772–2788. doi: 10.1093/jn/nxaa212
44. Krittananawong C, Tunhasirwet A, Wang Z, Farrell AM, Chirapongsathorn S, Zhang H, Kitai T, Mehta D. Is caffeine or coffee consumption a risk for new-onset atrial fibrillation? A systematic review and meta-analysis. *Eur J Prev Cardiol*. 2020;28:e13–e15. doi: 10.1177/2047487320908385
45. Casiglia E, Tikhonoff V, Albertini F, Gasparotti F, Mazza A, Montagnana M, Danese E, Benati M, Spinella P, Palatini P. Caffeine intake reduces incident atrial fibrillation at a population level. *Eur J Prev Cardiol*. 2018;25:1055–1062. doi: 10.1177/2047487318772945
46. Kim EJ, Hoffmann TJ, Nah G, Vittinghoff E, Delling F, Marcus GM. Coffee consumption and incident tachyarrhythmias: reported behavior, mendelian randomization, and their interactions. *JAMA Intern Med*. 2021;181:1185–1193. doi: 10.1001/jamainternmed.2021.3616

47. Yuan S, Larsson SC. No association between coffee consumption and risk of atrial fibrillation: a mendelian randomization study. *Nutr Metab Cardiovasc Dis*. 2019;29:1185–1188. doi: 10.1016/j.numecd.2019.07.015
48. Wong CX, Cheung CC, Montenegro G, Oo HH, Pena JJ, Tang JJ, Tu SJ, Wall G, Dewland TA, Moss JD, et al. Caffeinated coffee consumption or abstinence to reduce atrial fibrillation: the DECAF randomized clinical trial. *JAMA*. 2025;335:317. doi: 10.1001/jama.2025.21056
49. Liu DC, Yan JJ, Wang YN, Wang ZM, Xie ZY, Ma Y, Yang Y, Yang L, Wang LS. Low-dose green tea intake reduces incidence of atrial fibrillation in a Chinese population. *Oncotarget*. 2016;7:85592–85602. doi: 10.18632/oncotarget.12243
50. Mattioli AV, Pennella S, Farinetti A, Manenti A. Energy drinks and atrial fibrillation in young adults. *Clin Nutr*. 2018;37:1073–1074. doi: 10.1016/j.clnu.2017.05.002
51. Joglar JA, Chung MK, Armbruster AL, Benjamin EJ, Chyou JY, Cronin EM, Deswal A, Eckhardt LL, Goldberger ZD, Gopinathannair R, et al. 2023 ACC/AHA/ACCP/HRS guideline for the diagnosis and management of atrial fibrillation: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines [published corrections appear in *Circulation*. 2024;149:e167, *Circulation*. 2024;149:e936, and *Circulation*. 2024;149:e1413]. *Circulation*. 2024;149:e1–e156. doi: 10.1161/CIR.0000000000001193
52. Dixit S, Stein PK, Dewland TA, Dukes JW, Vittinghoff E, Heckbert SR, Marcus GM. Consumption of caffeinated products and cardiac ectopy. *J Am Heart Assoc*. 2016;5:e002503. doi: 10.1161/jaha.115.002503
53. Hasebe H, Yoshida K, Furiyashiki Y, Nogami A, Ieda M. Oral caffeine intake amplifies the effect of isoproterenol in patients with frequent premature ventricular contractions. *Europace*. 2020;22:1261–1269. doi: 10.1093/europace/evaa069
54. Martinez KA, Bains S, Neves R, Giudicessi JR, Bos JM, Ackerman MJ. Sudden cardiac arrest occurring in temporal proximity to consumption of energy drinks. *Heart Rhythm*. 2024;21:1083–1088. doi: 10.1016/j.hrthm.2024.02.018
55. Riku S, Yamamoto T, Kubota Y, Ichii T, Jinno Y, Suzuki S, Murohara T. Refractory ventricular fibrillation caused by caffeine intoxication. *J Cardiol Cases*. 2018;18:210–212. doi: 10.1016/j.jccase.2018.08.003
56. Chieng D, Canovas R, Segun L, Sugumar H, Voskoboinik A, Prabhu S, Ling L-H, Lee G, Morton JB, Kaye DM, et al. The impact of coffee subtypes on incident cardiovascular disease, arrhythmias, and mortality: long-term outcomes from the UK Biobank. *Eur J Prev Cardiol*. 2022;29:2240–2249. doi: 10.1093/eurjpc/zwac189
57. Dewland TA, van Dam RM, Marcus GM. Coffee and cardiovascular disease. *Eur Heart J*. 2025;46:3546–3554. doi: 10.1093/eurheartj/ehaf421
58. Mandayam MC, Vedantham V, Scheinman MM, Tseng ZH, Badhwar N, Lee BK, Lee RJ, Gerstenfeld EP, Olgin JE, Marcus GM. Alcohol and vagal tone as triggers for paroxysmal atrial fibrillation. *Am J Cardiol*. 2012;110:364–368. doi: 10.1016/j.amjcard.2012.03.033
59. Marcus GM, Whooley MA, Glidden DV, Pawlikowska L, Zaroff JG, Olgin JE. Interleukin-6 and atrial fibrillation in patients with coronary artery disease: data from the Heart and Soul Study. *Am Heart J*. 2008;155:303–309. doi: 10.1016/j.ahj.2007.09.006
60. Aviles RJ, Martin DO, Apperson-Hansen C, Houghtaling PL, Rautaharju P, Kronmal RA, Tracy RP, Van Wagener DR, Psaty BM, Lauer MS, et al. Inflammation as a risk factor for atrial fibrillation. *Circulation*. 2003;108:3006–3010. doi: 10.1161/01.CIR.0000103131.70301.4F
61. Freedman ND, Park Y, Abnet CC, Hollenbeck AR, Sinha R. Association of coffee drinking with total and cause-specific mortality. *N Engl J Med*. 2012;366:1891–1904. doi: 10.1056/NEJMoa1112010
62. Zhou A, Hypponen E. Long-term coffee consumption, caffeine metabolism genetics, and risk of cardiovascular disease: a prospective analysis of up to 347,077 individuals and 8368 cases. *Am J Clin Nutr*. 2019;109:509–516. doi: 10.1093/ajcn/nqy297
63. Ribeiro EM, Alves M, Costa J, Ferreira JJ, Pinto FJ, Caldeira D. Safety of coffee consumption after myocardial infarction: a systematic review and meta-analysis. *Nutr Metab Cardiovasc Dis*. 2020;30:2146–2158. doi: 10.1016/j.numecd.2020.07.016
64. Wilhelmsen L, Rosengren A, Eriksson H, Lappas G. Heart failure in the general population of men: morbidity, risk factors and prognosis. *J Intern Med*. 2001;249:253–261. doi: 10.1046/j.1365-2796.2001.00801.x
65. Bodar V, Chen J, Gaziano JM, Albert C, Djousse L. Coffee consumption and risk of atrial fibrillation in the Physicians' Health Study. *J Am Heart Assoc*. 2019;8:e011346. doi: 10.1161/JAHA.118.011346
66. Levitan EB, Ahmed HN, Mittleman MA, Wolk A. Coffee consumption and incidence of heart failure in women. *Circ Heart Fail*. 2011;4:414–418. doi: 10.1161/CIRCHEARTFAILURE.111.960898
67. Han Q, Chu J, Hu W, Liu S, Sun N, Chen X, He Q, Feng Z, Li T, Wu J, et al. Association between coffee and incident heart failure: a prospective cohort study from the UK Biobank. *Nutr Metab Cardiovasc Dis*. 2023;33:2119–2127. doi: 10.1016/j.numecd.2023.07.011
68. Stevens LM, Linstead E, Hall JL, Kao DP. Association between coffee intake and incident heart failure risk: a machine learning analysis of the FHS, the ARIC study, and the CHS. *Circ Heart Fail*. 2021;14:e006799. doi: 10.1161/CIRCHEARTFAILURE.119.006799
69. Mostofsky E, Rice MS, Levitan EB, Mittleman MA. Habitual coffee consumption and risk of heart failure: a dose-response meta-analysis. *Circ Heart Fail*. 2012;5:401–405. doi: 10.1161/CIRCHEARTFAILURE.112.967299
70. Nwabuo CC, Betoko AS, Reis JP, Moreira HT, Vasconcellos HD, Guallar E, Cox C, Sidney S, Ambale-Venkatesh B, Lewis CE, et al. Coffee and tea consumption in the early adult lifespan and left ventricular function in middle age: the CARDIA study. *ESC Heart Fail*. 2020;7:1510–1519. doi: 10.1002/ehf2.12684
71. Larsson SC, Woolf B, Gill D. Appraisal of the causal effect of plasma caffeine on adiposity, type 2 diabetes, and cardiovascular disease: two sample mendelian randomisation study. *BMJ Med*. 2023;2:1–8. doi: 10.1136/bmjmed-2022-000335
72. Nordestgaard AT, Nordestgaard BG. Coffee intake, cardiovascular disease and all-cause mortality: observational and mendelian randomization analyses in 95000–223000 individuals. *Int J Epidemiol*. 2016;45:1938–1952. doi: 10.1093/ije/dyw325
73. Shao C, Tang H, Wang X, He J. Coffee consumption and stroke risk: evidence from a systematic review and meta-analysis of more than 2.4 million men and women. *J Stroke Cerebrovasc Dis*. 2021;30:105452. doi: 10.1016/j.jstrokecerebrovasdis.2020.105452
74. Chung M, Zhao N, Wang D, Shams-White M, Karlsen M, Cassidy A, Ferruzzi M, Jacques PF, Johnson EJ, Wallace TC. Dose-response relation between tea consumption and risk of cardiovascular disease and all-cause mortality: a systematic review and meta-analysis of population-based studies. *Adv Nutr*. 2020;11:790–814. doi: 10.1093/advances/nmaa010
75. Kim Y, Je Y, Giovannucci E. Coffee consumption and all-cause and cause-specific mortality: a meta-analysis by potential modifiers. *Eur J Epidemiol*. 2019;34:731–752. doi: 10.1007/s10654-019-00524-3
76. van Dam RM, Hu FB, Willett WC. Coffee, caffeine, and health. *N Engl J Med*. 2020;383:369–378. doi: 10.1056/NEJMr1816604
77. US Department of Health and Human Services and US Department of Agriculture. 2015–2020 Dietary Guidelines for Americans, 8th Edition. US Department of Agriculture; 2020.