HIV Disease Activity as a Modulator of Lipoprotein(a) and Allele-Specific Apolipoprotein(a) Levels

Byambaa Enkhmaa, Erdembileg Anuurad, Wei Zhang, Adnan Abbuthalha, Xiao-Dong Li, William Dotterweich, Richard B. Pollard, David M. Asmuth, Lars Berglund

Objective—Mechanisms underlying the cardiovascular risk of lipoprotein(a) are poorly understood. We investigated the relationship of apolipoprotein(a) (apo(a)) size, lipoprotein(a), and allele-specific apo(a) levels with HIV disease activity parameters in a biethnic population.

Methods and Results—Lipoprotein(a) and allele-specific apo(a) levels were determined in 139 white and 168 black HIV-positive patients. Plasma HIV RNA viral load and CD4+ T-cell count were used as surrogates for disease activity. Lipoprotein(a) and allele-specific apo(a) levels were higher in blacks than whites (for both $P<0.001$). Apo(a) allele size distribution was similar between the 2 ethnic groups, with a median apo(a) size of 28 kringle 4 repeats. Allele-specific apo(a) levels were positively associated with CD4+ T-cell count ($P=0.027$) and negatively with plasma HIV RNA viral load ($P<0.001$). Further, allele-specific apo(a) levels associated with smaller (<28 kringle 4) atherogenic apo(a) sizes were higher in subjects with CD4+ T-cell counts of $\geq 350$ ($P=0.002$).

Conclusion—Allele-specific apo(a) levels were higher in subjects with high CD4+ T-cell count or low plasma HIV RNA viral load. The findings suggest that HIV disease activity reduced allele-specific apo(a) levels. Higher allele-specific apo(a) levels associated with atherogenic small apo(a) sizes might contribute to increased cardiovascular risk in HIV-positive subjects with improved disease status. (Arterioscler Thromb Vasc Biol. 2013;33:387-392.)

Key Words: Lp(a) apo(a) size HIV CD4+ T-cells cardiovascular risk

Cardiovascular disease (CVD) is the number 1 cause of mortality worldwide, and in the United States alone, >2200 people die of CVD each day, an average of 1 death every 39 seconds. It is projected that annual global CVD mortality will increase from 16.7 million in 2002 to 23.9 million by 2030. The HIV pandemic over the last decades has been identified as an important contributor to CVD mortality rates. A recent meta-analysis confirmed a significantly increased risk of CVD in HIV-infected versus uninfected people, and virus type, treatment, and disease activity (CD4+ T-cell count) were associated with elevated risk of CVD. Further, the Strategies for Management of Antiretroviral Therapy identified an increased cardiovascular-associated mortality rate among study subjects who interrupted antiretroviral therapy (ART). Although a number of traditional risk factors have been shown to contribute to an excess risk of CVD in HIV patients, the exact mechanisms underlying this increased risk are not well understood. This issue warrants further investigations, as CVD is likely to be one of the major conditions in the future to be confronted by people living with HIV.

A large body of genetic and epidemiological evidence now suggests a direct association between an elevated plasma lipoprotein(a) (Lp(a)) level and an increased risk of CVD. Lp(a) levels are, to a major extent, regulated by genetics, and thus less affected by nongenetic factors. The defining component of Lp(a)—apolipoprotein(a) (apo(a))—has an extensive size polymorphism with repeated loop structures, so called kringle (K), where one motif, K4 type 2, is present in multiple copies. Although smaller apo(a) sizes tend to associate with higher Lp(a) levels, leading to a high risk of CVD, there is considerable variability in Lp(a) levels for any given apo(a) size. Irrespective of size differences, Lp(a) levels vary across ethnicities with the most profound differences between populations of African compared with non-African, that is, European or Asian, descent. Beyond plasma Lp(a) levels, use of allele-specific apo(a) levels assessing the amount of Lp(a) associated with a defined apo(a) allele size provides a key characteristic of risk conveyed by Lp(a). In support of this concept, elevated Lp(a) levels for smaller apo(a) sizes were associated with coronary artery disease in black and white men. The contribution of Lp(a) plasma levels and apo(a) size variation to the observed increased risk of CVD in HIV patients has not been determined. Conversely, there is a paucity of data with regard to how HIV disease activity might impact cardiovascular risk associated with Lp(a). To explore these issues, we investigated the associations among Lp(a),
apo(a) size, allele-specific apo(a) levels, and HIV disease activity, as determined by CD4+ T-cell count and plasma HIV RNA viral load (pVL) in a biethnic HIV-patient cohort.

**Patients and Methods**

**Subjects**

Subjects were recruited from a HIV-positive patient population followed at the Center for AIDS Research, Education, and Services Clinic in Sacramento, CA. The samples used in this study were obtained from a repository established to examine the biological differences among sex, racial, and ethnic groups in response to HIV infection, and their complications. The demographic distribution of the enrolled subjects was predetermined to reflect the demographics of the clinic and the local HIV epidemic as a whole, with an intended overrepresentation of minorities to strengthen the power of analysis in these groups. Subjects were recruited into the cohort, irrespective of HIV disease or ART status. Samples from a total of 307 patients self-identified as whites (n=139) and blacks (n=168) were analyzed in this study.

HIV-negative black and white subjects were from the Harlem and Basset cohort study. The clinical characteristics of this cohort and study design, including exclusion and inclusion criteria, have been described in our previous studies, and exclusion criteria included the use of lipid-lowering drugs, as well as hormone-replacement therapy. The study was approved by the Institutional Review Board at University of California Davis, and informed consent was obtained from all study participants.

**Determination of Disease Activity and Plasma Lipid and Lipoprotein Levels**

Plasma HIV RNA quantification was performed using the Abbott Real-Time PCR HIV viral load assays (Abbott Laboratories, Abbott Park, IL). CD4+ T-cell counts were measured at local reference laboratories. Fasting blood samples were obtained, and plasma was separated and stored at −80°C before analysis. Concentrations of triglycerides (Sigma Diagnostics, St. Louis, MO), total and high-density lipoprotein (HDL) cholesterol (Roche, Sommerville, NJ), and glucose (Roche, Sommerville, NJ) were determined using standard enzymatic procedures. HDL cholesterol levels were measured after precipitation of apoB-containing lipoproteins with dextran sulphate. Plasma Lp(a) levels were measured by an apo(a) size-insensitive sandwich ELISA (Mercodia Inc, Uppsala, Sweden).

**Statistics**

Analysis of data was done with SPSS statistical analysis software (SPSS Inc, Chicago, IL). Results were expressed as means±SD or median (interquartile range) for non-normally distributed variables. Triglyceride and pVL were logarithmically transformed, and Lp(a) and allele-specific apo(a) levels were square-root transformed before statistical analyses. Both the larger and smaller apo(a) isoforms of subjects with 2 distinguishable bands and 1 isoform of subjects with a single band were considered for statistical analyses. Group means were compared using Student’s t test. The univariate relationship between allele-specific apo(a) levels and other variables, such as disease activity parameters, were described by Pearson correlation coefficients. All analyses were 2-tailed, and P<0.05 were considered statistically significant.

**Results**

The clinical characteristics of study participants are shown in Table 1. The mean age, body weight, and body mass index were similar in whites and blacks. There were no significant differences in the levels of low-density lipoprotein cholesterol and glucose between the 2 ethnic groups. Blacks tended to have higher levels of HDL cholesterol (51 mg/dL versus 46 mg/dL), although the difference was not statistically significant. As expected, blacks had significantly higher Lp(a) (39 mg/dL versus 11 mg/dL, P<0.001) and lower triglyceride (118 mg/dL versus 140 mg/dL, P=0.002) levels compared with whites. These clinical characteristics in HIV-positive subjects were comparable with those of HIV-negative subjects (Table I in the online-only Data Supplement). CD4+ T-cell

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Whites (n=139)</th>
<th>Blacks (n=168)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men/women*, n</td>
<td>90/48</td>
<td>105/58</td>
<td>NS</td>
</tr>
<tr>
<td>Age, y</td>
<td>47.2±8.5</td>
<td>48.0±8.4</td>
<td>NS</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>82.3±16.8</td>
<td>85.2±19.3</td>
<td>NS</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>27.3±5.8</td>
<td>28.4±6.3</td>
<td>NS</td>
</tr>
<tr>
<td>CD4+ T-cell count, cells/mm³</td>
<td>505±294</td>
<td>442±268</td>
<td>NS</td>
</tr>
<tr>
<td>Plasma viral load, copies/mL</td>
<td>50 (48–4241)</td>
<td>63 (48–12736)</td>
<td>NS</td>
</tr>
<tr>
<td>Plasma viral load, log₉, copies/mL</td>
<td>1.70 (1.68–3.63)</td>
<td>1.80 (1.68–4.11)</td>
<td>NS</td>
</tr>
<tr>
<td>LDL cholesterol, mg/dL</td>
<td>99±34</td>
<td>91±33</td>
<td>NS</td>
</tr>
<tr>
<td>HDL cholesterol, mg/dL</td>
<td>46±17</td>
<td>51±20</td>
<td>NS</td>
</tr>
<tr>
<td>Lipoprotein(a), mg/dL</td>
<td>11 (2–26)</td>
<td>39 (16–77)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Triglyceride, mg/dL</td>
<td>140 (106–213)</td>
<td>118 (81–167)</td>
<td>0.002</td>
</tr>
<tr>
<td>Glucose, mg/dL</td>
<td>92±15</td>
<td>101±48</td>
<td>NS</td>
</tr>
</tbody>
</table>

BMI indicates body mass index; NS, nonsignificant; LDL, low-density lipoprotein; and HDL, high-density lipoprotein.

Values are expressed as mean±SD and median (interquartile range) for non-normally distributed values. Values for triglycerides and plasma viral load were logarithmically transformed, and values for lipoprotein(a) were square-root transformed before analyses. *A total of 6 subjects (1 white and 5 blacks) fell into category of transgender.
count and pVL did not differ between the 2 ethnic groups for the HIV-positive subjects (Table 1).

We next analyzed the apo(a) size distribution and allele-specific apo(a) levels across ethnicity. Notably, the median apo(a) size was 28 K4 repeats in both whites and blacks. Consistent with the results of plasma Lp(a) levels, allele-specific apo(a) levels were significantly elevated in blacks versus whites (23 mg/dL versus 9 mg/dL, \(P<0.001\)). Next, we dichotomized apo(a) sizes by using the median apo(a) size (28 K4 repeats). As seen in Figure 1, allele-specific apo(a) levels associated with smaller apo(a) sizes (<28 K4 repeats) were significantly higher compared with allele-specific apo(a) levels associated with larger apo(a) sizes (22 K4 repeats) in both ethnic groups (12 mg/dL versus 7 mg/dL in whites and 37 mg/dL versus 15 mg/dL in blacks, respectively, \(P<0.001\) for both groups).

We examined the relationship of allele-specific apo(a) levels with HIV disease activity, as determined by CD4+ T-cell count and pVL. For all subjects, allele-specific apo(a) levels were significantly and positively associated with CD4+ T-cell count (\(r=0.106, P=0.027\)) and negatively with pVL (\(r=-0.180, P<0.001\)). When the analyses were done separately for the 2 ethnic groups, the corresponding associations were significant in blacks (\(r=0.158, P=0.009\) for CD4+ T-cell count and \(r=-0.232, P<0.001\) for pVL), but not in whites.

To investigate the associations between allele-specific apo(a) levels and HIV disease activity parameters in more depth, we divided the subjects into 2 groups based on CD4+ T-cell counts (above and below 350 cells/mm³; Table 2 and Figure 2). The median apo(a) size and levels of low-density lipoprotein cholesterol and HDL cholesterol or triglycerides did not differ across the CD4+ T-cell groups for either ethnic group. Regardless of ethnicity, allele-specific apo(a) levels were elevated among patients with CD4+ T-cell count of \(\geq 350\) cells/mm³ compared with <350 cells/mm³ (10 mg/dL versus 7 mg/dL, \(P=0.015\) in whites and 26 mg/dL versus 22 mg/dL, \(P=0.011\) in blacks, respectively; Figure 2). As seen in Figure 3, patients with CD4+ T-cell count of \(\geq 350\) cells/mm³ had significantly increased allele-specific apo(a) levels associated with smaller apo(a) sizes (<28 K4 repeats). In

Table 2. Associations Between Lp(a), Allele-Specific Apo(a) and Other Plasma Lipid and Lipoproteins With Disease Activity Assessed by CD4+ T-Cell Count

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>CD4+ T-Cell Count (Cells/mm³)</th>
<th>(P) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;350</td>
<td>(\geq350)</td>
</tr>
<tr>
<td>Whites, n</td>
<td>43</td>
<td>91</td>
</tr>
<tr>
<td>Lipoprotein(a), mg/dL</td>
<td>12 (2–25)</td>
<td>12 (2–30)</td>
</tr>
<tr>
<td>Allele-specific apo(a), mg/dL</td>
<td>7 (3–18)</td>
<td>10 (5–24)</td>
</tr>
<tr>
<td>Kringle 4 repeats, n</td>
<td>29 (23–32)</td>
<td>28 (23–31)</td>
</tr>
<tr>
<td>LDL cholesterol, mg/dL</td>
<td>98±34</td>
<td>99±34</td>
</tr>
<tr>
<td>HDL cholesterol, mg/dL</td>
<td>45±18</td>
<td>47±17</td>
</tr>
<tr>
<td>Triglyceride, mg/dL</td>
<td>125 (101–243)</td>
<td>142 (112–207)</td>
</tr>
<tr>
<td>Blacks, n</td>
<td>62</td>
<td>100</td>
</tr>
<tr>
<td>Lipoprotein(a), mg/dL</td>
<td>34 (15–52)</td>
<td>50 (17–92)</td>
</tr>
<tr>
<td>Allele-specific apo(a), mg/dL</td>
<td>22 (11–33)</td>
<td>26 (11–51)</td>
</tr>
<tr>
<td>Kringle 4 repeats, n</td>
<td>28 (26–30)</td>
<td>27 (24–30)</td>
</tr>
<tr>
<td>LDL cholesterol, mg/dL</td>
<td>99±34</td>
<td>91±33</td>
</tr>
<tr>
<td>HDL cholesterol, mg/dL</td>
<td>50±21</td>
<td>52±20</td>
</tr>
<tr>
<td>Triglyceride, mg/dL</td>
<td>99 (79–150)</td>
<td>127 (88–170)</td>
</tr>
</tbody>
</table>

Lp(a) indicates lipoprotein(a); apo(a), apolipoprotein(a); NS, nonsignificant; LDL, low-density lipoprotein; and HDL, high-density lipoprotein. Data are expressed as mean±SD or median (interquartile range) for non-normally distributed variables.
contrast, for larger (≥28 K4 repeats) apo(a) sizes, allele-specific apo(a) levels did not differ significantly across CD4+ T-cell count groups in either whites or blacks. Furthermore, when we dichotomized the cohort based on pVL, subjects with pVL of <1000 copies/mL had significantly elevated allele-specific apo(a) levels compared with those in subjects with pVL of ≥1000 copies/mL (19 mg/dL versus 13 mg/dL, respectively, P=0.001).

**Discussion**

This is the first study examining Lp(a), apo(a) size heterogeneity, and allele-specific apo(a) levels in relation to HIV disease activity and ethnicity. Consistent with many earlier studies in HIV-negative subjects,12,22 Lp(a) and allele-specific apo(a) levels were significantly elevated in blacks compared with whites in this HIV-positive cohort also. In addition, allele-specific apo(a) levels were elevated among patients with an improved HIV disease status, that is, with higher CD4+ T-cell counts and lower pVL, irrespective of ethnic background. Another important finding was that Lp(a) levels associated with smaller, more atherogenic apo(a) sizes were increased in patients with higher CD4+ T-cell counts and lower pVL. These findings suggest a modulation of Lp(a) risk factor properties (ie, allele-specific apo(a) levels) by HIV disease activity. Our findings further suggest that, although being considered as one of the most inheritable quantitative traits in human,9 Lp(a) levels can be affected by a clinically relevant nongenetic factor, that is, HIV disease status.

Many studies have reported that HIV-infected subjects are at increased risk of CVD compared with uninfected subjects.23,24 This was confirmed in a recent meta-analysis, where virus type, treatment, and disease activity, as determined by CD4+ T-cell count, were associated with elevated risk of CVD.3 Infection with HIV causes persistent immune-activation associated with CD4+ T-cell loss, HIV pVL, and disease progression, as well as a number of significant anthropometric and metabolic alterations, including dyslipidemia.25 HIV-positive patients in our cohort had comparatively low levels of low-density lipoprotein cholesterol, as well as triglyceride levels within the normal range, and these levels did not significantly differ between the high and low CD4+ T-cell count groups.

Furthermore, accumulating evidence now supports an association between ART and CVD in HIV-positive patients. An initial report by the large prospective observational Data Collection on Adverse Events of Anti-HIV Drugs (D:A:D) study demonstrated a positive association between highly active antiretroviral therapy and myocardial infarction.26 Subsequent reports indicated an association between protease inhibitor use and CVD.27,28 The use of nucleotide reverse transcriptase inhibitors was associated with increased rates of MI, after adjustment for the predicted 10-year risk of coronary heart disease.28 Another large prospective observational study, the French Hospital Database on HIV study, showed that administration of protease inhibitors resulted in a 2.5-fold increased risk of MI compared with patients not taking the treatment.29 Although we were unable to directly assess the potential impact of ART in our cohort, all subjects with pVL of >1000 copies/mL mainly represent treatment naive status in our clinic population. The findings of elevated allele-specific apo(a) levels in subjects with pVL of <1000 copies/mL compared with those in subjects with pVL of ≥1000 copies/mL suggest that elevated Lp(a) levels associated with smaller atherogenic apo(a) sizes may contribute to the increased risk of CVD in ART-treated HIV patients. Our findings of increased Lp(a) levels in patients with improved disease activity extend previous findings. Periard et al30 reported an increase in Lp(a) levels among protease inhibitor-treated HIV patients with pretreatment apo(a) levels >20 mg/dL. In contrast, Constans et al31 reported no difference in Lp(a) levels across different CD4+ T-cell count groups among HIV patients. However, in the latter study, Lp(a) levels were expressed as means, and importantly, allele-specific apo(a) levels were not analyzed. In a longitudinal study in 15 HIV patients, median Lp(a) levels were significantly increased in parallel with the progression of HIV disease.32 Further studies directly assessing the relationship between ART and allele- or isofom-associated Lp(a) levels are therefore warranted.

![Figure 2](http://atvb.ahajournals.org/)
The focus on apo(a) sizes and allele-specific apo(a) levels in the present study represents an expanded scope compared with previous studies, allowing a more detailed assessment of molecular properties. Lp(a) levels are largely determined by synthesis, and although the synthetic rate of both smaller and larger apo(a) isoforms within any given individual is subject to genetic regulation, our results suggest that an improvement of immune status and a decrease in pVL among HIV-positive individuals may preferentially impact smaller apo(a) size isoforms. This pattern resulting in higher Lp(a) levels associated with smaller apo(a) sizes was seen in both blacks and whites. Although there is a strong inverse relation between apo(a) size and Lp(a) levels, differences in apo(a) size distribution is unlikely to contribute to the observed findings. First, apo(a) size distribution in the present HIV-positive subjects was similar to the distribution reported for HIV-negative subjects. Second, as for HIV-negative subjects, the median apo(a) size was similar for whites and blacks in our HIV cohort. Finally, the apo(a) size distribution was similar between the 2 groups of HIV-positive subjects across CD4+ T-cell levels for both blacks and whites. Taken together, these findings indicate that the observed differences in allele-specific apo(a) levels across ethnicity and disease activity were not explained by differences in the apo(a) size distribution. Notably, some studies that have failed to detect an association between Lp(a) and coronary artery disease in blacks were based on either plasma Lp(a) levels or apo(a) isoform sizes alone, emphasizing the importance of allele-specific apo(a) levels.

Inflammation plays a key role in the development of atherosclerotic CVD involving several types of immunocytes, such as activated macrophages, T-cells, and mast cells. Previously, we have shown that a higher inflammatory burden increases Lp(a) levels associated with smaller apo(a) sizes in HIV-negative whites and blacks at high risk of CVD. Notably, increased levels of inflammatory markers have also been found in patients appropriately treated for HIV disease. In a combined analysis from the Women’s Interagency HIV Study and the Multicenter AIDS Cohort Study, the initiation of effective ART was associated with an apparent increase in C-reactive protein levels. Although it is tempting to suggest that HIV- and ART-induced inflammation that remains even after an adequate control of disease activity might contribute to the observed high allele-specific apo(a) levels, further studies are needed to address this possibility. Plasma markers of thrombosis and endothelial damage have been shown to better predict risk of CVD in HIV-positive populations. Ford et al reported an independent association between CVD risk and D-dimer, a soluble product of fibrinogen breakdown and a marker of thrombosis, in addition to conventional risk factors such as smoking and family history. This association persisted even after taking confounders into account. Interestingly, pVL was not associated with increased CVD risk; instead HIV patients were more likely to have lower pVL before a CVD event in this cohort. Because of its structural similarity to plasminogen, Lp(a) also participates in fibrinolysis exerting a prothrombotic effect, and our findings of increased allele-specific apo(a) levels associated with more atherogenic smaller apo(a) sizes at low pVL may therefore contribute to the observed increased risk in HIV patients.

Our study has some limitations. First, results were based on cross-sectional measurements of Lp(a) and disease activity parameters. Second, although we included both blacks and whites, further studies are needed to extend our findings to other racial and ethnic populations. Third, we were unable to address the potential impact of ART directly, although all subjects with pVL ≤1000 copies/mL mainly represent treatment naïve status in our clinic population. Strengths of our study include enrollment of 2 populations with differing characteristics of CVD risk factors, including Lp(a) levels. Second, it is the first study to report on the associations between HIV disease activity and Lp(a), with an emphasis on apo(a) size. Third, we assessed HIV disease activity with both CD4+ T-cell count and pVL. The findings of the current study contribute to our overall understanding of increased cardiovascular risk in HIV-positive population and emphasize the need for further studies focusing on emerging comprehensive risk factor assessment. In addition, the findings suggest that studies under HIV conditions may provide opportunities to better understand the regulation of Lp(a) levels and apo(a) molecular properties.

In conclusion, allele-specific apo(a) levels were higher in subjects with high CD4+ T-cell count or low pVL. The findings suggest that HIV disease activity reduced allele-specific apo(a) levels. Higher allele-specific apo(a) levels associated with atherogenic small apo(a) sizes might contribute to an increased cardiovascular risk in subjects with improved HIV disease status.

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Disclosures
None.

References
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