In Vivo Magnetic Resonance Evaluation of Atherosclerotic Plaques in the Human Thoracic Aorta: A Comparison With Transesophageal Echocardiography

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Background—The structure and composition of aortic atherosclerotic plaques are associated with the risk of future cardiovascular events. Magnetic resonance (MR) imaging may allow accurate visualization and characterization of aortic plaques.

Methods and Results—We developed a noninvasive MR method, free of motion and blood flow artifacts, for submillimeter imaging of the thoracic aortic wall. MR imaging was performed on a clinical MR system in 10 patients with aortic plaques identified by transesophageal echocardiography (TEE). Plaque composition, extent, and size were assessed from T1-, proton density-, and T2-weighted images. Comparison of 25 matched MR and TEE cross-sectional aortic plaque images showed a strong correlation for plaque composition ($\chi^2 = 43.5, P<0.0001; 80\%$ overall agreement; n=25) and mean maximum plaque thickness ($r=0.88, n=25; 4.56\pm0.21\text{ mm by MR and }4.62\pm0.31\text{ mm by TEE}$). Overall aortic plaque extent as assessed by TEE and MR was also statistically significant ($\chi^2 = 61.77, P<0.0001; 80\%$ overall agreement; n=30 regions).

Conclusions—This study demonstrates that noninvasive MR evaluation of the aorta compares well with TEE imaging for the assessment of atherosclerotic plaque thickness, extent, and composition. This MR method may prove useful for the in vivo study of aortic atherosclerosis. (Circulation. 2000;101:2503-2509.)

Key Words: atherosclerosis ▪ magnetic resonance imaging ▪ aorta ▪ echocardiography ▪ plaque

Aortoartery studies have shown that the amount of athero-
sclerotic plaque in the thoracic aorta directly correlates
with the degree of atherosclerotic disease in the coronary
arteries. Furthermore, thoracic aortic atherosclerosis is
a stronger predictor of coronary artery disease (CAD) than
conventional risk factors and is also a marker of increased
mortality, stroke, and visceral thromboembolic events. Ex-
amination of the descending thoracic aorta by transesopha-
geal echocardiography (TEE) and by fast computed tomo-
graphy (CT) is used to predict CAD and cardiovascular risk.

MR is a noninvasive imaging modality that can visualize
and characterize the composition of carotid atherosclerotic
plaques in vivo based on MR signal intensity. The principal
challenges associated with MR imaging of thoracic aorta are
obtaining sufficient sensitivity for submillimeter imaging and
exclusion of artifacts due to respiratory motion and blood
flow. This study presents the use of an MR imaging method
for the assessment of atherosclerotic plaque size, extent,
and composition in the thoracic aorta. The results show that
the MR findings compare well with those obtained from TEE
imaging. Therefore, MR may be a powerful noninvasive
imaging tool for directly detecting aortic atherosclerotic
plaques.

Methods

Patients

From a cohort of patients referred for TEE to rule out a cardiac or thoracic source of thromboemboli, 10 patients (average age 63.6 years; range 31 to 82 years; 8 men, 2 women; 3 with peripheral emboli, 4 with transient ischemic attacks, and 3 with stroke) were identified with evidence of atherosclerotic plaques ($\geq 2\text{ mm in thickness}$) in the descending thoracic aorta. MR imaging was performed in these patients after informed consent in a form approved by the institutional review board was obtained. MR studies were conducted within 39±13 days (mean±SEM) of the TEE examination. Three of the patients received warfarin anticoagulation between TEE and MRI. MR imaging was conducted without knowledge of the specific TEE results for each patient.

Transesophageal Echocardiography

TEE was performed by a physician (T.N. or M.G.) using a 7-MHz multiplane probe (ATL HDI 300 or Sequoia, Acuson). All patients were mildly sedated with Demerol (Sanofi Winthrop) and/or Versed (Roche Laboratories). With the patient in the lateral decubitus position, the TEE probe was advanced toward the level of the
diaphragm (typically 40 to 45 cm from the incisors), then a gradual pullback was performed. For each patient, all images were recorded on super VHS videotape in real time for display and evaluation. During the real-time examination, the position of aortic plaques (≥2 mm in thickness) with respect to the TEE probe (distance from dental incisors and origin of the left subclavian artery) and extent of each plaque were carefully recorded for later analysis. Images were obtained in the horizontal and vertical planes. However, only horizontal-plane TEE images were compared with the MR images.

**MR Imaging**

MR was performed on a 1.5-T Signa (General Electric Medical Systems) Echospeed (capable of delivering 2.2 G/cm with a rise time of 184 μs) or cardiovascular MR system (capable of delivering 4.0 G/cm with a rise time of 147 μs). Images were obtained with fast gradient-echo, conventional spin-echo (SE), and optimized double-inversion-recovery fast spin-echo (FSE) sequences. A body coil was used for excitation. A 4-element (2 anterior elements and 2 posterior elements) phased-array coil was used for signal reception to obtain an improved signal-to-noise ratio.10 Patients were positioned supine, and ECG electrodes were attached to trigger data acquisition.

Fast gradient-echo images were acquired initially in the coronal and sagittal planes. Transverse T1-weighted (T1W) ECG-gated images of the entire descending thoracic aorta were obtained with respiratory compensation, 20-cm field-of-view (FOV), 256 × 160 to 192 acquisition matrix, no phase wrap, 2-signal averaging (NSA), respiratory compensation, 20-cm field-of-view (FOV), 256 × 160 to 192 acquisition matrix, no phase wrap, 2-signal averaging (NSA), and ECG electrode were attached to trigger data acquisition.

The flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed. 12 Flow-inversion pulses were placed before the period of fast flow, ensuring that signal from flowing blood was adequately suppressed.

Atherosclerotic plaque characterization by MR was based on the signal intensities and morphological appearance of the plaque on T1W, PDW, and T2W images, as validated previously. 8 Lipid components were defined as echoluent regions within the plaque that were not attributable to attenuation caused by dense reflections. Fibrocellular components were defined as hyperechogenic reflections within the plaque presented by dense echoes without acoustic shadowing. Thrombotic plaques had irregularities of the plaque luminal surface and had a laminated or “layered” appearance, with variable echogenicity and sometimes a thin border of relative echolucency.7

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maximum plaque thickness was evaluated further by the approach of Bland and Altman\textsuperscript{16} by calculating the mean ($d$) and SD ($\sigma_d$) of the difference. From these data, the limits of agreements ($d-2\sigma_d$ and $d+2\sigma_d$) were calculated. Values are expressed as mean±SEM. A $P$ value <0.05 was considered statistically significant.

### Results

Before patient imaging, 6 young asymptomatic subjects (mean age 27 years; range 25 to 32 years; 3 men) were used for parameter optimization for aortic imaging with the double-inversion-recovery FSE sequence. Some of the parameters that were modified and optimized include ESP, ETL, acquisition matrix size, FOV, slice thickness, receiver bandwidth, TE, NSA, inversion slice thickness, and chemical shift suppression pulses. The images were assessed qualitatively, and the parameters that best visualized the aortic wall were chosen.

A typical image of the descending thoracic aorta in a normal subject is shown in Figure 1. This image demonstrates the results obtained with the optimized double-inversion-recovery FSE sequence, with excellent flow suppression. The normal aortic wall appears thin and of uniform thickness in both the ascending and descending aorta (Figure 1).

The MR imaging protocol described in Methods was kept constant for all patients except when image quality was severely compromised by respiratory motion artifacts. Then, breath-holding was used (3 of 10 patients). Also, in 2 patients, a chemical shift suppression pulse was used to improve visualization of small atherosclerotic plaques (<3 mm maximum thickness).

### Plaque Characterization

For each of the 10 patients, 1 to 5 plaques (≥2 mm thick) in the descending thoracic aorta, for a total of 25 plaques, were prospectively identified from the TEE data sets. The 25 TEE cross-sectional aortic plaque images were matched (anatomically and visually) with 25 MR slices containing the identical plaques.

All aortic plaques that were identified by TEE were also detected by MR (100%). Each of the 25 plaques was characterized according to the AHA criteria given in Methods. Comparison of the TEE and MR characterization showed 80% (20 of 25 segments) overall agreement (Table 1). There was a statistically significant correlation between the TEE and MR data for plaque characterization ($\chi^2=43.50$, $P<0.0001$).

MR and TEE images of a patient with a lipid-rich (type IV/Va) aortic plaque in the descending thoracic aorta are shown in Figure 2. Note the increased wall thickness in the descending thoracic aorta in the patient (Figure 2) compared with the normal subject (Figure 1). Another patient with an AHA type VI (thrombus and rupture) plaque in an ectatic descending aorta is shown in Figure 3. The site of plaque rupture is shown in Figure 3A (arrow).

### Plaque Extent

There was 80% (24 of 30 segments) overall agreement between TEE and MR findings (Table 2). There was a strong correlation between the TEE and MR findings for plaque extent ($\chi^2=61.77$, $P<0.0001$; $n=30$).

A patient with severe diffuse disease in the descending thoracic aorta is shown in Figure 4. The MR images show aortic plaques with different morphological and compositional characteristics.

### Maximum Plaque Thickness

The 25 TEE and MR matched cross-sectional aortic plaque images were used for the study of maximum plaque thickness. Mean maximum plaque thickness as measured by TEE and MR was 4.62±0.31 and 4.56±0.21 mm, respectively. The difference was not statistically significant ($P=0.68$).

There was a strong correlation between maximum plaque thickness measurements with both imaging modalities (correlation coefficient 0.88, $n=25$). Results from the Bland-Altman analysis are presented in Figure 5. As shown in Figure 5, the mean and SD of the difference were small ($d=0.056$ mm and $\sigma_d=0.66$ mm), and $>95\%$ of the differences were within the limits of agreement (−1.27 and 1.38 mm).

### Table 1. Thoracic Aortic Plaque Characterization by TEE and MR

<table>
<thead>
<tr>
<th>TEE</th>
<th>MR</th>
<th>IV/Va</th>
<th>Vb</th>
<th>Vc</th>
<th>VI</th>
<th>Total</th>
</tr>
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<td></td>
<td></td>
<td>10</td>
<td>2</td>
<td>0</td>
<td>1</td>
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<td></td>
<td>1</td>
<td>4</td>
<td>0</td>
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<td>5</td>
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<td></td>
<td>12</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>25</td>
</tr>
</tbody>
</table>

MR and TEE aortic cross sections were graded according to AHA classifications.\textsuperscript{14} There was 80% overall agreement between TEE and MR classification ($\chi^2=43.50$, $P<0.0001$).

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Discussion

In the present study, we evaluated the descending thoracic aortic wall using a fast MR technique that allows in vivo imaging of atherosclerotic plaque. We demonstrated that MR can assess aortic plaque composition, extent, and size. The MR findings closely correlated with TEE (the current noninvasive clinical “gold standard”) examination in the same patients.

Autopsy\(^1\) and TEE\(^2\) studies have shown that thoracic aortic atherosclerosis is a significant marker for coronary disease. In fact, parameters such as aortic wall thickness, luminal irregularities, and plaque composition are strong predictors of future vascular events.\(^7,17\) For example, using TEE, the French Study of Aortic Plaques in Stroke (FAPS) investigators\(^7,17\) found a significantly increased risk of all vascular events (stroke, myocardial infarction, peripheral embolism, and cardiovascular death) for patients who had noncalcified aortic plaques \(>4\) mm in thickness. These noncalcified plaques were thought to be lipid-laden plaques (AHA types IV/Va), which in coronary arteries are considered to be prone to rupture and thrombosis.\(^18\)

MR imaging has several advantages over currently available cardiovascular risk factor assessment methods and imaging modalities. MR is safe and noninvasive. Adult MR exams usually do not require injections, sedation, or anesthesia. Although not demonstrated in the present study, MR can detect atherosclerotic plaques at all locations in the aorta, including the aortic root,\(^11\) ascending aorta, and aortic arch, as

Figure 2. In vivo MR images from patient with 4.5-mm-thick plaque in descending thoracic aorta. A, T1W; B, PDW; C, T2W; D, corresponding TEE image. MR images show an example of AHA type IV/Va plaque with dark area in center (arrow) identified on T2W image as a lipid-rich core (C). Lipid-rich core is separated from lumen by fibrous cap. Plaque characterization was based on information obtained from T1W, PDW, and T2W MR images as described in text.

Figure 3. Complex 14-mm-thick AHA type VI lesion in descending thoracic aorta from a patient is shown on T2W images. Rupture in plaque is shown (arrow in A). A few centimeters below image in panel A, AHA type VI plaque with increased wall thickness and irregular surface (arrow) is shown in panel B. Left anterior descending (LAD) and left circumflex (LCx) coronary arteries are clearly seen (A). LV indicates left ventricle.
well as the descending thoracic and abdominal aorta. Examination of the carotid and peripheral arteries, brain, myocardium, and even the epicardial coronary arteries (Figures 3 and 4) may be performed during the same session. However, MR examination can be limited by claustrophobia, some arrhythmias and irregular heart rhythms, and implanted metallic devices.

Ex vivo aortic, carotid, peripheral, and coronary artery plaque characterization with MR is well validated.\(^8,15,19\) It was shown that MR accurately discriminates among the different plaque components of the carotid arteries in vivo using high-resolution T1W, T2W, and PDW images.\(^8\) A recent study by Moody and colleagues\(^9\) showed that carotid artery thrombus in patients with a recent stroke can be visualized with T1W MR.

Prior MR methods for clinical aortic imaging were hampered by severe blood flow and respiratory artifacts. This study demonstrates that the use of double-inversion-recovery–optimized FSE MR sequence with a short ESP value and rapid image acquisition limits these artifacts. Although not demonstrated in the present study, mobile plaque components may be evaluated with fast cine MR imaging or real-time MR imaging.\(^20\)

In the present study, there was good agreement between TEE and MR assessment of aortic plaque type (Table 1), plaque extent (Table 2), and maximum plaque thickness (Figure 5). In fact, there was 80% overall agreement between MR and TEE findings for both plaque type and extent. This compares well with a recent study showing 73% agreement between aortic plaques imaged in vivo with TEE and pathological findings after resection.\(^6\) The differences between TEE and MR assessments may be due to several factors. Three of the patients received warfarin anticoagulation between TEE and MRI. The data show that for these patients, the maximum plaque thickness was higher on TEE than on MRI, and this may be due to anticoagulant therapy between the time of TEE and MRI. Artifacts occur frequently with TEE,\(^21\) thus limiting the number of aortic image slices that could be compared with the corresponding MR images. Aortic calcification may make TEE assessment difficult as well. Moreover, there are several ultrasound parameters (eg, system gain and axial and lateral resolution) that interfere with accurate atherosclerotic plaque characterization by TEE.\(^22\) Finally, ultrasound is not a discriminator of chemical composition\(^23\); thus, it is difficult to differentiate AHA type VI

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**Table 2. Thoracic Aortic Plaque Extent by TEE and MR**

<table>
<thead>
<tr>
<th>TEE</th>
<th>Normal</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Mild</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Moderate</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>8</td>
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<tr>
<td>Severe</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>30</td>
</tr>
</tbody>
</table>

There was 80% overall agreement between TEE and MR findings ($\chi^2=61.77; P<0.0001$).

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**Figure 4. T2W MR images from patient with severe diffuse disease in descending thoracic aorta. Plaques are different in appearance and characteristics from one location to another. Insets in each panel represent magnified view of descending thoracic aorta. A, Type Vc (fibrotic) plaque. B, Type Vb (calcified) plaque. C and D, Lipid-rich plaques (type IV/Va). MR images are 5 mm thick and acquired with no interslice gap and are displayed cephalad (A) to caudal (D). Origin of right coronary artery (RCA) is clearly seen taking off from aortic root (Ao). Arrows in insets indicate plaque and its components.**
Our study is limited in its detection of thrombus. For example, the signal from intraplaque thrombus changes with time. Therefore, new MR contrast techniques such as diffusion imaging\(^{25}\) may prove more sensitive and accurate in the detection of thrombus. In addition, the use of respiratory motion compensation techniques such as MR navigators\(^{26}\) could further reduce respiratory motion artifacts and alleviate the use of breath-holding altogether.

Interobserver and intraobserver reliability of MR imaging, as well as sensitivity and specificity of our proposed criteria, must be documented in a larger number of patients. There is a potential for misregistration and measurement errors between the MR and TEE images. We carefully matched (visually and anatomically) the MR images with the corresponding TEE cross-sectional images using external anatomic structures as fiducial references. Our matching procedure is prone to error and is a limitation of this study. Computer-aided registration and 3D reconstruction methods can improve on this limitation and improve the measurement. In addition, studies that examine the cost-effectiveness of MR examination are needed.

In conclusion, we have demonstrated that MR is a method for direct noninvasive assessment of aortic atherosclerotic plaque thickness, extent, and composition. MR may allow the serial evaluation of progression and therapy-induced regression of atherosclerotic plaques.

**Acknowledgments**

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**References**


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