Gas Exchange Detection of Exercise-Induced Right-to-Left Shunt in Patients With Primary Pulmonary Hypertension

Xing-Guo Sun, MD; James E. Hansen, MD; Ronald J. Oudiz, MD; Karlman Wasserman, MD, PhD

Background—Because of high pulmonary vascular resistance in patients with primary pulmonary hypertension (PPH), right atrial pressure may exceed left atrial pressure during exercise, resulting in a right-to-left shunt via a patent foramen ovale (PFO). This shunting would disturb arterial Pco2 and H+ homeostasis if the pulmonary blood were not simultaneously hyperventilated to compensate for the high CO2 and H+ in the shunted blood. This article first hypothesizes and then describes unique changes in gas exchange when right-to-left exercise-induced shunting (EIS) occurs.

Methods and Results—Retrospectively, the cardiopulmonary exercise tests of 71 PPH patients were studied. Criteria postulated to document hyperventilation of the pulmonary blood flow due to a right-to-left EIS were (1) an abrupt and sustained increase in end-tidal O2 with a simultaneous sustained decrease in end-tidal CO2; (2) an abrupt and sustained increase in the respiratory exchange ratio; and (3) usually, an associated decline in pulse oximetry saturation. Each patient was evaluated for a PFO with resting echocardiography. The investigators interpreting the gas exchange evidence of EIS were blinded to the echocardiographic readings. Forty-five percent of the patients had demonstrable EIS by gas exchange criteria. Almost all were also positive for a PFO by echocardiography. Using the resting echocardiogram as the reference, the sensitivity, specificity, positive and negative predictive values, and accuracy were all between 90% to 96%.

Conclusions—Exercise-induced right-to-left shunting can be detected by noninvasive, cardiopulmonary exercise testing in patients with PPH. (Circulation. 2002;105:54-60.)

Key Words: shunts • echocardiography • exercise • hypertension, pulmonary

Patients with right-to-left intracardiac shunts regulate arterial Pco2 and pH by hyperventilating unshunted lung blood flow to compensate for the high CO2 content in shunted blood. During clinical cardiopulmonary exercise testing (CPET) of patients with primary pulmonary hypertension (PPH), we frequently observed gas exchange patterns indicating acute hyperventilation of pulmonary blood flow, suggesting shunting via a patent foramen ovale (PFO).

In normal persons, right-to-left shunting via a PFO is unlikely because left atrial pressure exceeds right atrial pressure. However, with abnormally high pulmonary vascular resistance (as in PPH), right atrial pressure can exceed left atrial pressure, especially during exercise, and force venous (low PO2 and high Pco2 and H+) blood through a PFO directly into the systemic circulation, stimulating systemic arterial chemoreceptors and causing hyperventilation of the unshunted pulmonary blood flow. This compensatory hyperventilation increases CO2 unloading, thereby maintaining arterial Pco2 and H+ homeostasis, despite the presence of an exercise-induced right-to-left shunt (EIS).

The objective of the present study was to describe the specific gas exchange changes that can be used to identify those patients with PPH who develop an EIS.
Detection of EIS by Gas Exchange Criteria
Three author-investigators (graders), who were blinded regarding all identifying patient information and echocardiographic findings, independently reviewed the 9-panel CPET plots using the following criteria to identify an EIS at the start of unloaded cycling exercise: (1) an abrupt and sustained increase in end-tidal O₂ (PETO₂), with a simultaneous, sustained decrease in end-tidal CO₂ (PETCO₂) (Figure 1, panel 9); (2) an abrupt and sustained increase in the respiratory exchange ratio (RER = CO₂ elimination/oxygen consumption [V˙CO₂/V˙O₂]); Figure 1, panel 8), and (3) usually, an associated SpO₂ decline (Figure 1, panel 9).

Echocardiography
All patients underwent resting transthoracic echocardiography with Valsalva maneuvers and bubble studies.7–10 The great majority had >1 echocardiogram on different days. In addition, ~1 of 10 had transesophageal echocardiography. If an atrial right-to-left shunt was detected during any echocardiographic study, the patient was categorized as PFO-positive (PFO+); if not, the patient was categorized as PFO-negative (PFO−).

Separation of PPH Patients into Groups
Using the above criteria applied to the 9-panel CPET graphic array, the 71 CPET studies were independently graded as either EIS-positive (EIS+) or EIS-negative (EIS−) by 3 graders. Two graders also used tabular data to aid in their decision-making when the changes in the graphic data were less obvious. Patients who were PFO+ by echocardiography and unanimously EIS+ were placed in the shunt group; those who were PFO− by echocardiography and unanimously EIS− were placed in the no-shunt group. Any PFO+ patient categorized as EIS− or any PFO− patient categorized as EIS+ by any grader was placed in the discordant group. During this process, all 3 graders independently identified 3 patients who were EIS− during unloaded cycling but converted to EIS+ near the end of their CPET; these were excluded from the grouping.

Statistical Analyses
Data are expressed as mean±SD, except where specifically noted. Most CPET values are expressed as a percent of predicted value.2,3,11,12 Repeated ANOVA with 2-tailed Scheffe tests were used to identify differences between groups; paired t tests were used to identify changes from rest.13,14 P<0.05 was considered significant. Sensitivity, specificity, and predictive values of EIS detection of shunt were calculated,14 despite knowing that a PFO induced during exercise might be unrecognizable during resting echocardiography.

Results
Similarities of PPH Groups at Rest and Peak Exercise
All CPET studies were completed without adverse events. The demographics of the shunt, no-shunt, discordant, and
control groups were similar (Table 1). Except for a higher ventilatory equivalent for CO$_2$ (VE/VCO$_2$) at the anaerobic threshold and a higher slope of VE versus VCO$_2$, all of the peak exercise CPET findings of the 3 PPH patient groups were similar to each other (Table 1) but dissimilar from findings in the control group.

**Differences in Gas Exchange Between Shunt and No-Shunt Groups**

Figure 2 contrasts key CPET measurements that distinguish 2 representative PPH patients (one EIS+ and one EIS−) from a normal subject. Figure 3 describes the second-by-second mean values at rest and during the 3 minutes of unloaded cycling exercise for the same variables in the shunt, no-shunt, and control groups. In the CPET groups, gas exchange was impaired at rest (low PETCO$_2$ with high ventilatory equivalent for O$_2$ [VE/VO$_2$], VE/VCO$_2$, and PETO$_2$), with the PETCO$_2$ lowest in the shunt group (Figures 2 and 3). After beginning unloaded cycling, the shunt group abruptly decreased their PETCO$_2$, while the PETO$_2$, VE/VCO$_2$, and RER concurrently abruptly increased (Figures 2 and 3). Shortly thereafter, the SpO$_2$ declined in most of the shunt patients. In contrast to the shunt group, the no-shunt group showed lesser changes in PETO$_2$, PETCO$_2$, RER, VE/VCO$_2$, and SpO$_2$.

Table 2 summarizes the changes in PETO$_2$, PETCO$_2$, VE/VO$_2$, VE/VCO$_2$, RER, VE, and SpO$_2$ from rest to the end of unloaded cycling that distinguish the shunt group from the no-shunt group and the statistical significance of these changes. However, by the end of unloaded cycling, all groups had normal and similar increases in VO$_2$ and VCO$_2$.

**The Late-Developing EIS**

Figure 4 depicts 1 of 3 patients who developed unmistakable gas exchange evidence of a late-developing EIS during CPET, just before stopping. As with an EIS during unloaded cycling, a late-developing EIS is characterized by abrupt and striking decreases in PETCO$_2$ and SpO$_2$, with concurrent striking increases in PETO$_2$, RER, and VE/VCO$_2$ more than VE/VCO$_2$. This patient was PFO− on repeated echocardiography. Her CPET pattern persisted until 2 years after starting epoprostenol therapy, at which time no further CPET evidence of EIS was noted, reflecting her improvement. The second patient had a similar late-developing EIS, but was PFO− by echocardiography at the time of CPET. Two years previously, before treatment, she had been PFO+ by echocardiography. The third patient with CPET changes typical of a late-developing EIS was PFO− on repeated echocardiography.

**Grouping of PPH Patients**

Excluding the 3 patients with a late-developing EIS, Figure 5 shows the distribution of the 68 patients among the shunt (n=18) and no-shunt (n=39) groups (all 3 graders agreed) and the discordant group (n=11).

If the resting echocardiogram was used as a reference for PFO detection, the overall sensitivity and specificity for CPET EIS detection would be 90% and 96%, respectively (Table 3). Overall, PFO+ PPH patients would also be CPET EIS+ 94% of the time, whereas PFO− PPH patients would be EIS− 95% of the time. Within the discordant group, echocardiography documented a PFO in 6 patients (Figure 5), but 2 of them had been PFO− on one or more other echocardiographic studies, illustrating the inconsistent nature of shunting, even at rest.

Considering all 71 PPH patients, 18 were early EIS+ (by all 3 graders) and PFO+, 6 others were PFO+ and EIS+ by the evaluations of 1 or 2 graders (Figure 5), and 3 others were late EIS+ by all 3 graders. Thus, 38% [(18+6+3=21)/71=38%] had convincing evidence for right-to-left shunting during CPET. Five others (Figure 5), although PFO−, had

**Table 1. Demographics and CPET Parameters in PPH Patients and Control Subjects**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Shunt (n=18)</th>
<th>No Shunt (n=39)</th>
<th>Discordant (n=11)</th>
<th>Control Subjects (n=20)</th>
</tr>
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<tbody>
<tr>
<td>Age, y</td>
<td>42±12</td>
<td>44±12</td>
<td>38±14</td>
<td>42±13</td>
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<tr>
<td>Sex, female/male</td>
<td>16/2</td>
<td>33/6</td>
<td>11/0</td>
<td>17/3</td>
</tr>
<tr>
<td>Height, cm</td>
<td>161±9</td>
<td>164±9</td>
<td>164±10</td>
<td>165±7</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>73±21</td>
<td>73±17</td>
<td>70±16</td>
<td>64±12</td>
</tr>
<tr>
<td>NYHA class</td>
<td>3.0±0.6</td>
<td>2.7±0.6</td>
<td>2.8±0.4</td>
<td>...</td>
</tr>
<tr>
<td>Peak VO$_2$, %pred</td>
<td>40±12</td>
<td>46±14</td>
<td>43±13</td>
<td>104±16*</td>
</tr>
<tr>
<td>Peak WR, %pred</td>
<td>32±13</td>
<td>40±18</td>
<td>37±15</td>
<td>108±25*</td>
</tr>
<tr>
<td>Peak HR, %pred</td>
<td>76±8</td>
<td>77±13</td>
<td>74±11</td>
<td>96±13*</td>
</tr>
<tr>
<td>Peak VE, %MVV</td>
<td>52±12</td>
<td>45±14</td>
<td>48±12</td>
<td>70±15*</td>
</tr>
<tr>
<td>AT, %pred</td>
<td>53±15</td>
<td>61±16</td>
<td>58±16</td>
<td>101±19*</td>
</tr>
<tr>
<td>V/E vs VCO$_2$ slope, %pred</td>
<td>205±71†</td>
<td>151±22</td>
<td>176±40</td>
<td>98±13*</td>
</tr>
<tr>
<td>Ve vs VCO$_2$ slope, %pred</td>
<td>210±110†</td>
<td>137±27</td>
<td>164±46</td>
<td>88±11*</td>
</tr>
</tbody>
</table>

Values are mean±SD. VO$_2$ indicates exercise oxygen uptake; %pred, percentage of predicted value; VE, minute ventilation; MVV, directly measured maximal voluntary ventilation; AT, anaerobic threshold; VE/VO$_2$ at AT, ratio of ventilation to carbon dioxide output at anaerobic threshold.

*P<0.001, control group vs each group of PPH patients; †P<0.05, shunt group versus no-shunt group; all other comparisons, P>0.05 using 2-tailed repeated ANOVA.
Figure 2. CPET responses in 3 women: one normal (Control; aged 52 years; height, 178 cm; weight, 54 kg), one with PPH without development of a right-to-left shunt (No-Shunt-PPH; aged 45 years; height, 167 cm; weight, 65 kg) and one with PPH with development of a right-to-left shunt (Shunt-PPH; aged 41 years; height, 166 cm; weight, 87 kg) at the start of unloaded cycling exercise. Points are 10-second averages for 3 minutes of rest followed by 3 minutes of unloaded cycling, followed by progressively increasing exercise to maximum. WR was incremented at 10 W/min in the PPH patients and at 20 W/min in the control. In the Shunt-PPH patient, shunted venous blood with high PCO2 and H+ and low O2 reaches the systemic arterial chemoreceptors and stimulates ventilation, with rapid increases in VE/VCO2 and a decrease in PETCO2. The concurrent increase in VE/VCO2 is considerably less than that of VE/VCO2, because unshunted blood passing through the pulmonary circulation continues to unload CO2 but is unable to load more O2 once its hemoglobin becomes fully saturated. In the No-Shunt-PPH patient, the VE/VCO2 and VE/VCO2 do not increase as in the Shunt-PPH patient or decrease as much during mild and moderate exercise as in the control patient. Near the end of maximum exercise, the hyperventilation accompanying metabolic acidosis causes PETCO2, VE/VCO2, and RER to rise and PETCO2 to decrease in all individuals with good chemoreceptor sensitivity.

Discussion
In the presence of a PFO and increased pulmonary vascular resistance, exercise-induced increases in venous return cause right atrial pressure to increase. When it exceeds left atrial pressure, venous return can shunt through a PFO, diverting deoxygenated, acidic, CO2-rich blood to the systemic circulation. This stimulates arterial chemoreceptors (carotid bodies) to maintain arterial H+ and PaCO2 homeostasis, causing an immediate increase in ventilation, as manifested by rapid increases in alveolar PO2 (reflected in a PETO2 increase) and decreases in alveolar PCO2 (reflected in a PETCO2 decrease) (Figures 1 through 4). Consequently, CO2 unloading from the unshunted pulmonary blood flow increases as alveolar PCO2 falls, but O2 loading increases less because pulmonary capillary PO2 reaches the flat part of the oxyhemoglobin dissociation curve. Thus, ventilation increases more steeply relative to VO2 than VCO2, resulting in a greater increase in VE/VO2 than VE/VCO2 and a stepwise increase in RER (Figures 1 through 4).

Even at rest, there are distinctly more gas exchange abnormalities (higher VE/VCO2, VE/VCO2, and PETCO2 and lower PETCO2 and SpO2) in the shunt than no-shunt groups (Figures 2 and 3). These pre-exercise abnormalities can be attributed to hypoperfusion of well-ventilated lung and probable chronic hyperventilation.2,15

With unloaded cycling, the group differences become more obvious (Figures 2 and 3 and Table 2). In the shunt group, VE/VCO2, PETCO2, and RER all increased and PETCO2 decreased (indicating an acute ventilatory increase disproportionate to metabolism), and SpO2 decreased. In the no-shunt group, SpO2 declined slightly. In contrast, VE/VCO2 and PETCO2 decreased and PETCO2 increased in the control group. An abrupt increase in VE/VCO2 always indicated an EIS in our study.

Figure 4 illustrates the concurrent, dramatic, unambiguous gas exchange findings seen when shunting abruptly begins and ends at the end of exercise rather than earlier. Near the end of exercise, the stimuli to the chemoreceptors (and oximeter probe) are robust because the shunted mixed-venous blood is more acidic, hypercarbic, and hypoxemic; thus, it more strikingly alters ventilation to maintain arterial homeostasis.1

Pitfalls in Detection of a PFO and EIS
Because a PFO may be so small or the intrapulmonary pressure differences so trivial, shunt blood flow may not be demonstrable by echocardiography, even with Valsalva maneuvers.8–10

During CPET, the shunt fraction may be so small or the data so noisy that interpretation of EIS criteria are ambiguous. Other potential problems for clinicians using CPET to detect an EIS include a delayed or imperfect response of the SpO2 or the other oxygen saturation monitor, the CPET becoming data so noisy that interpretation of EIS criteria are ambiguous.

Two exercise-induced conditions that might lead the clinician to identify an EIS incorrectly are anxiety-induced hyperventilation or a very low anaerobic threshold.

Acute hyperventilation decreases PETCO2 while increasing PETO2, VE/VCO2, and RER. However, hyperventilation without shunting of venous CO2 into the systemic circulation is rarely sustained with a stable RER for more than a minute or two during exercise because these patients become CO2-unloaded and acutely alkalemic. With hyperventilation and no other disease, SpO2 does not decrease and MRT for VO2 is normal, in contrast to PPH.2,3

With a low anaerobic threshold, the development of lactic acidosis at a low WR causes PETO2, VE/VCO2, and RER to
continue to increase, in contrast to the abrupt but stable increases seen with an EIS. Evidence that the anaerobic threshold is reached later during exercise confirms that the earlier changes are due to an EIS.

Validity of Patient Groupings
As demonstrated in Figures 4 and 5, the absence of a detectable PFO at rest does not preclude right-to-left shunting during exercise. Because shunting is a dynamic process

| TABLE 2. Changes in CPET Parameters From Rest to End of Unloaded Cycling in PPH Patients and Controls |
|---------------------------------------------------|----------------------------------|
| PPH Patients                                       | Shunt (n=18) | No Shunt (n=39) | Discordant (n=11) | Control Subjects (n=20) |
| ΔPETO₂, mm Hg                                       | 8.1±3.3†  | 1.5±4.0‡   | 6.1±2.5†   | -1.9±6.1            |
| ΔPETCO₂, mm Hg                                      | -4.3±2.4†† | -0.1±1.8‡‡ | -2.6±1.0†† | 1.8±2.5            |
| ΔVe/Vo₂                                             | 12.2±10.9†† | -2.3±6.8‡‡ | 4.9±4.5††  | -4.2±7.1            |
| ΔVe/VCO₂                                            | 1.8±11.0* | -6.6±9.3  | -3.5±7.9  | -4.9±3.7           |
| ΔRER                                                | 0.18±0.07† | 0.07±0.08‡ | 0.14±0.08† | 0.01±0.14          |
| ΔSPO₂, %                                             | -6±5†† | -1.7±2*   | -1.5±2*  | -0.4±0.6          |
| ΔVO₂, L/min                                          | 0.22±0.14 | 0.24±0.10 | 0.22±0.07 | 0.24±0.10         |
| ΔVCO₂, L/min                                         | 0.28±0.15 | 0.23±0.09 | 0.25±0.07 | 0.22±0.09         |
| ΔVe, L/min                                           | 16.9±8.2† | 9.1±3.9‡  | 12.6±4.1†  | 6.7±3.5           |

Values are mean ± SD. Δ denotes the changes from rest to the end of unloaded cycling exercise.
*P<0.05 vs control group; †P<0.05 vs no-shunt PPH group; ‡P<0.05 vs discordant PPH group using 2-tailed repeated ANOVA.
dependent on transient pressure differentials, we did not expect to find an absolute concordance between the resting echocardiograph and CPET evidence of an EIS. It is unlikely that even the most sensitive echocardiographic methods at rest would detect PFOs in the 39 patients who were graded as EIS or that the 18 patients who had a detectable PFO by echocardiography would not also have right-to-left shunting during exercise. Therefore, we used both CPET and echocardiographic findings to define and compare the shunt and no-shunt groups.

Incidence of Right-to-Left Shunting

The high sensitivity, specificity, positive and negative predictive values, and accuracy comparing CPET with echocardiography (Table 3) demonstrate the utility of the gas exchange method in EIS detection. With respect to intraobserver variability, it seems that using tabular data to detect small changes increased sensitivity but slightly decreased specificity.

Ultimately we found, using both the resting and exercise measurements of our 71 PPH patients, that in addition to the 18 patients who were both PFO+ and EIS+ by all graders, 9 more patients (6 by echocardiography and 3 by distinctive late-exercise changes) had convincing evidence of a right-to-left shunt either at rest or during exercise (Figures 4 and 5). Five more may have had right-to-left shunting by CPET criteria (Figure 5). Thus, the incidence of right-to-left shunting through a PFO in our PPH patients during exercise seems to be 38% to 45%.

An autopsy study of 965 “normal” hearts showed a PFO incidence of 20% to 34%, with decreasing PFO frequency but increasing size with advancing age. Using Valsalva maneuvers during echocardiography, the incidence of PFO in normal subjects is reported at just 5% to 18%, in part because most normal adults do not shunt blood through their PFO and also because the Valsalva maneuver does not always produce sufficient interatrial pressure differences to cause shunting. An 18% echocardiographic incidence of PFO or interatrial defects was detected in a recent

![Figure 4](https://example.com/figure4.png)

**Figure 4.** Cycle CPET in a PPH patient who developed an EIS just before the end of exercise. Symbols indicate 10-second averaged values. Three minutes of rest was followed by 3 minutes of unloaded cycling (left vertical line), increasing WR (10 W/min) exercise to peak tolerance (middle vertical line), and 2 minutes of recovery (right vertical line). During the 11th minute of the study, the patient developed sudden dyspnea with abrupt and marked gas exchange findings of a right-to-left shunt (increasing PetO2 and RER, decreasing PetCO2 and Spo2, and Ve/Vco2 increasing more Ve/Vo2). These changes abruptly returned toward their pre-shunt values when exercise stopped. All 3 patients with a late exercise-induced right-to-left shunt had an increase in Ve/Vco2 as their shunt opened.

![Figure 5](https://example.com/figure5.png)

**Figure 5.** Concordant and discordant findings in determination of shunt or no-shunt groups in 68 PPH patients. The bars quantify the independent decisions of 3 graders (investigators) who were blinded to the results of the resting echocardiography. The presence or absence of an EIS during CPET is marked by + or −, respectively. Hatched bars depicts the presence (+) and open bars depicts the absence (−) of a demonstrable PFO during resting echocardiography. A total of 18 patients were described as having a shunt and 39 patients were described as having no shunt by all 3 graders, and resting echocardiography concurred in these grades. The 11 patients in the 2 center columns are placed in the discordant group because one or more of the investigators’ grades differed from the resting echocardiography findings.

**TABLE 3.** Analysis of Grading of Exercise-Induced Right-To-Left Shunt Assuming PFO Detected By Resting Echocardiography Is “Gold Standard”

<table>
<thead>
<tr>
<th>Grader</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>Average</th>
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<tbody>
<tr>
<td>Sensitivity</td>
<td>75</td>
<td>100</td>
<td>96</td>
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<td>PV−, %</td>
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<td>100</td>
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<td>95</td>
</tr>
<tr>
<td>Accuracy, %</td>
<td>91</td>
<td>97</td>
<td>94</td>
<td>94</td>
</tr>
</tbody>
</table>

PV+ indicates positive predictive value; PV−, negative predictive value.

*Did not use CPET tabular data.
series of untreated PPH patients. Stroke patients have a higher incidence of PFO (as high as 78% in young patients with cryptogenic strokes, possibly due to paradoxical emboli). The relatively high EIS incidence in our series argues that chronic pulmonary hypertension also increases the potential for shunting through foramina ovale that might otherwise remain undetected and that such shunting may favor an increased survival.

**Implications**

CPET is a safe, noninvasive, cost-effective, and easily repeatable method for assessing PPH patients and detecting an EIS. The 9-panel graphic array (Figure 1) not only helps in the general interpretation of CPET studies, but also assists in the recognition of the distinctive gas exchange pattern of an EIS.

**References**

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Circulation. 2002;105:54-60
doi: 10.1161/hc0102.101509

Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

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