Paneth Suture Annuloplasty Abolishes Acute Ischemic Mitral Regurgitation but Preserves Annular and Leaflet Dynamics

Frederick A. Tibayan, MD; Filiberto Rodriguez, MD; David Liang, MD, PhD; George T. Daughters, MS; Neil B. Ingels, Jr, PhD; and D. Craig Miller, MD

Background—Ring annuloplasty, the standard treatment for ischemic mitral regurgitation (IMR), abolishes normal annular dynamics and freezes the posterior leaflet. We examined the impact of Paneth suture annuloplasty during acute IMR on motion of the mitral annulus and leaflets in an ovine model.

Methods and Results—Eight sheep had radiopaque markers placed on the left ventricle, anterior mitral leaflet, posterior mitral leaflet, and mitral annulus. A Paneth suture annuloplasty that could be reversibly tightened was anchored to each fibrous trigone and externalized through the mid-lateral mitral annulus. Acute IMR was induced by proximal circumflex artery occlusion. Transesophageal echocardiography assessed the degree of IMR, and biplane cinefluoroscopy measured 3-dimensional marker coordinates before and during circumflex ischemia, and tightening of the Paneth suture. Paneth suture annuloplasty eliminated acute IMR, and reduced septal-lateral and commissure-commissure mitral annular dimensions. Tightening of the annuloplasty sutures, even beyond the degree necessary to eliminate mitral regurgitation (MR), did not reduce septal-lateral or commissure-commissure annular shortening, shortening of the muscular annular perimeter, annular flexion, or angular excursion of the anterior or posterior leaflets relative to ischemic conditions.

Conclusions—In contrast to ring annuloplasty, annular reduction sufficient to restore mitral competence during acute IMR can be achieved with a Paneth suture annuloplasty while simultaneously maintaining normal annular and leaflet dynamic motion. These findings should prompt additional investigation and design of repair methods that preserve the mobility of the mitral apparatus. 

Key Words: mitral repair ■ ischemic mitral regurgitation ■ acute myocardial ischemia
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left fibrous trigone; RFT

at each fibrous trigone (LFT

right

/H11005

Two double-armed 2 to 0 polypropylene sutures were anchored

Figure 2.

Schematic drawing of the Paneth suture annuloplasty.

filling multiple tetrahedral volume method.10 The severity of IMR

was computed from the epicardial LV markers by using a space-

peak of the electrocardiographic R wave. Instantaneous LV volume

of LV pressure (-dP/dt), and end-diastole as the frame containing the

fined as the videofluoroscopic frame containing the peak rate of fall

leaflet edges.

fixed as the videofluoroscopic frame containing the peak rate of fall

of LV pressure (-dP/dt), and end-diastole as the frame containing the

peak of the electrocardiographic R wave. Instantaneous LV volume

was computed from the epicardial LV markers by using a space-

filling multiple tetrahedral volume method.10 The severity of IMR

was graded by an experienced cardiologist (DL) using transesopha-

gal echocardiography according to the extent and width of the color

Doppler regurgitant jet, and categorized as none (0), trace (0.5 +),
mild (+1), moderate (+2), moderate to severe (+3), or severe (+4).

All of the animals received humane care in compliance with the

“Principles of Laboratory Animal Care” formulated by the National

Society for Medical Research and the “Guide for Care and Use of

Laboratory Animals” prepared by the National Academy of Sciences

and published by the National Institutes of Health (DHEW NIHG

publication 85 to 23, revised 1985). This study was approved by the

Stanford Medical Center Laboratory Research Animal Review com-

mittee and conducted according to Stanford University policy.

Figure 1. Schematic of the marker array used in the experiment,

with the aortic valve shown on the left for orientation. Markers

were placed at the left ventricular (LV) apex, at 2 LV levels

around 4 meridians, around the mitral annulus, and on the mitral

leaflet edges.

Data Analysis

Mitral Valve Geometry

For each videographic frame, septal-lateral annular diameter

was calculated as the distance in 3-dimensional space be-

tween markers placed on the midseptal and midlateral annu-

lus. The commissure-commissure annular dimension was

calculated as the distance between the commissural markers.

Septal-lateral annular shortening was calculated as the per-

centage of change from maximum to minimum, and

commissure-commissure shortening was defined similarly.

Muscular annulus length was measured as the sum of the 6

contiguous segments defined by the annular markers extend-

ing from the left fibrous trigone, around the posterior annulus,
to the right fibrous trigone (excluding the intertrigonal dis-

tance). The height of the midseptal annular marker above the

plane fitted to the lateral annular markers was determined

throughout the cardiac cycle. Annular flexion was defined as

the change in this height during systole.

Mitral Leaflet Excursion

To assess leaflet motion throughout the cardiac cycle, anterior

mitral leaflet angle, \( \Theta_{AML} \), was calculated as the angle in

3-dimensional space between the annular septal-lateral diam-

eter and the chord between the midseptal annular marker and

anterior leaflet edge marker; similarly, the posterior mitral

leaflet edge angle, \( \Theta_{PML} \), was defined as the angle formed by

the septal-lateral diameter and the chord between the midlat-

eral annulus and the posterior leaflet edge marker. Leaflet

excursion was calculated as the range (maximum to minimum

angle) of the respective leaflet angles throughout the

cardiac cycle.

Statistical Analysis

All of the data are reported as mean \pm 1 SD, unless otherwise

stated. Hemodynamic and geometrical data were compared

determine changes after induction of ischemia and after

tightening of the suture annuloplasty (Baseline versus Ische-

mia and Ischemia versus ASP-1 and ASP-2) using repeated

measures ANOVA with Dunnett’s test for multiple compar-

isons when ANOVA yielded a significant F value (P<0.05).

Results

Table 1 summarizes group mean hemodynamic data at

Baseline, Ischemia, and during ischemia with cinching of the

suture annuloplasty (ASP-1 and ASP-2). During ischemia,

LV end-diastolic volume, IMR, and LV end-diastolic pres-

sure increased significantly, whereas LV dP/dt decreased.
The first stage of annuloplasty tightening (ASP-1) returned

IMR to baseline levels, but did not affect heart rate, dP/dt,

end-diastolic volume, or end-diastolic pressure. The second

pull on the Paneth sutures did not additionally affect the

measured hemodynamic variables.

Table 2, and Figures 3 and 4 summarize annular dynamics

during baseline conditions, during ischemia, and during

ischemia with suture annuloplasty cinching. As expected,
during ischemia both maximum and minimum mitral annular

septal-lateral and commissure-commissure diameters in-

creased, and septal-lateral and commissure-commissure an-
nular shortening decreased. Tightening of the suture annulo-

Figure 2. Schematic drawing of the Paneth suture annuloplasty.

Two double-armed 2 to 0 polypropylene sutures were anchored

at each fibrous trigone (LFT=left fibrous trigone; RFT=right

fibrous trigone) extended around the annulus, and exteriorized

through the midlateral annulus to adjustable tourniquets.
plasty sufficient to eliminate acute IMR (ASP-1) reduced sepal-lateral and commissure-commissure annular diameters, but did not reduce annular diameter shortening relative to the ischemic state. Additional tightening of the annuloplasty suture (ASP-2) still did not decrease annular shortening.

During ischemia, the length of the muscular annulus increased, and shortening of this muscular perimeter decreased. Tightening the suture annuloplasty (ASP-1 and ASP-2) reduced the length of the muscular annulus, without any additional effect on its relative shortening compared with ischemia. Annular height and annular flexion fell with ischemia compared with baseline, but tightening of the suture annuloplasty had no additional effect on annular flexion relative to ischemic conditions.

Table 3 and Figure 5 summarize the mitral leaflet maximum and minimum angles and angular leaflet excursion at Baseline, Ischemia, ASP-1, and ASP-2. Ischemia had no effect on anterior leaflet excursion, and tightening the suture annuloplasty did not change anterior leaflet mobility. During ischemia, posterior leaflet angular excursion also did not change. Annular reduction with suture annuloplasty at 2 successive stages, even beyond that necessary to restore mitral competence (ASP-2), also did not affect posterior leaflet excursion.

Discussion

Preservation of the normal physiology and mobility of the mitral valve apparatus has long been a goal of mitral valve reparative surgery. Chordal-sparing mitral valve replacement,11 Carpentier’s mitral repair techniques,12 flexible ring annuloplasty,11 suture,8 and pericardial strip14 annuloplasty have all attempted to restore or maintain normal mitral valve function. Whereas ring annuloplasty is the most commonly used reparative procedure in treating patients with IMR, rings of all types, whether rigid1,2,4 or flexible1,4,15, partial4,16 or complete1,15, abolish normal annular dynamics and freeze the posterior leaflet in the semiopen position. Methods of annular reduction without a ring have been proposed to maintain more physiological annular and leaflet motion,2,14,17,18 but the effects of such methods on annular and leaflet dynamics are unknown. The key findings of this study are: (1) annular reduction with a Paneth suture annuloplasty eliminated acute IMR and maintained annular dynamic shortening and flexion; and (2) tightening the Paneth suture annuloplasty did not reduce either anterior or posterior mitral leaflet excursion.

Paneth suture annuloplasty abolished acute IMR in this study by decreasing sepal-lateral and commissure-commissure annular diameters. Septal-lateral annular dilation has been shown to be the principal cause of leaflet malcoap-

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**TABLE 1. Hemodynamic Variables**

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Ischemia</th>
<th>ASP-1</th>
<th>ASP-2</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>MR (0–4+)</td>
<td>0.3±0.3*</td>
<td>2.1±0.4</td>
<td>0.6±0.5*</td>
<td>0.5±0.4*</td>
<td>35.5</td>
</tr>
<tr>
<td>Heart rate (min⁻¹)</td>
<td>106±21</td>
<td>96±31</td>
<td>99±21</td>
<td>99±21</td>
<td>1.1</td>
</tr>
<tr>
<td>LV dP/dt (mm Hg/s)</td>
<td>2.666±0.351*</td>
<td>1.813±0.425</td>
<td>1.648±0.301</td>
<td>1.636±0.319</td>
<td>28.5</td>
</tr>
<tr>
<td>EDV (ml)</td>
<td>132±46*</td>
<td>158±50</td>
<td>151±53</td>
<td>151±54</td>
<td>14.1</td>
</tr>
<tr>
<td>ESV (ml)</td>
<td>101±33*</td>
<td>127±39</td>
<td>126±44</td>
<td>126±44</td>
<td>18.4</td>
</tr>
<tr>
<td>LVEDP (mm Hg)</td>
<td>14±4*</td>
<td>21±4</td>
<td>20±4</td>
<td>20±4</td>
<td>15.1</td>
</tr>
</tbody>
</table>

*P<0.05 vs. Ischemia by repeated measures ANOVA and Dunnett’s test. MR=mitral regurgitation; dP/dt=maximum rate of LV pressure versus time; EDV=end-diastolic volume; ESV=end-systolic volume; F=F value from repeated measures ANOVA.

**TABLE 2. Annular Dynamics**

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Ischemia</th>
<th>ASP-1</th>
<th>ASP-2</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-L max (cm)</td>
<td>2.6±0.3*</td>
<td>3.0±0.4</td>
<td>2.6±0.7*</td>
<td>2.5±0.7*</td>
<td>16.7</td>
</tr>
<tr>
<td>S-L min (cm)</td>
<td>2.2±0.2*</td>
<td>2.6±0.4</td>
<td>2.4±0.6*</td>
<td>2.3±0.6*</td>
<td>11.5</td>
</tr>
<tr>
<td>S-L shortening (%)</td>
<td>15±4*</td>
<td>10±4</td>
<td>8±4</td>
<td>8±3</td>
<td>21.1</td>
</tr>
<tr>
<td>C-C max (cm)</td>
<td>3.3±0.4*</td>
<td>3.6±0.3</td>
<td>3.3±0.6*</td>
<td>3.2±0.7*</td>
<td>10.6</td>
</tr>
<tr>
<td>C-C min (cm)</td>
<td>3.0±0.4*</td>
<td>3.4±0.3</td>
<td>3.2±0.6*</td>
<td>3.1±0.7*</td>
<td>13.8</td>
</tr>
<tr>
<td>C-C shortening (%)</td>
<td>8±3*</td>
<td>5±1</td>
<td>5±3</td>
<td>6±3</td>
<td>3.9</td>
</tr>
<tr>
<td>Muscular annulus max (cm)</td>
<td>6.6±0.9*</td>
<td>7.1±0.7</td>
<td>6.4±1.1*</td>
<td>6.1±1.1*</td>
<td>8.7</td>
</tr>
<tr>
<td>Muscular annulus min (cm)</td>
<td>6.0±0.9*</td>
<td>6.7±0.6</td>
<td>6.1±1.0*</td>
<td>5.8±1.0*</td>
<td>8.2</td>
</tr>
<tr>
<td>Muscular annulus shortening (%)</td>
<td>10±4*</td>
<td>5±2</td>
<td>5±2</td>
<td>5±2</td>
<td>8.7</td>
</tr>
<tr>
<td>Annular height max (cm)</td>
<td>0.8±2*</td>
<td>0.6±0.2</td>
<td>0.6±0.3</td>
<td>0.6±0.3</td>
<td>6.9</td>
</tr>
<tr>
<td>Annular height min (cm)</td>
<td>0.5±0.2</td>
<td>0.4±0.2</td>
<td>0.4±0.3</td>
<td>0.4±0.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Annular flexion (cm)</td>
<td>0.3±0.1*</td>
<td>0.2±0.1</td>
<td>0.2±0.1</td>
<td>0.2±0.1</td>
<td>9.9</td>
</tr>
</tbody>
</table>

*P<0.05 vs. Ischemia by repeated measures ANOVA and Dunnett’s test. S-L max=maximum septal-lateral annular diameter; S-L min=minimum septal-lateral annular diameter; C-C max=maximum commissure-commissure diameter; C-C min=minimum commissure-commissure diameter; F=F value from repeated measures ANOVA.
Figure 3. Septal-lateral (above) and commissure-commissure (below) mitral annular diameters are plotted versus time throughout the cardiac cycle (time-registered data centered at end-diastole). Baseline=squares; Ischemia=circles; first stage of suture tightening (ASP-1)=upright triangles; second stage of suture tightening (ASP-2)=upside-down triangles.

tation and functional MR in ovine models of acute ischemia and dilated cardiomyopathy. On the other hand, whereas isolated commissure-commissure annular dilation is apparently not sufficient to cause IMR, it may stretch the leaflets over a larger area thereby limiting the available leaflet surface for coaptation.

Normal annular dynamics play a role in both LV filling and ejection. The diastolic increase in annular size may contribute to the efficient passive transfer of blood from the atrium to the ventricle as the annulus recoils away from the LV apex toward the atrium. Although in patients with IMR, infarcted or ischemic myocardium may be the primary cause of impaired LV diastolic filling, preserved annular flexibility would theoretically provide an incremental benefit in compromised hearts by possibly reducing trans-mitral gradients. During systole, sphincteric shortening of the annulus facilitates leaflet coaptation. Thus, loss of annular shortening and flexion associated with ring annuloplasty (particularly rigid rings) is probably deleterious, and, in fact, has been shown to increase leaflet and chordal stress in finite element models.

Systolic annular flexion displaces the septal annulus away from the LV outflow tract, assisting ejection. Complete rings may predispose toward LV outflow tract obstruction by flattening the annulus and reducing annular flexion. Paneth suture tightening did not reduce annular shortening or flexion compared with the ischemic state, thus preserving the putative advantages of normal annular dynamic motion. Notably, although partial flexible rings abolish septal-lateral and commissure-commissure shortening and freeze the posterior leaflet, they also preserve annular flexion. Semirigid and flexible annuloplasty experimentally and clinically “freeze” the posterior leaflet in the semiopen position, effectively creating a functionally unileaflet mitral valve. Computer models of rigid rings, and animal studies of both rigid and flexible rings have associated such abnormal leaflet closure dynamics with relative rigidity of the annulus after ring placement. Freezing the posterior leaflet in the open

Figure 4. Length of the mitral muscular annulus (above) and height of the annular saddle horn (or “fibrosa”) above the plane of the lateral annulus (below) are plotted versus time (data centered at end-diastole). The change in this height over the cardiac cycle is an indication of annular flexion. Baseline=squares; Ischemia=circles; first stage of suture tightening (ASP-1)=upright triangles; second stage of suture tightening (ASP-2)=upside-down triangles.

Figure 5. Mitral leaflet excursion. Anterior mitral leaflet angle (\(\Theta_{AML}\), above) and posterior mitral leaflet angle (\(\Theta_{PML}\), below) are plotted versus time with the data time-registered at end-diastole. Baseline=squares; Ischemia=circles; first stage of suture tightening (ASP-1)=upright triangles; second stage of suture tightening (ASP-2)=upside-down triangles.

### Table 3. Dynamic Motion of the Mitral Leaflets

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>Ischemia</th>
<th>ASP-1</th>
<th>ASP-2</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>(\Theta_{AML}) max (deg)</td>
<td>82 ± 8</td>
<td>76 ± 8</td>
<td>76 ± 6</td>
<td>77 ± 9</td>
<td>0.8</td>
</tr>
<tr>
<td>(\Theta_{AML}) min (deg)</td>
<td>36 ± 4</td>
<td>34 ± 4</td>
<td>35 ± 4</td>
<td>36 ± 6</td>
<td>1.0</td>
</tr>
<tr>
<td>AML excursion (deg)</td>
<td>46 ± 7</td>
<td>42 ± 5</td>
<td>41 ± 4</td>
<td>41 ± 4</td>
<td>1.7</td>
</tr>
<tr>
<td>(\Theta_{PML}) max (deg)</td>
<td>95 ± 15</td>
<td>93 ± 12</td>
<td>99 ± 16</td>
<td>101 ± 17</td>
<td>0.4</td>
</tr>
<tr>
<td>(\Theta_{PML}) min (deg)</td>
<td>39 ± 14</td>
<td>35 ± 8</td>
<td>36 ± 11</td>
<td>35 ± 12</td>
<td>1.0</td>
</tr>
<tr>
<td>PML excursion (deg)</td>
<td>57 ± 9</td>
<td>63 ± 12</td>
<td>63 ± 12</td>
<td>66 ± 11</td>
<td>1.2</td>
</tr>
</tbody>
</table>

* \(P<0.05\) vs. Ischemia by repeated measures ANOVA and Dunnett’s test.

\(\Theta_{AML}\) max = maximum anterior mitral leaflet angle; \(\Theta_{AML}\) min = minimum anterior mitral leaflet angle; \(\Theta_{PML}\) max = maximum posterior mitral leaflet angle; \(\Theta_{PML}\) min = minimum posterior mitral leaflet angle; \(F=F\) value from repeated measures ANOVA.
position increases the degree of annular reduction required to achieve valve competence, and markedly alters the distribution of systolic closing stress on the leaflets. Increased leaflet stress has been linked to leaflet thickening and collagen deposition that may additionally perturb leaflet motion and closure dynamics.27,28 In contrast, Paneth suture tightening, even beyond the amount required to restore mitral competence, had no apparent deleterious impact on either anterior or posterior mitral leaflet excursion.

The mechanism by which annular and leaflet dynamics are preserved after Paneth suture annuloplasty remains undetermined. It has been suggested that annular shortening is abolished by any annuloplasty (whether suture or ring), which reduces annular size below the normal systolic minimum dimension.29 Standard sizing of semirigid and flexible rings results in the annular septal-lateral and commissure-commissure diameters being smaller than normal.19 In contrast, septal-lateral and commissure-commissure annular minimal dimensions after both pulls on the Paneth sutures were still greater than the Baseline values (Table 2 and Figure 3). It is possible that the lesser degree of annular reduction required by the Paneth suture annuloplasty allowed preservation of shortening of the mitral annular diameters. Another possible factor favoring annular flexibility is the use of 2 separate Paneth sutures (Figure 2), allowing the anterior and posterior sectors of the annulus to move independently, as opposed to rings (or even a single long suture) that are continuous.

Green et al from this laboratory conjectured that posterior leaflet freezing after semirigid or flexible ring annuloplasty occurs when the lateral annulus is pulled excessively toward the septum and further away from the papillary muscle tips, thereby tethering the leaflet in the open position.4 In support of this theory, Dagum et al demonstrated that a semirigid (C-E Physio) complete ring markedly displaced the lateral annulus (by 6.9±3.5 mm) toward the septum at end-isovolumic contraction (before ejection began), and the anterolateral papillary muscle moved septally by 3.1±1.6 mm; conversely, a complete flexible (Medtronic Duran) ring displaced the lateral annulus by 4.1±4.7 mm toward the septum at end-isovolumic contraction without dislocating either papillary muscle.26 Applying that same reference system (origin based on the highest septal marker) to the present dataset revealed that pulling the Paneth annuloplasty sutures moved the lateral annulus closer to the septum by only 3±1 mm without moving the papillary muscles, and the posterior leaflet remained mobile.

Another mechanism maintaining physiological posterior leaflet dynamics after Paneth suture annuloplasty may be residual flexibility of the muscular (or posterior) mitral annulus. Glasson et al demonstrated that semirigid and flexible rings completely abolish shortening of the muscular annular perimeter.15 On the other hand, compared with the ischemic state, tightening the Paneth sutures had no additional dampening effect on shortening of the muscular annular perimeter. Perhaps this preservation of annular flexibility along the insertion of the posterior leaflet allows the normal complex folding pattern of the closed posterior leaflet to continue, as suggested by finite element models.6

**Study Limitations.** This investigation of acute IMR in open-chest sheep who previously had normal hearts is far different from the clinical scenario of chronic IMR; direct extrapolation of the present findings to the clinical situation is inappropriate. Proximal main circumflex artery occlusion was used in this experiment to create acute myocardial ischemia, an acutely dilated annulus, and acute IMR in order to examine the in vivo effects of Paneth suture annular reduction on annular and leaflet dynamics. We cannot speculate on the durability of this type of suture repair in the clinical setting. As in the similar DeVega tricuspid repair, there is a risk of sutures loosening or tearing out. Nonetheless, demonstrating that annular reduction can be achieved while maintaining physiological annular flexibility and leaflet motion in this acute, open-chest model may catalyze new studies aimed at designing better mitral reparative techniques. Future studies are required to establish any clinical benefit of preserved annular flexibility suggested by computer and experimental models.

Quantitative measures of MR, such as effective regurgitant orifice and regurgitant volume, have proved useful in studies of chronic IMR,30,31 whereas in this experiment, the severity of IMR was only graded subjectively using the conventional clinical semiquantitative scale of 0 to 4+ by the same echocardiographer (DL). The large distance between the esophagus and the heart in sheep resulted in echocardiographic images of suboptimal quality, precluding the calculation of more quantitative measures of the degree of IMR, such as effective regurgitant orifice.

**Acknowledgments**

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**References**


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