Clinical Investigation and Reports

Lipoprotein-Associated Phospholipase A<sub>2</sub>, High-Sensitivity C-Reactive Protein, and Risk for Incident Coronary Heart Disease in Middle-Aged Men and Women in the Atherosclerosis Risk in Communities (ARIC) Study

Christie M. Ballantyne, MD; Ron C. Hoogeveen, PhD; Heejung Bang, PhD; Josef Coresh, MD, PhD; Aaron R. Folsom, MD, MPH; Gerardo Heiss, MD, PhD; A. Richey Sharrett, MD, DrPH

**Background**—Measuring C-reactive protein (CRP) has been recommended to identify patients at high risk for coronary heart disease (CHD) with low LDL cholesterol (LDL-C). Lipoprotein-associated phospholipase A<sub>2</sub> (Lp-PLA<sub>2</sub>) is a proinflammatory enzyme associated primarily with LDL.

**Methods and Results**—In a prospective, case cohort study in 12,819 apparently healthy middle-aged men and women in the Atherosclerosis Risk in Communities study, the relation between Lp-PLA<sub>2</sub>, CRP, traditional risk factors, and risk for CHD events over a period of ≈6 years was examined in a proportional hazards model, stratified by LDL-C. Lp-PLA<sub>2</sub> and CRP levels were higher in the 608 cases than the 740 noncases. Both Lp-PLA<sub>2</sub> and CRP were associated with incident CHD after adjustment for age, sex, and race with a hazard ratio of 1.78 for the highest tertile of Lp-PLA<sub>2</sub> and 2.53 for the highest category of CRP versus the lowest categories. Lp-PLA<sub>2</sub> correlated positively with LDL-C ($r=0.36$) and negatively with HDL-C ($r=-0.33$) but not with CRP ($r=-0.05$). In a model adjusted for traditional risk factors including LDL-C, the association of Lp-PLA<sub>2</sub> with CHD was attenuated and not statistically significant. For individuals with LDL-C below the median (130 mg/dL), Lp-PLA<sub>2</sub> and CRP were both significantly and independently associated with CHD in fully adjusted models. For individuals with LDL-C <130 mg/dL, those with both Lp-PLA<sub>2</sub> and CRP levels in the highest tertile were at the greatest risk for a CHD event.

**Conclusions**—Lp-PLA<sub>2</sub> and CRP may be complementary in identifying individuals at high CHD risk who have low LDL-C. (Circulation. 2004;109:837-842.)

Key Words: coronary disease ■ epidemiology ■ inflammation ■ risk factors

Although screening for elevated LDL cholesterol (LDL-C) remains a major component of national guidelines for the prevention of coronary heart disease (CHD), LDL-C level is insufficient to identify individuals who would develop CHD, because many CHD events occur in individuals without elevated LDL-C,<sup>1</sup> indicating the influence of other risk factors. Inflammation plays an important role in both atherogenesis and atherothrombotic events, and several biomarkers of inflammation, including high-sensitivity C-reactive protein (hs-CRP),<sup>2</sup> interleukin-6,<sup>3</sup> and soluble intercellular adhesion molecule-1,<sup>4</sup> have been associated with increased risk for CHD events. hs-CRP measurement has been recommended for some patients to refine risk assessment<sup>5</sup> because hs-CRP levels have been shown to provide additional predictive information beyond traditional risk factors such as LDL-C.<sup>6</sup> Increased hs-CRP levels may also be useful to identify patients with low LDL-C who are at increased CHD risk and may benefit from statin therapy.<sup>7</sup>

Lipoprotein-associated phospholipase A<sub>2</sub> (Lp-PLA<sub>2</sub>) is an enzyme that can hydrolyze oxidized phospholipids to generate lysophosphatidylcholine and oxidized fatty acids, which have proinflammatory properties. However, hydrolysis of platelet-activating factor and other phospholipids by Lp-PLA<sub>2</sub> could also reduce inflammation,<sup>8</sup> and it is not clear whether Lp-PLA<sub>2</sub> is proinflammatory or anti-inflammatory in humans.
Lp-PLA₂ is associated primarily with LDL, and enzyme activity is increased in small, dense LDL.⁹

In a case–cohort analysis of the West of Scotland Coronary Prevention Study (WOSCOPS), high baseline Lp-PLA₂ levels were associated with increased risk for CHD events, even after adjustment for traditional risk factors and hs-CRP.¹⁰ In a case–control analysis from the Women's Health Study, baseline Lp-PLA₂ levels were higher in women with subsequent cardiovascular events but were not associated with increased CHD risk after adjustment for traditional risk factors and hs-CRP.¹¹

The purpose of this study was to examine whether levels of Lp-PLA₂ and hs-CRP in middle-aged American men and women were associated with increased risk for incident CHD in the Atherosclerosis Risk in Communities (ARIC) study.

Methods

Study Population

The ARIC design, objectives, sampling strategies, and examination techniques have been described previously.¹² ARIC is a large, biracial cohort study of 15,792 adults 45 to 64 years old. A baseline examination was conducted in 1987 to 1989, with 3 more examinations through 1998.

Participants were followed up for incident CHD, defined by combinations of chest pain, ECG changes, cardiac enzyme levels, and surgical revascularization. Potential CHD events were reviewed by 2 members of the ARIC Morbidity and Mortality Classification Committee, and any differences between reviewers were adjudicated by the committee chairperson.

Study Design

Because plasma samples from the first visit were depleted, Lp-PLA₂ and hs-CRP were measured in duplicate in plasma from visit 2 (1990–1992) in individuals who subsequently developed a CHD event (cases) and in a cohort random sample (CRS). Of the 14,560 participants with visit 2 data, 1272 were excluded because of CHD or missing CHD information before visit 2, 376 for transient ischemic attack or stroke, and 93 who belonged to an underrepresented minority group. The potential full cohort consisted of 12,819 participants with visit 2 data, 1272 were excluded because of CHD or missing CHD information before visit 2, 376 for transient ischemic attack or stroke, and 93 who belonged to an underrepresented minority group. The potential full cohort consisted of 12,819 individuals who were followed up for the subsequent development of a CHD event, including CHD-related death. Subjects alive and event-free at the end of 1998 or lost to follow-up were censored. We constructed a case–cohort design (n = 1652)¹³ in which cases are compared with a CRS of all participants at the beginning of follow-up. The case–cohort design has the advantages that a single comparison group can be used for multiple disease outcomes (such as incident CHD and stroke), the comparison group is representative of the entire study population, and both absolute risks and relative hazards can be obtained with appropriate statistical analyses.

We selected the CRS by stratification on sex, race (black versus white) and age at baseline (≥55 versus <55). After exclusion of 304 subjects with missing information, the final sample size for the analysis was 1348 (608 cases and 740 noncases). The CRS included 785 individuals: 45 cases and all 740 noncases. The statistical method and computer software used for case–cohort design within a framework of proportional hazard regression, with an appropriate modification to take into account the stratified nature of the CRS and robust variance estimation.¹²¹³ The results were summarized as hazard ratios (HRs) with 95% CIs.

Tests for various potential interactions and (non)linearity were conducted as a secondary analysis, and subgroup analyses were considered to confirm findings. For the overall association of Lp-PLA₂ and outcome, a χ² test statistic was calculated. All other overall associations were tested similarly. SAS version 8 was used for all statistical analyses, except that SUDAAN version 8.0.0 was used to compute probability values for weighted correlation coefficients.

Results

Of the 608 CHD events, 41.6% were nonfatal myocardial infarctions, 9.5% were silent myocardial infarctions, 39.0% were revascularization procedures, and 9.9% were fatal events, with mean time to event 4.1 years. Baseline charac-
TABLE 1. Weighted-Adjusted Means or Prevalences of Risk Factors at Baseline (Visit 2)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Cases (n=608)</th>
<th>Noncases (n=740)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y*</td>
<td>58.5</td>
<td>56.7</td>
<td>...</td>
</tr>
<tr>
<td>Female, %*</td>
<td>32.2</td>
<td>58.9</td>
<td>...</td>
</tr>
<tr>
<td>African American, %*</td>
<td>22.9</td>
<td>25.0</td>
<td>...</td>
</tr>
<tr>
<td>Current smoker, %</td>
<td>28.2</td>
<td>19.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>28.7</td>
<td>28.1</td>
<td>0.014</td>
</tr>
<tr>
<td>Diabetes, %</td>
<td>27.8</td>
<td>15.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hypertension (history), %</td>
<td>51.0</td>
<td>32.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg</td>
<td>127.5</td>
<td>121.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diastolic blood pressure, mm Hg</td>
<td>73.1</td>
<td>72.6</td>
<td>0.350</td>
</tr>
<tr>
<td>Total cholesterol, mg/dL</td>
<td>219.7</td>
<td>207.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Triglycerides, mg/dL</td>
<td>144.8</td>
<td>124.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>HDL-C, mg/dL</td>
<td>45.6</td>
<td>51.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>LDL-C, mg/dL†</td>
<td>145.1</td>
<td>131.2</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Lp-PLA₂, μg/L</td>
<td>404</td>
<td>373</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>hs-CRP, mg/L</td>
<td>4.05</td>
<td>3.04</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

*Unadjusted mean or proportion; all others are age-, race-, and sex-adjusted mean or proportion.
†Median LDL-C was 145 mg/dL for cases and 129 mg/dL for noncases.
‡Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C, HDL-C, and diabetes.
§n=204 cases and 369 noncases.

**Risk Factor**

Compared with noncases, individuals with incident CHD had significantly higher BMI, systolic blood pressure, and levels of total cholesterol, triglycerides, and LDL-C and significantly lower HDL-C levels. Hypertension, diabetes, and current smoking were more prevalent in CHD cases. In addition to these differences in traditional risk factors, the weighted mean levels of both Lp-PLA₂ and hs-CRP were higher in cases than noncases, 404 versus 372 μg/L and 4.05 versus 3.04 mg/L, respectively.

Lp-PLA₂ level was positively correlated with LDL-C (r=0.36) and total cholesterol (r=0.23) levels and negatively correlated with HDL-C level (r=-0.33) in both men and women (Table 2). There was a weak positive correlation with triglyceride (r=0.13) and no significant correlation with BMI. Spearman’s rank correlation gave similar results. Weighted mean Lp-PLA₂ was 421 μg/L in men and 339 μg/L in women, 366 μg/L in individuals <55 years old and 384 μg/L in individuals ≥55 years old, 388 μg/L in whites and 333 μg/L in African Americans, 362 μg/L in diabetics and 376 μg/L in nondiabetics, and 404 μg/L in current smokers and 366 μg/L in nonsmokers.

Because hs-CRP tertiles in ARIC (<1 mg/L, 1 to 2.82, and >2.82 mg/L) were similar to the cutpoints defined in the AHA/CDC guidelines (<1 mg/L, 1 to 3 mg/L, >3 mg/L), the AHA/CDC cutpoints were used to facilitate comparison across studies. In a Cox proportional hazards model adjusted for age, sex, and race, high hs-CRP as defined by the AHA/CDC cutpoint of >3.0 mg/L was associated with a significant increase in risk (2.53 HR, 95% CI 1.88 to 3.40) (Table 3). Further adjustment for smoking, hypertension, diabetes, LDL-C, and HDL-C attenuated risk associated with high hs-CRP, but risk remained significantly elevated (1.72 HR, 95% CI 1.24 to 2.39). For individuals with LDL-C <130 mg/dL, approximately the median LDL-C in this population, high hs-CRP was associated with increased CHD risk (1.76 HR, 95% CI 1.02 to 3.03). The use of tertiles for hs-CRP and the addition of BMI to the model did not significantly alter the findings (data not shown).

Lp-PLA₂ levels in the highest tertile (≥422 μg/L) were associated with increased CHD risk (1.78 HR, 95% CI 1.33 to 2.38) in a model adjusted for age, sex, and race (Table 4). In a Cox proportional hazards model also adjusted for traditional risk factors, including LDL-C and HDL-C, the relative risk

TABLE 2. Weighted Correlation Between Lp-PLA₂ and Other Risk Factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Pearson Correlation Coefficient</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cholesterol</td>
<td>0.23</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>LDL-C</td>
<td>0.36</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>HDL-C</td>
<td>-0.33</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Systolic blood pressure</td>
<td>0.04</td>
<td>NS</td>
</tr>
<tr>
<td>Diastolic blood pressure</td>
<td>-0.01</td>
<td>NS</td>
</tr>
<tr>
<td>hs-CRP</td>
<td>-0.05</td>
<td>NS</td>
</tr>
<tr>
<td>BMI</td>
<td>-0.02</td>
<td>NS</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>0.13</td>
<td>0.0006</td>
</tr>
</tbody>
</table>

NS indicates nonsignificant (P≥0.05)

TABLE 3. CHD HRs (95% CI) by hs-CRP Categories Defined by AHA/CDC§

<table>
<thead>
<tr>
<th>hs-CRP Categories*</th>
<th>Average Risk (1.0–3.0 mg/L)</th>
<th>High Risk (&gt;3.0 mg/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1 †</td>
<td>1.61 (1.21–2.16)</td>
<td>2.53 (1.88–3.40)</td>
</tr>
<tr>
<td>Model 2 †</td>
<td>1.31 (0.96–1.80)</td>
<td>1.72 (1.24–2.39)</td>
</tr>
<tr>
<td>Model 2,‡ LDL-C &lt;130 mg/dL§</td>
<td>1.18 (0.71–1.96)</td>
<td>1.76 (1.02–3.03)</td>
</tr>
</tbody>
</table>

*Low risk (<1 mg/L) is reference;‡ARIC tertiles were <1.01, 1.01–2.82, and >2.82 mg/L.
†Adjusted for age, sex, and race.
‡Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C, HDL-C, and diabetes.
§n=204 cases and 369 noncases.

Because hs-CRP tertiles in ARIC (<1.01, 1.01 to 2.82, and >2.82 mg/L) were similar to the cutpoints defined in the AHA/CDC guidelines (<1 mg/L, 1 to 3 mg/L, >3 mg/L), the AHA/CDC cutpoints were used to facilitate comparison across studies. In a Cox proportional hazards model adjusted for age, sex, and race, high hs-CRP as defined by the AHA/CDC cutpoint of >3.0 mg/L was associated with a significant increase in risk (2.53 HR, 95% CI 1.88 to 3.40) (Table 3). Further adjustment for smoking, hypertension, diabetes, LDL-C, and HDL-C attenuated risk associated with high hs-CRP, but risk remained significantly elevated (1.72 HR, 95% CI 1.24 to 2.39). For individuals with LDL-C <130 mg/dL, approximately the median LDL-C in this population, high hs-CRP was associated with increased CHD risk (1.76 HR, 95% CI 1.02 to 3.03). The use of tertiles for hs-CRP and the addition of BMI to the model did not significantly alter the findings (data not shown).

Lp-PLA₂ levels in the highest tertile (≥422 μg/L) were associated with increased CHD risk (1.78 HR, 95% CI 1.33 to 2.38) in a model adjusted for age, sex, and race (Table 4). In a Cox proportional hazards model also adjusted for traditional risk factors, including LDL-C and HDL-C, the relative risk

TABLE 4. CHD HRs (95% CI) by Lp-PLA₂ Tertiles

<table>
<thead>
<tr>
<th>Lp-PLA₂ Tertiles*</th>
<th>2 (310–422 μg/L)</th>
<th>3 (≥422 μg/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1 †</td>
<td>1.26 (0.94–1.69)</td>
<td>1.78 (1.33–2.38)</td>
</tr>
<tr>
<td>Model 2 †</td>
<td>1.02 (0.73–1.43)</td>
<td>1.16 (0.82–1.65)</td>
</tr>
<tr>
<td>Model 2,‡ LDL-C &lt;130 mg/dL§</td>
<td>1.83 (1.11–3.00)</td>
<td>1.99 (1.17–3.38)</td>
</tr>
<tr>
<td>Model 3 §</td>
<td>1.00 (0.71–1.41)</td>
<td>1.15 (0.81–1.63)</td>
</tr>
<tr>
<td>Model 3,§ LDL-C &lt;130 mg/dL§</td>
<td>1.83 (1.10–3.05)</td>
<td>2.08 (1.20–3.62)</td>
</tr>
</tbody>
</table>

*Lowest tertile (<310 μg/L) is reference.
†Adjusted for age, sex, and race.
‡Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C, HDL-C, and diabetes.
§Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C, HDL-C, diabetes, and hs-CRP.
Discussion

In the ARIC study, Lp-PLA₂ and hs-CRP levels were higher in middle-aged American men and women who subsequently developed CHD events than in those who remained free of CHD.

Two previous studies have examined Lp-PLA₂ and hs-CRP levels in cases with incident CHD and controls, and both studies found positive associations of Lp-PLA₂ and hs-CRP with CHD risk. However, the relation between Lp-PLA₂ and CHD risk was attenuated after adjustment for traditional risk factors including LDL-C and HDL-C, but further analysis motivated by the significant interactions among Lp-PLA₂, hs-CRP, and LDL-C indicated that the association remained significant, independent of other traditional risk factors but modifiable by hs-CRP in individuals with low LDL-C (<130 mg/dL). We did not find any significant, meaningful nonlinearity of Lp-PLA₂ using polynomial and spline regression, but complex nonlinearity remains a possibility. Moreover, the significant 3-way interaction (P=0.02 in a model with categorical variables and P=0.001 in a model with continuous variables) needs more statistical investigation in future research in this and other populations. The differing results among these studies may be attributed to the markedly different populations. WOSCOPS enrolled middle-aged hypercholesterolemic men in Scotland, with LDL-C entry criterion within a narrow range of 174 to 232 mg/dL, high prevalence of other risk factors, and 5-year event rate of 7.9% in the placebo group (1.6%/yr). In addition, half the patients in WOSCOPS were assigned to pravastatin therapy, which lowered LDL-C by 26% on average. The Women’s Health Study examined middle-aged American women who were mostly professionals and had a lower event rate (1.4% over 6.2 years, or 0.2%/yr), enrolled fewer African Americans (2.3%) and fewer diabetic patients (2.6%) than ARIC, and included only 123 cases (49 of which were stroke) and 123 controls in the Lp-PLA₂ analysis. In contrast, participants in ARIC were both men and women, including a substantial number of African Americans, and had a wide range of LDL-C levels, as would be expected in the US population; in this analysis of ARIC, the 10th percentile for LDL-C was 89 mg/dL and the 90th percentile was 179 mg/dL, and the event rate was 6.1% over 7 years, or 0.9%/yr.

For the hs-CRP analysis, the cutpoints defined in the AHA/CDC guidelines (1 and 3 mg/L) were used because they were similar to the tertile cutpoints in ARIC (1.01 and 2.82 mg/L). A previous analysis that examined hs-CRP in a different ARIC cohort showed similar risk for the upper 2 quintiles. The AHA/CDC guidelines provide for the assessment of hs-CRP in individuals at intermediate CHD risk (10% to 20% 10-year risk) as an adjunct to major risk factors to refine risk assessment and in considering whether to...
intensify therapy. There is a consensus that individuals with CHD risk >20% need preventive intervention and therefore CRP measurement will not influence therapy. Screening very-low-risk populations is not recommended and not thought to be cost-effective, although some groups have considered intermediate risk to include 6% to 20%.27

The ATP III guidelines recommend that calculated 10-year risk for a CHD event be used to determine which patients should receive lipid-lowering therapy and the target level for LDL-C. Two large placebo-controlled randomized clinical trials of statins in high-risk patients have shown that patients benefited from therapy regardless of baseline LDL-C.28,29 In the current guidelines, for individuals with LDL-C <130 mg/dL, drug therapy is not recommended in primary prevention and is considered optional for individuals with CHD or equivalent (ie, 10-year risk estimate >20%).30 If high-risk patients with LDL-C <130 mg/dL receive significant benefit from lipid-lowering drug therapy, as suggested by recent clinical trials, future guidelines may focus more on novel ways to assess CHD risk in low–LDL-C patients to determine who should be selected. This is an important population for CHD prevention, because approximately one third of all events (204 cases in ARIC) occurred in persons with LDL-C <130 mg/dL.

A post hoc analysis of the Air Force/Texas Coronary Atherosclerosis Prevention Study (AFCAPS/TexCAPS) suggested that measuring hs-CRP may be useful for targeting statin therapy in primary prevention of acute coronary events.31 AFCAPS/TexCAPS enrolled middle-aged men and women with average LDL-C and low HDL-C levels, and for individuals with LDL-C below the median (149.1 mg/dL), only those with elevated hs-CRP had reduced risk with lovastatin therapy.

The results from ARIC support the rationale that Lp-PLA2 and hs-CRP may be useful to identify patients at increased CHD risk who have low LDL-C (<130 mg/dL) and are not targeted for drug therapy by the current guidelines. ARIC had only a single measurement of Lp-PLA2 and hs-CRP; associations might have been stronger with multiple measurements of these biomarkers. In addition, the risk for Lp-PLA2 may have been underestimated because of a lower reliability coefficient for the Lp-PLA2 manual ELISA than for the hs-CRP automated immunoturbidimetric assay (0.76 versus 0.95). A large prospective randomized trial will test the hypothesis that hs-CRP measurement can identify high-risk patients with LDL-C <130 mg/dL and no clinical evidence of CHD who may benefit from statin therapy.32

Although our results support the use of novel blood tests to identify high-risk patients who may benefit from primary prevention, they are also consistent with a putative causal role for both Lp-PLA2 and hs-CRP in atherogenesis and CHD events. Lp-PLA2 is bound primarily with LDL, with an increased concentration in small, dense LDL.33 Small LDL has enhanced penetration into the vessel wall34 and enhanced susceptibility to oxidation.35 Lp-PLA2 is the enzyme responsible for the hydrolysis of oxidized phospholipids and the generation of lysophosphatidylcholine, which can lead to increased expression of adhesion molecules. Thus, increased Lp-PLA2 in LDL may enhance the atherogenicity of LDL by increasing vascular inflammation. High levels of hs-CRP, which is an acute-phase reactant, may also provoke vascular inflammation.36 and hs-CRP may preferentially bind to oxidized LDL.37 Individuals with low LDL-C but high Lp-PLA2 and hs-CRP may therefore have much greater atherogenicity from LDL than would be expected by the absolute level of LDL-C. Statins lower LDL-C level and LDL particle number, reduce hs-CRP level,7 and reduce Lp-PLA2 activity.38 However, many patients continue to have elevated hs-CRP and Lp-PLA2 even on statin therapy (Chris J. Packard, DSc, personal communication, 2003). Other therapies, such as weight loss and high-dose aspirin, also reduce hs-CRP levels. Fibrates have been shown to reduce Lp-PLA2 activity,38 and a novel agent that inhibits Lp-PLA2 is currently in phase II development.39 Therefore, in addition to potentially identifying high-risk but currently untreated patients who may benefit from therapies such as statins to reduce CHD events, measurement of Lp-PLA2 and hs-CRP may be useful to identify cohorts of patients for clinical trials to determine whether inhibition of Lp-PLA2, or reduction/inhibition of hs-CRP reduces CHD events. In summary, both Lp-PLA2 and hs-CRP may be complementary in identifying middle-aged individuals with high CHD risk but low LDL-C.

Acknowledgments

This research was supported by National Heart, Lung, and Blood Institute contracts N01-HC-55015, N01-HC-55016, N01-HC-55018, N01-HC-55019, N01-HC-55020, N01-HC-55021, and N01-HC-55022 and by an unrestricted research grant from diaDexus, Inc, South San Francisco, Calif. The atherosclerosis laboratory is supported by donations from George and Cynthia Mitchell, Nijad Fares, and Jeffrey Hines. The authors acknowledge the editorial assistance of Kerrie Jara.

References


Lipoprotein-Associated Phospholipase A₂, High-Sensitivity C-Reactive Protein, and Risk for Incident Coronary Heart Disease in Middle-Aged Men and Women in the Atherosclerosis Risk in Communities (ARIC) Study
Christie M. Ballantyne, Ron C. Hoogeveen, Heejung Bang, Josef Coresh, Aaron R. Folsom, Gerardo Heiss and A. Richey Sharrett

Circulation. published online February 2, 2004;
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2004 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/early/2004/02/02/01.CIR.0000116763.91992.F1.citation

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org//subscriptions/