Lipoprotein-Associated Phospholipase A2, High-Sensitivity C-Reactive Protein, and Risk for Incident Ischemic Stroke in Middle-aged Men and Women in the Atherosclerosis Risk in Communities (ARIC) Study

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Background: Measurement of inflammatory markers has been reported to identify individuals at increased risk for ischemic stroke. Lipoprotein-associated phospholipase A2 (Lp-PLA2) is a proinflammatory enzyme secreted by macrophages. We assessed Lp-PLA2 and C-reactive protein (CRP) levels along with traditional risk factors to examine their relation to ischemic stroke.

Methods: A proportional hazards model was used in a prospective case-cohort study of 12,762 apparently healthy middle-aged men and women in the Atherosclerosis Risk in Communities (ARIC) study who were observed for about 6 years.

Results: Mean Lp-PLA2 and CRP levels adjusted for sex, race, and age were higher in the 194 stroke cases than the 766 noncases, whereas low-density lipoprotein cholesterol (LDL-C) level was not significantly different. Both Lp-PLA2 and CRP levels were associated with ischemic stroke after adjustment for age, sex, and race: hazard ratios were 2.23 for the highest vs the lowest tertile of Lp-PLA2 and 2.70 for CRP level higher than 3 vs lower than 1 mg/L. In a model that included smoking, systolic hypertension, lipid levels, and diabetes, Lp-PLA2 and CRP levels in the highest category were associated with hazard ratios of 1.91 (95% confidence interval, 1.15-3.18; \( P = .01 \)) and 1.87 (95% confidence interval, 1.13-3.10; \( P = .02 \)), respectively. Individuals with high levels of both CRP and Lp-PLA2 were at the highest risk after adjusting for traditional risk factors compared with individuals with low levels of both, whereas others were at intermediate risk.

Conclusion: Levels of Lp-PLA2 and CRP may be complementary beyond traditional risk factors in identifying middle-aged individuals at increased risk for ischemic stroke.

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An estimated 700,000 strokes occur each year in the United States, making stroke the third leading cause of death and the leading cause of neurologic disability. Although the incidence of stroke increases with age and is highest in the elderly, almost a third of strokes occur in individuals younger than 65 years. Pharmacologic therapy with aspirin, antihypertensive medications, and statins are beneficial in the prevention of stroke; however, current US guidelines for screening and prevention of cardiovascular disease as recommended by the National Cholesterol Education Program Adult Treatment Panel III (ATP III) are based on the risk for development of coronary heart disease (CHD) and do not include risk for stroke. Although lipid fractions such as low-density lipoprotein cholesterol (LDL-C) and high-density lipoprotein cholesterol (HDL-C) are strongly associated with development of CHD in middle-aged Americans, and lipid screening should improve risk assessment for prevention of CHD, lipid levels are not highly predictive of stroke in middle-aged Americans.

See also pages 2454 and 2473

Inflammation is postulated to play an important role in cerebrovascular disease as well as CHD, and levels of C-reactive protein (CRP) are associated with increased risk for stroke. Lipoprotein-associated phospholipase A2 (Lp-PLA2) is a proinflammatory enzyme secreted by macrophages that is primarily bound to LDL in the circulation. It hydrolyzes oxidized phospholipids to generate lysophosphatidylcholine and oxidized fatty acids, which have proinflammatory properties, and its activity is increased in small, dense LDL.
In this study, levels of Lp-PLA2 and CRP were examined in a large population of middle-aged Americans in the Atherosclerosis Risk in Communities (ARIC) study to determine whether these inflammatory markers were associated with increased risk for incident ischemic stroke.

**METHODS**

**STUDY POPULATION**

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

**STUDY DESIGN**

Because plasma samples from the first visit were depleted, Lp-PLA2 and high-sensitivity (hs)–CRP levels were measured in duplicate in plasma from visit 2 (1990-1992) in individuals who subsequently had an ischemic stroke (cases) and in a cohort random sample (CRS). Participants were excluded from follow-up if they did not return for visit 2 (n = 1214), had a history of stroke at visit 2 (n = 442), had prevalent CHD before visit 2 or missing CHD information (n = 1272), belonged to an underrepresented minority group (n = 91), or had no valid follow-up time (n = 11). Therefore, the potential full cohort consisted of 12,762 individuals who were observed for incident ischemic stroke, a first definite or probable hospitalized stroke in a participant who did not have a history of physician-diagnosed stroke at visit 2. Criteria and classification for stroke have been described previously.

A case-cohort design (n = 1225) was used to compare participants who developed a stroke with a CRS of all participants at the beginning of follow-up. The CRS was selected by stratification on sex, race (black vs white), and age at visit 2 (≥ 55 vs < 35 years). After exclusion of 265 subjects with missing information, the final sample size for the analysis was 960 (194 cases and 766 noncases). The CRS included 784 individuals (18 cases and 766 noncases).

**RISK FACTOR ASSESSMENT**

Medical history, cigarette smoking, and alcohol consumption were determined by standardized, validated, interviewer-administered questionnaires at visit 2. Body mass index (BMI) (calculated as weight in kilograms divided by the square of height in meters) was calculated from measured height at visit 1 and weight at visit 2. Waist-hip ratio was calculated from measurements obtained at visit 2. Hypertension was defined as a systolic blood pressure of 140 mm Hg or higher, a diastolic blood pressure of 90 mm Hg or higher, or use of antihypertensive medication in the past 2 weeks. Diabetes was defined as a fasting blood glucose level of 126 mg/dL (7.0 mmol/L) or higher, nonfasting blood glucose level of 200 mg/dL (11.1 mmol/L) or higher, a physician’s diagnosis of diabetes, or use of antidiabetic medication in the past 2 weeks.

**LABORATORY MEASUREMENTS**

Plasma lipid levels were measured in centralized laboratories by standard, validated methods as previously described. We assessed Lp-PLA2 levels by a dual monoclonal antibody immunoassay standardized to recombinant Lp-PLA2 (PLAC; DiaDexus Inc, South San Francisco, Calif). Interassay precision for Lp-PLA2 measurement was assessed by measuring 2 controls of known concentration (low and high) in 40 separate assays; the interassay coefficients of variation on all 40 plates were 12.7% and 9.6%, respectively. We assessed CRP levels by the immunoturbidimetric CRP-Latex (II) high-sensitivity assay from Denka Seiken (Tokyo, Japan) performed according to the manufacturer’s protocol and using a Hitachi 717 analyzer (Roche Diagnostics, Indianapolis, Ind). This assay has been validated against the Dade Behring method (Deerfield, Ill).

For quality control, each sample was measured in duplicate, and about 6% of samples were measured as blinded replicates on different dates to assess repeatability of measurements of levels of Lp-PLA2, CRP, and other analytes. The reliability coefficient for blinded quality control replicates was 0.76 for the Lp-PLA2 assay (67 blinded replicates) and 0.95 for the CRP assay (70 blinded replicates).

**STATISTICAL ANALYSIS**

For the primary analysis, variables were categorized, using cut points from the ATP III guidelines for cholesterol and the US Joint National Committee VI guidelines for blood pressure (the guidelines in effect when this analysis was designed). Some categories were combined to maintain sufficient numbers of events per cell. For Lp-PLA2, the major study covariate, tertiles were used. For hs-CRP, both tertiles and cut points from Pearson et al were used (hereinafter, Centers for Disease Control and Prevention/American Heart Association [CDC/AHA] guidelines) were examined. The primary null hypothesis was that Lp-PLA2 level is not predictive of stroke beyond traditional risk factors, including consideration of the interrelationship of Lp-PLA2 level with LDL-C and hs-CRP levels, as suggested in our research team’s previous study of CHD. A Wald test for the 2-sided alternative was used to test the association at the .05 level.

Means or proportions of baseline variables were examined in incident stroke cases vs noncases by analysis of covariance (adjusting for key demographic factors such as age, sex, and race whenever pertinent) and logistic regression, respectively. Baseline demographic variables and risk factors included in the ATP III algorithm for CHD risk assessment, and thus chosen on an a priori basis, were considered as potential confounders, including LDL-C, HDL-C, and total cholesterol levels, diabetes, smoking, and hypertension. Weighted Pearson and Spearman rank correlation coefficients between variables were calculated for subjects in the CRS. In all analyses, weights based on sampling proportions were used to allow inferences to the entire cohort.

The Cox proportional hazards model was used to examine the independent and joint associations of Lp-PLA2 level with incident ischemic stroke. The statistical method and computer software for case-cohort design within a framework of proportional hazard regression were modified to take into consideration the stratified nature of the CRS and robust variance estimation. The results are presented as hazard ratios (HRs) with 95% confidence intervals (CIs).

As a secondary analysis, tests were performed to assess for various potential interactions and (non)linearity, and subgroup analyses were conducted to confirm results. A χ² test was used to assess the overall association of Lp-PLA2 level and outcome; all other overall associations were tested similarly. All statistical analyses were performed using SAS software, version 8 (SAS Institute Inc, Cary, NC), and SUDAAN version 8.0.0 (Research Triangle Institute, Research Triangle Park, NC).

**RESULTS**

Of the 223 incident strokes, 194 were classified as ischemic strokes, with mean time to ischemic stroke 4.4 years.
Baseline characteristics of the study population are summarized in Table 1. Traditional stroke risk factors such as hypertension, diabetes, and current smoking were more prevalent in stroke cases. Compared with noncases, individuals with incident stroke had significantly higher systolic and diastolic blood pressure, higher triglyceride levels, and lower HDL-C levels than noncases. There was no significant difference in LDL-C levels between cases and noncases (136.6 vs 132.0 mg/dL [3.53 vs 3.41 mmol/L]). In addition to these differences in traditional risk factors of smoking status, systolic blood pressure, LDL-C and HDL-C levels, and diabetes, high levels of Lp-PLA2 were still associated with a significant increase in risk for incident ischemic stroke (HR, 1.91; 95% CI, 1.14-3.27); results were similar when the waist-hip ratio was substituted for BMI. Hazard ratios were similar for all incident stroke (data not shown). In the fully adjusted model, blood pressure, diabetes, current smoking, age, and race were all significant predictors of ischemic stroke, whereas LDL-C and HDL-C levels and sex were not.

Tests for potential interaction with variables used in the model did not show an interaction with race or sex, but a significant interaction was observed between Lp-PLA2 and CRP levels (P = .03 for χ² test). Therefore, we examined the HR for ischemic stroke when both Lp-PLA2 and CRP levels were included along with traditional risk factors in the same Cox proportional hazards model also adjusted for traditional risk factors of smoking status, systolic blood pressure, LDL-C and HDL-C levels, and other factors in the model did not show an interaction with race or sex. Individuals with CRP levels lower than 1.0 mg/L and Lp-PLA2 levels in the lowest tertile (≤310 µg/L) were at the lowest risk; individuals with high levels of both Lp-PLA2 and CRP. Therefore, we examined the HR for ischemic stroke when both Lp-PLA2 and CRP levels were included along with traditional risk factors in the same Cox proportional hazards model also adjusted for traditional risk factors of smoking status, systolic blood pressure, LDL-C and HDL-C levels, and diabetes, high levels of Lp-PLA2 were still associated with a significant increase in risk for incident ischemic stroke (HR, 1.91; 95% CI, 1.14-3.27); results were similar when the waist-hip ratio was substituted for BMI. Hazard ratios were similar for all incident stroke (data not shown). In the fully adjusted model, blood pressure, diabetes, current smoking, age, and race were all significant predictors of ischemic stroke, whereas LDL-C and HDL-C levels and sex were not.

Table 1. Baseline Characteristics in Cases of Incident Ischemic Stroke and Noncases*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Incident Stroke (n = 194)</th>
<th>Noncases (n = 766)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y†</td>
<td>59.7</td>
<td>56.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Female, %†</td>
<td>43.8</td>
<td>57.6</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>African American, %†</td>
<td>43.3</td>
<td>24.3</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Current smoker, %</td>
<td>33.7</td>
<td>19.7</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>BMI</td>
<td>28.3</td>
<td>28.1</td>
<td>.59</td>
</tr>
<tr>
<td>Diabetes, %</td>
<td>31.0</td>
<td>16.0</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Hypertension history, %</td>
<td>58.9</td>
<td>32.6</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Systolic blood pressure, mm Hg</td>
<td>129.6</td>
<td>121.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Diastolic blood pressure, mm Hg</td>
<td>75.0</td>
<td>72.5</td>
<td>.01</td>
</tr>
<tr>
<td>Total cholesterol, mg/dL</td>
<td>212.6</td>
<td>208.0</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Triglycerides, mg/dL</td>
<td>147.3</td>
<td>128.1</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>HDL-C, mg/dL‡</td>
<td>46.6</td>
<td>50.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>LDL-C, mg/dL‡</td>
<td>136.6</td>
<td>132.0</td>
<td>.17</td>
</tr>
<tr>
<td>Lp-PLA2, µg/L§</td>
<td>443</td>
<td>374</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>hs-CRP, mg/L§</td>
<td>3.85</td>
<td>3.08</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Data are reported as mean values unless otherwise noted.
†Median LDL-C level was 136.2 mg/dL for cases and 131.6 mg/dL for noncases.
‡Median hs-CRP level was 3.07 mg/L for cases and 1.76 mg/L for noncases.
§Median Lp-PLA2 level was 136.2 mg/dL for cases and 131.6 mg/dL for noncases.

Table 2. Ischemic Stroke Risk by CDC/AHA" High-Sensitivity C-Reactive Protein Categories*

<table>
<thead>
<tr>
<th>Model No.</th>
<th>Average Risk (1.0-3.0 mg/L)</th>
<th>HR (95% CI)</th>
<th>P Value</th>
<th>High Risk (3.0 mg/L)</th>
<th>HR (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1†</td>
<td>1.65 (1.02-2.67)</td>
<td>.04</td>
<td>2.70 (1.69-4.31)</td>
<td>&lt;.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2‡</td>
<td>1.41 (0.85-2.35)</td>
<td>.19</td>
<td>1.87 (1.13-3.10)</td>
<td>.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3§</td>
<td>1.54 (0.91-2.62)</td>
<td>.11</td>
<td>1.97 (1.14-3.39)</td>
<td>.02</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ARIC, Atherosclerosis Risk in Communities Study; CDC/AHA, Centers for Disease Control and Prevention/American Heart Association; CI, confidence interval; HDL-C, high-density lipoprotein cholesterol; LDL-C, low-density lipoprotein cholesterol; Lp-PLA2, lipoprotein-associated phospholipase A2.

3.34) in a model adjusted for age, sex, and race. In a Cox proportional hazards model also adjusted for traditional risk factors of smoking status, systolic blood pressure, LDL-C and HDL-C levels, diabetes, high levels of Lp-PLA2 were still associated with a significant increase in risk for incident ischemic stroke (HR, 1.91; 95% CI, 1.14-3.27); results were similar when the waist-hip ratio was substituted for BMI. Hazard ratios were similar for all incident stroke (data not shown). In the fully adjusted model, blood pressure, diabetes, current smoking, age, and race were all significant predictors of ischemic stroke, whereas LDL-C and HDL-C levels and sex were not.
In the ARIC population, levels of Lp-PLA₂ and CRP were higher in middle-aged Americans who subsequently had an ischemic stroke than in those who did not. As previously reported,²⁵ traditional risk factors such as diabetes, hypertension, age, and race were significantly associated with stroke in ARIC. Levels of LDL-C did not differ between incident stroke cases and noncases, and in fully adjusted models, LDL-C, HDL-C, and triglyceride levels were not associated with increased risk for stroke, as reported previously.²⁴

One small study of 33 patients identified at least 2 months after an ischemic stroke found that the mean ± SD activity of Lp-PLA₂ was significantly higher in cases than in healthy controls (41 ± 18 nmol/mL per minute vs 29 ± 17 nmol/mL per minute).²³ While the present report was in preparation, another case-cohort study, performed in Rotterdam and including 110 ischemic stroke cases and a random sample of 1820 subjects, reported that the HR for stroke in the highest quartile for Lp-PLA₂ activity compared with the lowest quartile was 1.97 after adjustment for age, sex, race, smoking status, systolic blood pressure, LDL-C and HDL-C levels, and diabetes.²⁶

Table 3. Ischemic Stroke Risk by Lipoprotein-Associated Phospholipase A₂ Tertiles

<table>
<thead>
<tr>
<th>Tertile 2 (310-422 µg/L)</th>
<th>Tertile 3 (&gt;422 µg/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model No.</td>
<td>HR (95% CI)</td>
</tr>
<tr>
<td>1†</td>
<td>0.87 (0.55-1.37)</td>
</tr>
<tr>
<td>2‡</td>
<td>0.87 (0.52-1.46)</td>
</tr>
<tr>
<td>3§</td>
<td>0.86 (0.51-1.45)</td>
</tr>
<tr>
<td>4¶</td>
<td>0.89 (0.52-1.52)</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; HDL-C, high-density lipoprotein cholesterol; HR, hazard ratio; hs-CRP, high-sensitivity C-reactive protein; LDL-C, low-density lipoprotein cholesterol.

*Lowest tertile (<310 µg/L) is the referent.
†Adjusted for age, sex, and race.
‡Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C and HDL-C level, and diabetes.
§Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C and HDL-C levels, diabetes, and hs-CRP level.
¶Adjusted for age, sex, race, smoking status, systolic blood pressure, LDL-C and HDL-C levels, diabetes, hs-CRP level, antihypertensive medication, and body mass index.

Figure. Association of lipoprotein-associated phospholipase (Lp-PLA₂) and high-sensitivity C-reactive protein (hs-CRP) with incident ischemic stroke. Ischemic stroke risk in individuals with elevated levels of both Lp-PLA₂ (highest tertile) and hs-CRP (high-risk category as defined in the Centers for Disease Control and Prevention/American Heart Association guidelines) was more than 11 times greater than in individuals with low levels (first tertile) of Lp-PLA₂ and hs-CRP (P=.001; 95% confidence interval, 3.13-41.41). Compared with the individuals in the lowest categories of both variables, individuals in each of the other categories had significantly increased stroke risk except for individuals in the highest category of CRP and the middle tertile of Lp-PLA₂.

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ecule and chemokine expression to promote vascular inflammation.\textsuperscript{32,33} Therefore, Lp-PLA\textsubscript{2} and CRP, along with factors that promote endothelial dysfunction and inflammation such as hypertension, diabetes, and tobacco, may drive both intimal proliferation in large arteries, which are susceptible to atherosclerosis, and adventitial proliferation and fibrosis in smaller cerebral arteries.

If LDL-C is not a major risk factor for stroke, then how can one explain the reduction of stroke observed in statin trials? The recently published results on stroke reduction with simvastatin in the Heart Protection Study\textsuperscript{34} show no association in the placebo group between incidence of stroke and baseline LDL-C level (5.7% stroke incidence for LDL-C $< 116$ mg/dL [\(\leq 3.0\) mmol/L]; 5.4% for LDL-C $\geq 135$ mg/dL [\(\geq 3.5\) mmol/L]) or baseline level of HDL-C (5.6% stroke incidence for HDL-C $< 35$ mg/dL [\(\leq 0.9\) mmol/L]; 5.7% for HDL-C $\geq 43$ mg/dL [\(\geq 1.1\) mmol/L]). In contrast, CHD event rates in placebo patients were associated with baseline LDL-C level (22.2% for LDL-C $< 116$ mg/dL [\(\leq 3.0\) mmol/L]; 27.2% for LDL-C $\geq 135$ mg/dL [\(\geq 3.5\) mmol/L]) and HDL-C level (29.9% for HDL-C $< 35$ mg/dL [\(\leq 0.9\) mmol/L]; 20.9% for HDL-C $\geq 43$ mg/dL [\(\geq 1.1\) mmol/L]).\textsuperscript{35} Nonetheless, simvastatin therapy was associated with an approximate 25% reduction in stroke and CHD events in all categories of lipids. Although statins have a pronounced effect on lowering levels of LDL-C, statins significantly reduce the levels of CRP (by 20%-40%)\textsuperscript{36} and also significantly reduce Lp-PLA\textsubscript{2} activity (by 28%-42%),\textsuperscript{37} reductions similar to the event reduction observed in stroke.

Alternatively, the reductions in CRP and Lp-PLA\textsubscript{2} levels observed with statin therapy may not be mechanistically linked to reductions in stroke or myocardial infarction but may be markers of other anti-inflammatory effects of statins.\textsuperscript{36} Fibrates, which are peroxisome proliferator-activated $\alpha$-receptor agonists, have been shown to reduce levels of CRP and Lp-PLA\textsubscript{2}.\textsuperscript{36,40} In the Veterans Affairs HDL Intervention Trial,\textsuperscript{41} the fibrate gemfibrozil reduced incidence of ischemic stroke and whether statins and/or fibrates are complementary to traditional risk factors to identify middle-aged individuals at increased risk for stroke. Future studies should determine whether selective inhibition of Lp-PLA\textsubscript{2} or reduction and/or inhibition of CRP reduces ischemic stroke and whether statins and/or fibrates are more effective for stroke prevention in patients with elevated levels of Lp-PLA\textsubscript{2}.

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