Metabolic Syndrome

Differential Effects of Nebivolol and Metoprolol on Insulin Sensitivity and Plasminogen Activator Inhibitor in the Metabolic Syndrome

Katie Ayers, Loretta M. Byrne, Anthony DeMatteo, Nancy J. Brown

Abstract—Early-generation β-blockers lower blood pressure and reduce cardiovascular mortality in coronary artery disease and congestive heart failure but worsen glucose homeostasis and fibrinolytic balance. Nebivolol is a third-generation β-blocker that increases the bioavailability of nitric oxide. We compared the effect of nebivolol (5 mg/d) and the β1-selective antagonist metoprolol (100 mg/d) on glucose homeostasis and markers of fibrinolysis in 46 subjects with metabolic syndrome. Subjects underwent a frequently sampled IV glucose tolerance test after 3-week washout and placebo treatment and after randomized treatment with study drug. After 12-week treatment, nebivolol and metoprolol equivalently decreased systolic blood pressure, diastolic blood pressure, and heart rate. Neither drug affected β-cell function, disposition index, or acute insulin response to glucose. Metoprolol significantly decreased the insulin sensitivity index. In contrast, nebivolol did not affect insulin sensitivity, and the decrease in sensitivity was significantly greater after metoprolol than after nebivolol (−1.5±2.5×10−4* min−1 per milliunit per liter versus 0.04±2.19×10−4* min−1 per milliunit per liter after nebivolol; P=0.03). Circulating plasminogen activator inhibitor also increased after treatment with metoprolol (from 9.8±6.8 to 12.3±7.8 ng/mL) but not nebivolol (from 10.8±7.8 to 10.5±6.2 ng/mL; P=0.05 versus metoprolol). Metoprolol, but not nebivolol, increased F2-isoprostane concentrations. In summary, treatment with metoprolol decreased insulin sensitivity and increased oxidative stress and the antifibrinolytic plasminogen activator inhibitor 1 in patients with metabolic syndrome, whereas nebivolol lacked detrimental metabolic effects. Large clinical trials are needed to compare effects of nebivolol and the β1 receptor antagonist metoprolol on clinical outcomes in patients with hypertension and the metabolic syndrome. (Hypertension. 2012;59:893-898.)

Key Words: clinical science ■ insulin resistance ■ hypertension ■ cardiovascular pathophysiology ■ antihypertensive therapy

The prevalence of obesity and the metabolic syndrome has reached epidemic proportions in developed countries and conveys an increased risk of cardiovascular mortality.1,2 Elevated circulating concentrations of plasminogen activator inhibitor 1 (PAI-1), the major physiological inhibitor of fibrinolysis in vivo, are a hallmark of insulin resistance and the metabolic syndrome and, in turn, are associated with an increased risk of thrombotic cardiovascular events.3,4 Insulin resistance and impaired fibrinolysis contribute to increased cardiovascular morbidity and mortality in the metabolic syndrome.4 Importantly, commonly used antihypertensive agents differ in their impact on insulin sensitivity and biomarkers of impaired fibrinolysis. For example, angiotensin-converting enzyme inhibitors and angiotensin receptor blockers improve glucose homeostasis in observational studies and some prospective trials.5-7 Angiotensin-converting enzyme inhibitors also decrease PAI-1 antigen and activity under conditions in which the renin-angiotensin-aldosterone system is activated.8 Angiotensin receptor blockers may have a transient beneficial effect on fibrinolytic balance, but this effect is not sustained.9 In contrast, diuretics impair glucose homeostasis and increase PAI-1 antigen and activity.10 Early-generation β-blockers can worsen glucose homeostasis and have little effect or a detrimental effect on fibrinolytic balance.11-17 Nebivolol is a third-generation β-blocker that increases the bioavailability of endogenous nitric oxide (NO).18,19 NO decreases the expression of PAI-120 and improves insulin sensitivity and muscle glucose uptake.21 Based on the mechanism of action of nebivolol, we hypothesized that nebivolol would have a relatively favorable effect on insulin sensitivity and fibrinolytic balance compared with an earlier-generation β-blocker.

Methods

Subjects

Subjects between the ages of 18 to 70 years with the metabolic syndrome were studied. All of the subjects gave written informed...
consent, and the study was approved by the institutional review board and implemented according to the Declaration of Helsinki. Metabolic syndrome was defined using the National Cholesterol Education Program criteria of ≥3 of the following: fasting plasma glucose of ≥100 mg/dL (5.5 mmol/L), serum triglycerides of ≥150 mg/dL (1.7 mmol/L), serum high-density lipoprotein cholesterol <40 mg/dL (1.04 mmol/L) in men or 50 mg/dL in women, untreated blood pressure of ≥130/85 mmHg, or waist girth of >102 cm in men or >88 cm in women. Subjects with significant cardiovascular (other than hypertension), renal, pulmonary, endocrine (other than insulin resistance or hyperlipidemia), or hematologic disease were excluded, as were pregnant women. Patients with diabetes mellitus, defined by a fasting glucose of 126 mg/dL (7 mmol/L) or medication use, were also excluded.

**Study Protocol**

After screening history and physical examination, all of the antihypertensive medications were discontinued for 3 weeks (Figure 1, top). Spironolactone was discontinued 4 weeks before study initiation. After washout, subjects were treated with placebo in a single-blind fashion for 21 days. For the last 3 days they were provided a nitrate-controlled diet. On the 20th day, subjects provided a 24-hour urine collection for measurement of electrolytes and NO metabolites. The subjects reported to the Clinical Research Center the following day for measurement of fibrinolytic biomarkers and for a frequently sampled IV glucose tolerance test. After the first study day, patients were randomly assigned to double-blind treatment with 5 mg of nebivolol once daily or 100 mg of metoprolol succinate ER once daily for 12 weeks. These doses were chosen based on published comparative studies indicating similar effects on blood pressure. Randomization was stratified by the presence or absence of hypertension and by race. Subjects returned for blood pressure checks and pill counts 1, 2, 4, 6, 8, and 10 weeks after randomization to active study medication. After 12 weeks of study drug, subjects then repeated the nitrate-controlled diet, urine collection, and study day with IV glucose tolerance test.

**Hemodynamic Measurements**

Blood pressure was measured with an aneroid sphygmomanometer (Tycos 767, Welch Allyn, Skaneateles Falls, NY) during office visits, using the appearance and complete disappearance of the Korotkoff sounds (K1 and K5) as systolic and diastolic blood pressures. The mean of 3 supine measurements was used. During the IV glucose tolerance test, blood pressures were collected with an automated oscillometric recording device (Dinamap, Critikon, Carlsbad, CA).

**Insulin-Modified Frequently Sampled Intravenous Glucose Tolerance Test**

Subjects reported to the Clinical Research Center between 7:00 AM and 8:00 AM after a 12-hour fast and were studied in the supine position. Thirty minutes to 1 hour after taking their last dose of study medication, subjects rested in the supine position for 15 minutes before their blood pressure was measured as described above. Intravenous catheters were then placed and, 30 minutes later, blood was obtained through a catheter for the measurement of fibrinolytic, endocrine, and inflammatory biomarkers. Two baseline samples were collected 10 minutes apart for measurement of glucose and insulin (Figure 1, bottom). At t=0 minutes, a bolus of 300 mg of glucose per kilogram of body weight was administered in a 25% glucose-saline solution over 1 minute. At t=20 minutes, a bolus of 0.02 U/kg of body weight of regular insulin (Actrapid, Novo Nordisk, Princeton, NJ) was given intravenously. Blood samples were collected for measurement of glucose and insulin at time t=2, 3, 4, 5, 6, 8, 10, 14, 16, 19, 22, 25, 30, 40, 50, 60, 70, 90, 110, 130, 150, 170, and 180 minutes. Plasma glucose was measured by glucose oxidase method with a Beckman glucose analyzer at every time point. Plasma insulin concentrations were determined by radioimmunoassay.

The acute insulin response to glucose, the area under the insulin curve between 0 and 10 minutes, and sensitivity index, the capacity for insulin to promote the disposal of glucose and to inhibit the endogenous production of glucose, were calculated using a modified version of the program MINMOD based on the Bergman minimal model. Disposition index, representing the overall ability of islet cells to secrete insulin normalized to the degree of insulin resistance, was also calculated using this model. β-Cell function was assessed by the computer model from the residual insulin secretion after the initial IV dextrose infusion.

**Laboratory Analysis**

Blood samples were collected on ice and centrifuged immediately at 0°C for 20 minutes. All of the plasma or serum were separated and
stored at −80°C until the time of assay. Blood for measurement of PAI-1 and tissue plasminogen activator (t-PA) was collected in Vacutainer tubes containing acidified 0.105 mol/L of sodium citrate (Becton Dickinson, Rutherford, NJ), because use of anticoagulant minimizes the contribution of platelet activation to PAI-1 antigen concentrations. PAI-1 antigen and t-PA antigen levels were both determined using 2-site ELISAs (Imulysc, Biopol AB).

Plasma renin activity was determined by radioimmunoassay (Dia-Sorin, Stillwater, MN). Aldosterone was determined using a radioimmunoassay with 125I-aldosterone (MP Biomedicals, Irvine, CA), a primary antibody to aldosterone (National Institute of Diabetes and Digestive and Kidney Diseases National Hormone and Peptide Program, Torrance, CA), and a secondary antibody rabbit γ-globulin antibody (Linco Research, St Charles, MO).

NO metabolites were measured in plasma and urine using a modified Griess reaction (Oxford Biomedical Research, Oxford, MI). Commercially available radioimmunoassay kits were used to measure plasma levels of cGMP (Amersham Pharmacia Biotech AB, Uppsala, Sweden.) Urine NO metabolites were normalized per milligram of creatinine. Asymmetrical dimethylarginine was measured by mass spectroscopy, F₂-isoprostanes were measured in urine using negative ion gas chromatography mass spectroscopy, as described previously.24

Statistical Analysis
Data are presented as mean±SD unless otherwise stated. Baseline characteristics of the 2 treatment groups were compared using a Student’s t test or χ² testing as appropriate. The effects of nebivolol and metoprolol on hemodynamic, metabolic, and fibrinolytic variables were compared using general linear models in which the between-subject variable was β-blocker. Race, age, body mass index, and pretreatment PAI-1 antigen were included as between-subject variables or covariates as indicated. A P value ≤0.05 was considered significant. Analyses were performed using IBM SPSS Statistics version 19.0.0.

Results
Baseline Characteristics
Forty-six subjects completed the study protocol. Table 1 provides their characteristics at screening. Subjects randomized to metoprolol were significantly older than those randomized to nebivolol. There were no other differences between the study groups at baseline.

Hemodynamic Effects of Metoprolol and Nebivolol
Twelve-week treatment with either metoprolol or nebivolol significantly decreased systolic blood pressure, diastolic blood pressure, and heart rate (P<0.05), and the hemodynamic effects of the 2 drugs were similar (Figure 2). Metoprolol (from 8.4±0.76 to 0.50±0.52 ng of angiotensin I per milliliter per minute; P=0.007) and nebivolol (from 0.67±0.72 to 0.23±0.31 ng of angiotensin I per milliliter per minute; P=0.009) similarly reduced plasma renin activity (P=0.61 for metoprolol versus nebivolol.). Metoprolol significantly reduced serum aldosterone (from 9.6±2.9 to 8.3±2.8 ng/dL; P=0.006). The effect of nebivolol on aldosterone was not statistically significant (from 9.5±3.0 to 8.5±2.3 ng/dL; P=0.057) but similar to that of metoprolol (P=0.82 for metoprolol versus nebivolol). Twenty-four-hour urine sodium excretion was also similar in the 2 groups at baseline (123.3±59.1 mmol in the metoprolol group and 117.2±47.3 mmol in the nebivolol group) and after 12 weeks of treatment (108.0±49.7 mmol in the metoprolol group and 123.9±40.8 mmol in the nebivolol group).

Metabolic Effects of Metoprolol and Nebivolol
Table 2 shows the effect of treatment with metoprolol or nebivolol on measures of insulin sensitivity and β-cell function calculated from the IV glucose tolerance test. Twelve-week treatment with metoprolol significantly decreased the insulin sensitivity index. Nebivolol did not affect insulin sensitivity. Thus, the change in insulin sensitivity index differed significantly in the metoprolol and nebivolol treatment groups (−1.5±2.5×10⁻⁴×min⁻¹ per milliunit per liter after 12 weeks of metoprolol versus 0.04±2.19×10⁻⁴×min⁻¹ per milliunit per liter after nebivolol; P=0.03).

Effects of Metoprolol and Nebivolol on Fibrinolytic Balance
Pretreatment PAI-1 antigen concentrations were similar in the metoprolol (9.8±6.8 ng/mL) and nebivolol (10.8±7.8 ng/mL) groups, but PAI-1 antigen concentrations were significantly higher in the metoprolol-treated subjects after 12 weeks of therapy (12.3±7.8 versus 10.5±6.2 ng/mL in nebivolol-treated subjects; P=0.05 after controlling for race and pretreatment PAI-1). There was a significant relationship between pretreatment PAI-1 antigen and posttreatment PAI-1 antigen (P=0.001). There was a significant effect of race on PAI-1 antigen in the nebivolol treatment group (P=0.017). The change

Table 1. Subjects Characteristics Before Randomization

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Nebivolol Group (N=23)</th>
<th>Metoprolol Group (N=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>41.3±11.5</td>
<td>47.4±8.5*</td>
</tr>
<tr>
<td>Sex, male:female</td>
<td>8:15</td>
<td>8:15</td>
</tr>
<tr>
<td>Race, black:white:other</td>
<td>6:16:1</td>
<td>5:17:1</td>
</tr>
<tr>
<td>SBP, mm Hg</td>
<td>133.8±11.7</td>
<td>138.9±14.4</td>
</tr>
<tr>
<td>DBP, mm Hg</td>
<td>83.5±9.2</td>
<td>85.8±9.2</td>
</tr>
<tr>
<td>HR, bpm</td>
<td>75.8±9.8</td>
<td>75.6±12.7</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>37.0±7.4</td>
<td>36.6±7.0</td>
</tr>
<tr>
<td>Waist circumference, cm</td>
<td>119.5±16.6</td>
<td>113.7±11.4</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>124.0±49.8</td>
<td>124.4±44.9</td>
</tr>
<tr>
<td>HDL cholesterol</td>
<td>39.0±7.4</td>
<td>42.0±8.0</td>
</tr>
<tr>
<td>Fasting blood glucose</td>
<td>95.7±9.3</td>
<td>98.2±10.9</td>
</tr>
</tbody>
</table>

SBP indicates systolic blood pressure; DBP, diastolic blood pressure; HR, heart rate; BMI, body mass index; HDL, high-density lipoprotein.

*P=0.045 vs nebivolol group.

Figure 2. Effect of metoprolol and nebivolol on systolic blood pressure (SBP), diastolic blood pressure (DBP), and heart rate (HR). Pressures are measured in millimeter of mercury (mm Hg) and heart rate in beats per minute (bpm). Changes are shown as both absolute change (Δ) and percentage of change (%Δ) vs baseline. ● metoprolol; ■, nebivolol.
Effects of Metoprolol and Nebivolol on NO Metabolites and Oxidative Stress

Neither metoprolol nor nebivolol treatment altered plasma concentrations of NO metabolites (Table 3). Metoprolol increased urine NO metabolites, whereas nebivolol significantly increased plasma cGMP; however, the change in urine NO metabolites and plasma cGMP did not differ between treatment groups. Plasma cGMP correlated inversely with PAI-1 antigen concentrations (Table 3). Metoprolol did not significantly affect F$_2$-isoprostanes (1.78±0.83 ng/mg Cr pretreatment and 1.95±1.63 ng/mg Cr posttreatment). Neither metoprolol nor nebivolol altered plasma concentrations of asymmetric dimethylarginine (Table 3) or inflammatory cytokines (data not shown).

Discussion

This study tested the hypothesis that the β-blockers nebivolol and metoprolol differ in their effects on insulin sensitivity and fibrinolytic balance. At doses that were equipotent with respect to reductions in blood pressure, heart rate, and renin activity, metoprolol treatment decreased insulin sensitivity, increased PAI-1 antigen concentrations, and increased oxidative stress, whereas nebivolol treatment did not.

Metoprolol is a β$_1$-receptor–selective antagonist widely used to prevent cardiovascular disease. Like nonselective β-blockers, metoprolol has been reported to increase fasting glucose concentrations and/or insulin concentrations and to decrease insulin sensitivity as measured by homeostasis model assessment-insulin resistance. The mechanism through which metoprolol decreases insulin sensitivity is not known but may involve decreased blood flow because of unopposed α-receptor–mediated vasoconstriction. It follows that nebivolol, a vasodilator, did not reduce insulin sensitivity; previous studies have reported that nebivolol reduces homeostasis model

---

**Table 2. Effect of Treatment on Metabolic Parameters**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>12 wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting plasma glucose, mg/dL</td>
<td>101.5±10.5</td>
<td>99.7±9.9</td>
</tr>
<tr>
<td>Nebivolol</td>
<td>99.5±10.7</td>
<td>101.6±9.3</td>
</tr>
<tr>
<td>Metoprolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fasting insulin, mU/L</td>
<td>5.55±3.12</td>
<td>6.04±3.21</td>
</tr>
<tr>
<td>Nebivolol</td>
<td>4.91±2.73</td>
<td>6.04±3.41</td>
</tr>
<tr>
<td>Metoprolol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AIRg indicates acute insulin response to glucose; ISI, insulin sensitivity index.

---

**Table 3. Effect of Treatment on Plasma and Urine NO Metabolites**

<table>
<thead>
<tr>
<th>Marker</th>
<th>Baseline</th>
<th>12 wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma NO metabolites, µM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebivolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metoprolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plasma cGMP, nM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebivolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metoprolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine NO metabolites, µmol/mg of Cr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebivolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metoprolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymmetric dimethylarginine, nM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebivolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metoprolol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Figure 3. Effect of metoprolol and nebivolol on plasminogen activator inhibitor 1 (PAI-1) and tissue plasminogen activator (t-PA).** *P*<0.05 vs pretreatment, †P<0.05 vs the metoprolol treatment group, after controlling for race and baseline PAI-1 antigen, ‡metoprolol; #nebivolol.
assessment-insulin resistance.17 Poirier et al28 compared the effects of atenolol and nebivolol and found that, like metoprolol, atenolol significantly reduced insulin sensitivity (insulin-induced glucose disposal rate/mean insulin concentration ratio), but nebivolol did not.

This study is the first to compare the effects of nebivolol and an early-generation β-blocker on fibrinolytic balance. Earlier studies reported that β1-receptor–selective antagonists have no impact or a negative impact on PAI-1. For example, Boman et al33 reported that 36-week treatment with atenolol increases PAI-1 activity in patients with hypertension and left ventricular hypertrophy, as we observed with metoprolol in individuals with the metabolic syndrome. Only 2 previous studies have examined the effect of nebivolol on fibrinolytic balance in humans. In an uncontrolled study in hypertensive patients, nebivolol decreased the PAI-1/α2-antiplasmin ratio but did not affect PAI-1 antigen or activity concentrations.29 Vyssoulis et al30 reported that nebivolol and celiprolol reduced PAI-1, whereas carvedilol did not, in patients with uncomplicated hypertension; however, 20% of patients were also taking hydrochlorothiazide, which increases PAI-1.

Circulating PAI-1 concentrations are increased during insulin resistance and both glucose and insulin stimulate response elements in the PAI-1 promoter.31,32 In the current study, PAI-1 antigen concentrations correlated with the effect of β-blockade on both insulin and glucose concentrations, suggesting that increased insulin resistance contributed to the increase in PAI-1 concentrations during metoprolol. We hypothesize that the preservation of fibrinolytic balance during nebivolol treatment reflected preserved insulin sensitivity. Stimulation of NO synthase during nebivolol treatment would also be expected to moderate PAI-1 concentrations; NO decreases PAI-1 expression through a cGMP-dependent mechanism.20 Circulating cGMP and NO metabolite concentrations are imperfect measures of NO production in humans, however, and we did not find evidence of an effect of nebivolol on vascular NO production.

Increased oxidative stress contributes to cardiovascular risk in the metabolic syndrome.33 Nebivolol has been reported to reduce oxidative stress in vivo in rodent models. In vivo, liquid chromatography-mass spectrometry measurement of F2-isoprostanes has become the gold standard for assessing oxidative stress.34 For the most part, studies using less accurate ELISA assays for F2-isoprostanes report no effect of atenolol, carvedilol, or metoprolol on F2-isoprostanes in hypertensive or diabetic patients.35,36 Fahlbusch et al37 also reported no effect of 6-day treatment with either carvedilol or metoprolol on urinary F2-isoprostane excretion, measured by liquid chromatography-mass spectrometry, in healthy volunteers. Fratta et al38 reported that nebivolol reduced plasma F2-isoprostanes, measured using a commercially available ELISA, in patients with essential hypertension. Troost et al39 reported that 7-day treatment with nebivolol decreased urinary F2-isoprostanes, measured by liquid chromatography-mass spectrometry, in healthy volunteers. In the present study in subjects with the metabolic syndrome, the finding that metoprolol increased F2-isoprostanes whereas nebivolol had no effect may reflect the high baseline levels of F2-isoprostanes in this obese study population.

Perspectives
The prevalence of obesity and the metabolic syndrome has reached epidemic proportions in developed countries.12 Although metoprolol and other early-generation β-blockers have been shown to reduce cardiovascular mortality in patients with coronary artery disease40 and congestive heart failure,29 this is not true in hypertension without these conditions,41 and negative effects of these drugs on insulin resistance, plasminogen activator inhibitor-1, and oxidative stress may diminish their beneficial effects in the obese.11–17 The present randomized study in individuals with the metabolic syndrome suggests that nebivolol has a favorable effect on fibrinolytic balance compared with metoprolol and lacks negative effects on insulin sensitivity and oxidative stress. Large clinical trials are needed to compare the effects of these 2 drugs on cardiovascular outcomes in obese patients with the metabolic syndrome.

Sources of Funding
This work was funded through a grant from Forest Laboratories, Inc, as well as from funding from National Institutes of Health grants HL060906, UL1RR024975, and T35007383.

Disclosures
N.J.B. consults for Novartis, Merck, and Boehringer-Ingelheim; received research funding from Forest Laboratories, Inc; and receives research funding from Shire HRT.

References


Differential Effects of Nebivolol and Metoprolol on Insulin Sensitivity and Plasminogen Activator Inhibitor in the Metabolic Syndrome
Katie Ayers, Loretta M. Byrne, Anthony DeMatteo and Nancy J. Brown

Hypertension. 2012;59:893-898; originally published online February 21, 2012;
doi: 10.1161/HYPERTENSIONAHA.111.189589

Hypertension is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://hyper.ahajournals.org/content/59/4/893

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Hypertension 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 Hypertension is online at:
http://hyper.ahajournals.org//subscriptions/