Lipoprotein-Associated Phospholipase A$_2$ and C-Reactive Protein for Risk-Stratification of Patients With TIA

Brett L. Cucchiara, MD; Steve R. Messe, MD; Lauren Sansing, MD; Larami MacKenzie, MD; Robert A. Taylor, MD; James Pacelli, MD; Qaisar Shah, MD; Scott E. Kasner, MD

Background and Purpose—Lipoprotein-associated phospholipase A$_2$ (Lp-PLA$_2$) is a marker of unstable atherosclerotic plaque, and is predictive of both primary and secondary stroke in population-based studies. Biomarkers indicating the presence of unstable atherosclerotic plaque might represent a useful supplement to improve risk prediction. Lipoprotein-associated phospholipase A$_2$ (Lp-PLA$_2$) and C-reactive protein (CRP) are 2 candidate markers which have been associated with inflammation and plaque instability in histopathologic studies of the carotid arteries. The primary aims of this study were to determine whether measurement of LpPLA$_2$ and high-sensitivity C-reactive protein (CRP) could improve risk-stratification of patients with TIA and to examine the relationship between these blood markers and TIA mechanism.

Methods—We conducted a prospective study of patients with acute TIA who presented to the ED. Clinical risk scoring using the ABCD$^2$ score was determined and Lp-PLA$_2$ mass (LpPLA$_2$-M) and activity (LpPLA$_2$-A) and high-sensitivity C-reactive protein (CRP) were measured. The primary outcome measure was a composite end point consisting of stroke or death within 90 days or identification of a high-risk stroke mechanism requiring specific early intervention (defined as ≥50% stenosis in a vessel referable to symptoms or a cardioembolic source warranting anticoagulation).

Results—The composite outcome end point occurred in 41/167 (25%) patients. LpPLA$_2$-M levels were higher in end point–positive compared to –negative patients (mean, 192±48 ng/mL versus 175±44 ng/mL, P<0.04). LpPLA$_2$-A levels showed similar results (geometric mean, 132 nmol/min/mL, 95% CI 119 to 146 versus 114 nmol/min/mL, 95% CI 108 to 121, P=0.01). There was no relationship between CRP and outcome (P=0.82). Subgroup analysis showed that both LpPLA$_2$-M (P=0.04) and LpPLA$_2$-A (P=0.06) but not CRP (P=0.36) were elevated in patients with >50% stenosis. In multivariate analysis using cut-off points defined by the top quartile of each marker, predictors of outcome included LpPLA$_2$-A (OR 3.75, 95% CI 1.58 to 8.86, P=0.003) and ABCD$^2$ score (OR 1.30 per point, 95% CI 0.97 to 1.75, P=0.08).

Conclusion—Many patients with TIA have a high-risk mechanism (large vessel stenosis or cardioembolism) or will experience stroke/death within 90 days. In contrast to CRP, both Lp-PLA$_2$ mass and activity were associated with this composite end point, and LpPLA$_2$-A appears to provide additional prognostic information beyond the ABCD$^2$ clinical risk score alone. (Stroke. 2009;40:2332-2336.)

Key Words: transient ischemic attack • lipid and lipoprotein metabolism • secondary prevention

Despite the development of clinical risk prediction scores such as the ABCD$^2$ score, risk stratification of patients with TIA remains imperfect. Biomarkers indicating the presence of unstable atherosclerotic plaque might represent a useful supplement to improve risk prediction. Lipoprotein-associated phospholipase A$_2$ (Lp-PLA$_2$) and C-reactive protein are 2 candidate markers which have been associated with inflammation and plaque instability in histopathologic studies of the carotid arteries. The primary aims of this study were to determine whether measurement of LpPLA$_2$ and high-sensitivity C-reactive protein (CRP) could improve risk-stratification of patients with TIA and to examine the relationship between these blood markers and TIA mechanism.

Typically, risk stratification schemes for patients with TIA have been tested in observational studies evaluating subsequent stroke occurrence. However, these studies occur on a background of variable diagnostic testing and therapeutic intervention which alter patient outcome. Ideally, risk stratification schemes would identify both patients who will experience stroke and those with a high-risk cause for which specific early intervention (such as carotid endarterectomy or initiation of anticoagulant therapy) is warranted and would alter subsequent stroke risk. For the purposes of this study, therefore, the primary outcome measure was a composite end point consisting of: (1) the presence of a treatment-emergent mechanism for which a specific therapy other than an antiplatelet agent is indicated (ie, >50% large vessel stenosis or cardioembolic source warranting anticoagulation) or (2) occurrence of subsequent stroke or death despite currently available standard therapy.

Methods

We conducted a prospective study of patients with suspected TIA evaluated within 48 hours of symptom onset. TIA was defined as acute onset of focal cerebral or monocular symptoms lasting <24 hours and thought to be attributable to a vascular cause in the opinion of the neurologist evaluating the patient. All patients for whom there

Received March 23, 2009; accepted April 8, 2009.
From the University of Pennsylvania (B.L.C., S.R.M., L.S., L.M., S.E.K.), Philadelphia; the University of Minnesota (R.A.T.), Minneapolis; the Lancaster General Hospital (J.P.), Pa; and the Abington Memorial Hospital (Q.S.), Pa.
Correspondence to Brett Cucchiara, MD, Department of Neurology, University of Pennsylvania Medical Center, 3400 Spruce Street, Philadelphia, PA 19104. E-mail cucchiar@mail.med.upenn.edu
© 2009 American Heart Association, Inc.

Stroke is available at http://stroke.ahajournals.org 
DOI: 10.1161/STROKEAHA.109.553545

2332
was sufficient clinical suspicion to justify diagnostic testing for a neurovascular cause were eligible for inclusion in this study, with 2 exceptions. First, patients with severe or terminal illness likely to preclude full evaluation and follow-up were excluded. Second, patients taking warfarin with an INR ≥ 1.5 were excluded because of concerns that therapeutic anticoagulation might confound measurement of marker levels. A detailed description of our study methodology has been published previously.8 Informed consent was obtained from all subjects and the protocol was approved by our local Institutional Review Board.

On enrollment, a standardized case report form was completed collecting data on clinical features of the TIA, medical history, and examination findings. Subsequently, all relevant diagnostic testing was recorded and an assessment of the presumed cause of the TIA was determined at hospital discharge and 90-day follow-up. Clinical events and therapeutic interventions were determined at hospital discharge and 90-day follow-up. The primary outcome measure was a composite end point including stroke or death within 90 days, ≧50% stenosis in a vessel referable to symptoms, or a cardioembolic source warranting anticoagulation. This outcome measure was pre-specified as the primary end point at the time of study conception and design, before patient enrollment or data analysis.

Findings on early MRI (when performed) were also evaluated, though MRI evaluation was not a study requirement, and patient selection for MRI was not systematic but based on individual clinician practice and resource availability. Patients with acute infarction on diffusion weighted imaging (DWI) were classified as DWI+. and those without infarction as DWI−. Determination of ABCD² risk score was performed in a manner identical to that reported by the originators of this score.3 This 7-point score incorporates age (≧60 years = 1 point), blood pressure (SBP ≧ 140 mm Hg or DBP ≧ 90 mm Hg = 1 point), clinical features (unilateral weakness = 2 points; speech disturbance without weakness = 1 point; other symptoms = 0 points), duration of symptoms (≧60 minutes = 2 points; 10 to 59 minutes = 1 point; <10 minutes = 0 points), and history of diabetes (1 point). Although the actual ABCD² score was computed retrospectively, all components of the score were prospectively collected as part of the described data set.

Categorization of ABCD² scores into 3 groups (0 to 3, 4 to 6, 7 to 10) were used as was done in the initial ABCD² publication.1

Collection of all clinical and radiographic information, and final determination of outcome category, was performed blinded to results of biomarker testing.

**Blood Sampling**

Venous blood samples were obtained under sterile conditions. Samples were collected in tubes containing 3.2% sodium citrate and immediately centrifuged at 1300 g for 10 minutes. Plasma was then extracted and additionally centrifuged at 10,000 g for 3 minutes. Samples were frozen promptly at −80°C until testing was performed.

Lp-PLA₂ mass (Lp-PLA₂-M) was assayed using a microplate-based enzyme linked immunosorbent assay (diaDexus Inc). Lp-PLA₂ activity (Lp-PLA₂-A) was measured with a colorimetric activity method (diaDexus Inc). This method measures a kinetic rate over time and verification of the linearity of the kinetics is necessary to ensure accurate measurement; samples with nonlinear kinetics represent unreliable measurements attributable to interference in the assay and results are not reported. High-sensitivity C-reactive protein (CRP) was measured on a Hitachi 917 analyzer (Roche Diagnostics) using a turbidimetric immunoassay (Kamiya K assay, Kamiya Biomedical Corp). All assays were performed at a central laboratory at diaDexus Inc with laboratory personnel blinded to all clinical data. Twenty percent of Lp-PLA₂-M and Lp-PLA₂-A samples were tested in duplicate, and the coefficient of variation was <10% in 97% of Lp-PLA₂-A samples and 92% of Lp-PLA₂-M samples. All of the Lp-PLA₂-M and Lp-PLA₂-A samples had coefficients of variation of <15%.

**Statistical Analysis**

Groups of patients were compared with χ² tests, Wilcoxon ranked sum tests, or logistic regression, as indicated. In analyses using LpPLA₂-A as a continuous variable, log-transformed values were used given the nonnormal distribution of LpPLA₂-A. For descriptive purposes, geometric means of LpPLA₂-A levels are presented which closely represent the mean of a ln sample.7 Median and intraquartile range were used for analysis of CRP, as this was not normally distributed even after log transformation. Separate analysis of the association between marker levels and outcome category was performed using (1) threshold levels defined by the top quartile of levels within the study population, and (2) using previously reported threshold levels for general cardiovascular risk for LpPLA₂-M and CRP (there is no currently accepted threshold value for LpPLA₂-A). Both 200 ng/mL and 235 ng/mL have been recommended as appropriate threshold levels for LpPLA₂-M.9,10 We therefore included analysis using both of these cut points. For CRP, a threshold value of 300 μg/dL has been recommended.10 For both LpPLA₂-M and CRP, the threshold values used are recommended for improving classification of general cardiovascular risk, and not specifically for risk-stratification after TIA. Odds ratios (OR) and 95% confidence intervals were used for all comparisons when appropriate. C-statistics (area under receiver-operator characteristic curves) were calculated to estimate predictive discriminatory ability. All tests were 2-sided. An association was considered significant if P<0.05.

All statistical analyses were performed using STATA version 10.0 (Stata Corporation).

**Results**

From November 2002 to June 2007, 167 patients were enrolled. Three patients could not be reached for follow-up at 90 days; 1 of these was diagnosed with carotid occlusion at presentation and thus included in the end point–positive group, and the other 2 had no identified cause of their TIA and an remarkable hospital course and were included in the end point–negative group. Characteristics of enrolled patients are shown in Table 1.

Time from symptom onset to blood sampling was a mean of 26.2±12.7 hours. Overall, the composite end point oc-
curred in 41 patients (25%). Clinical events occurred in 8 patients (5%), including 5 strokes and 3 deaths; 6 of these patients also had a high-risk cause of TIA. Four of the 5 strokes occurred within 48 hours after TIA onset; the other stroke occurred 9 days after TIA. Two of 3 deaths were strokes occurred within 48 hours after TIA onset; the other death occurred 9 days after TIA. Two of 3 deaths were attributed to cardiac disease; the cause of death in the remaining case was unknown. A ≥50% stenosis in a vessel referable to the patients’ symptoms was found in 25 patients (15%), of which 21 were attributable to atherosclerosis and 4 attributable to arterial dissection, and a cardioembolic source warranting anticoagulation was found in 14 patients (8%). Increasing ABCD² scores were associated with increasing risk (P for trend=0.017). When comparing groupings of ABCD² scores (0 to 3, 4 to 5, 6 to 7) and outcome, higher scores were associated with greater risk (OR 1.9 per group, 95% CI 1.1 to 1.3, P=0.018). Blood samples for analysis were available for 162 subjects; in 4 subjects blood samples could not be obtained, and 1 subject had insufficient sample volume for testing. Results for LpPLA₂-M and CRP were available for 162 subjects. Results for LpPLA₂-A were available for 136 patients; 26 samples had nonreportable results because of interference in the assay. Table 2 summarizes the results of biomarker testing. LpPLA₂-M levels were normally distributed and were increased in end point–positive compared to end point–negative patients (mean, 192 ng/mL versus 175 ng/mL, P=0.04). LpPLA₂-A levels were normally distributed when log-transformed and showed similar results (geometric mean, 132 nmol/min/mL versus 114 nmol/min/mL, P=0.01). There was no relationship between CRP and outcome (median 116 μg/dL versus 121 μg/dL, P=0.82). Subgroup analysis showed that both LpPLA₂-M (P=0.04) and LpPLA₂-A (P=0.06) were elevated in patients with large vessel stenosis. LpPLA₂-A levels were also increased in patients with stroke or death (P=0.001). There was no relationship between any of the markers and presence of a cardioembolic source, MRI DWI lesion, or ABCD² score.

In univariate analysis using cut-off points defined by the top quartile of each marker (LpPLA₂-M ≥208 ng/mL, LpPLA₂-A ≥143 nmol/min/mL, CRP ≥351 μg/dL), predictors of outcome category included ABCD² score (OR 1.37 per point, P=0.02) and LpPLA₂-A (OR 3.68, P=0.003) with a trend for LpPLA₂-M (OR 2.11, P=0.06). In multivariate analysis, LpPLA₂-A remained predictive of outcome (OR 3.75, 95% CI 1.58 to 8.86, P=0.003) and there was a trend for ABCD² score (OR 1.30 per point, 95% CI 0.97 to 1.75, P=0.08). The C-statistic for ABCD² score alone predicting outcome was 0.63; this improved to 0.68 with LpPLA₂-A added to the model.

Exploratory analysis of LpPLA₂-M and LpPLA₂-A dichotomized by top quartile versus bottom 3 quartiles stratified by ABCD² category is presented in Table 3. The additive predictive value of both LpPLA₂-M and LpPLA₂-A seemed to be greatest in patients classified as moderate risk by the ABCD² clinical risk score. Similar analysis for CRP is presented in Table 4, in which there was no additive predictive value within any ABCD² score category. Similar results were seen using the previously reported threshold levels.

Table 2. Levels of Lp-PLA₂ Mass (LpPLA₂-M), Lp-PLA₂ Activity (LpPLA₂-A), and High-Sensitivity C-Reactive Protein (CRP) by Selected Characteristics of the Patient Population

<table>
<thead>
<tr>
<th></th>
<th>LpPLA₂-M (ng/mL)</th>
<th></th>
<th>LpPLA₂-A (nmol/min/ml)</th>
<th></th>
<th>CRP (μg/dL)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean±SD (n=162)</td>
<td>P</td>
<td>Mean±SD (n=136)</td>
<td>P</td>
<td>Median (IQR) (n=162)</td>
<td>P</td>
</tr>
<tr>
<td>Overall</td>
<td>179±46</td>
<td>0.04</td>
<td>118 (113–124)</td>
<td>0.01</td>
<td>120 (41–351)</td>
<td>0.82</td>
</tr>
<tr>
<td>Outcome category</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endpoint negative</td>
<td>175±44</td>
<td></td>
<td>114 (108–121)</td>
<td></td>
<td>121 (39–369)</td>
<td></td>
</tr>
<tr>
<td>Endpoint positive</td>
<td>192±48</td>
<td></td>
<td>132 (119–146)</td>
<td></td>
<td>116 (50–322)</td>
<td></td>
</tr>
<tr>
<td>ABCD² score</td>
<td>0.64</td>
<td>0.17*</td>
<td>0.14†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 3</td>
<td>183±43</td>
<td></td>
<td>123 (114–132)</td>
<td></td>
<td>99 (37–216)</td>
<td></td>
</tr>
<tr>
<td>4 to 5</td>
<td>178±44</td>
<td></td>
<td>119 (111–127)</td>
<td></td>
<td>128 (40–339)</td>
<td></td>
</tr>
<tr>
<td>6 to 7</td>
<td>174±57</td>
<td></td>
<td>105 (87–126)</td>
<td></td>
<td>392 (49–934)</td>
<td></td>
</tr>
<tr>
<td>Large vessel stenosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>197±40</td>
<td>0.04</td>
<td>132 (118–148)</td>
<td>0.06</td>
<td>167 (100–409)</td>
<td>0.36</td>
</tr>
<tr>
<td>Absent</td>
<td>176±40</td>
<td></td>
<td>116 (110–122)</td>
<td></td>
<td>111 (40–351)</td>
<td></td>
</tr>
<tr>
<td>Cardioembolism</td>
<td>0.37</td>
<td></td>
<td>0.65</td>
<td></td>
<td>0.28</td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>190±60</td>
<td></td>
<td>123 (102–149)</td>
<td></td>
<td>62 (42–221)</td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>178±44</td>
<td></td>
<td>118 (112–124)</td>
<td></td>
<td>124 (40–360)</td>
<td></td>
</tr>
<tr>
<td>Stroke/death</td>
<td>0.82</td>
<td>0.001</td>
<td>0.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>183±38</td>
<td></td>
<td>178 (132–240)</td>
<td>95 (47–181)</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>179±46</td>
<td></td>
<td>116 (111–122)</td>
<td></td>
<td>121 (41–369)</td>
<td></td>
</tr>
<tr>
<td>MRI DWI</td>
<td>0.84</td>
<td>0.15</td>
<td>0.31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DWI+</td>
<td>181±47</td>
<td></td>
<td>126 (108–147)</td>
<td></td>
<td>145 (46–433)</td>
<td></td>
</tr>
<tr>
<td>DWI−</td>
<td>175±46</td>
<td></td>
<td>112 (104–121)</td>
<td></td>
<td>122 (37–483)</td>
<td></td>
</tr>
</tbody>
</table>

Variables were tested with χ² tests or Wilcoxon ranked sum tests as appropriate. *P value based on ANOVA; †P value based on Kruskal–Wallis test.
instance, using the threshold value of 200 ng/mL for Lp-PLA2-M, there was a trend toward Lp-PLA2-M predicting outcome category (21% end point–positive with Lp-PLA2-M <200 ng/mL versus 32% end point–positive with Lp-PLA2-M ≥200, P=0.12). Using the previously reported threshold level of 235 ng/mL, Lp-PLA2-M was significantly predictive of outcome category (22% end point–positive with Lp-PLA2-M <235 versus 47% end point–positive with Lp-PLA2-M ≥235, P=0.02). Using the reported threshold level of 300 μg/dL for CRP, there was no association with outcome category (28% end point–positive with CRP <300 μg/dL versus 28% end point–positive with CRP ≥300, P=0.99).

Discussion

A number of prior studies assessing the long-term prognostic value of Lp-PLA2 mass and activity have shown both markers to be predictive of future stroke, both in patients with and without a previous history of cerebrovascular disease. An additional study assessing shorter-term risk (at 6 months after an index stroke or TIA) found Lp-PLA2-A to be a significant predictor of recurrent stroke. In contrast, in the VA-HIT study, Lp-PLA2-A was not predictive of stroke, though it was predictive of myocardial infarction and vascular death, whereas Lp-PLA2-M was strongly predictive of subacute stroke. Our results suggest a potential role for measurement of both Lp-PLA2 mass and activity to improve short-term risk stratification of patients with TIA. This is particularly true for patients classified as moderate-risk using the ABCD2 clinical score (score of 4 to 5), in which there was a substantially greater likelihood of subsequent stroke or death or harboring a high-risk TIA mechanism among patients in the highest quartile of Lp-PLA2-M and Lp-PLA2-A levels. This may also be the case for patients in the highest risk ABCD2 category (scores of 6 to 7), although the number of patients available for analysis was too small to reach firm conclusions. Conversely, it does not appear that Lp-PLA2 adds prognostic value to patients classified as low risk by ABCD2 scoring. In addition to our prespecified composite end point, Lp-PLA2-A was also significantly associated with subsequent stroke or death, possibly suggesting that it is a more powerful predictor of short-term clinical events than Lp-PLA2-M, although this conclusion is limited by the smaller number of patients for which Lp-PLA2-A could be tested.

It appears that the most likely basis by which Lp-PLA2 predicts stroke is as a biomarker of unstable atherosclerotic plaque. A recent analysis of plaque specimens obtained after carotid endarterectomy demonstrated increased Lp-PLA2 expression in patients with recent TIA or stroke compared to asymptomatic patients, and a correlation between Lp-PLA2 content and markers of oxidative stress, inflammation and instability. The results of our study provide further support for the role of Lp-PLA2 as a biomarker of unstable atherosclerotic plaque. Both Lp-PLA2 mass and activity were significantly associated with symptomatic >50% large vessel stenosis, but not with cardioembolism, consistent with a specific role in atherosclerotic disease.

Unlike Lp-PLA2, we did not find CRP useful for risk stratification of patients with TIA. The role of CRP in predicting recurrent events in patients with cerebrovascular disease is controversial. In a cohort of 467 patients with ischemic stroke from the Northern Manhattan Stroke Study, CRP was not associated with recurrent stroke or the composite of stroke, MI, and vascular death, but was associated with mortality. In several smaller cohorts of patients with acute ischemic stroke, CRP has been predictive of recurrent vascular events or death, but with variable results depending on the timing of CRP measurement. We are aware of only 1 study that evaluated CRP exclusively in patients with acute TIA. In this study, 135 patients with acute TIA were followed up for one year, and an association between CRP and risk of recurrent ischemic events was found. However, the supplemental value of CRP measurement in addition to clinical risk scoring was not assessed, and given the longer time of follow-up, these results are less applicable to early risk stratification.

Strengths of our study include its prospective design, detailed follow-up and data collection, and patient population reflective of the type of patients in whom a biomarker for risk-stratification would most likely be used. The enrollment of only patients with TIA also largely eliminates the confounding effect of stroke severity on marker levels, which has been shown to be a relevant concern with CRP measurement, although not with Lp-PLA2. There are also some limitations to our study, most notably the sample size and small number of clinical events. Additionally, the effect of the timing of marker measurement in relation to TIA onset remains uncertain. One study evaluating stroke patients demonstrated stability of inflammatory biomarkers, including CRP, over

---

### Table 3. No. of Patients With Composite End Point in ABCD² Categories Stratified by Lp-PLA₂ Activity (LpPLA₂-A, nmol/min/ml) and Lp-PLA₂ Mass (LpPLA₂-M, ng/ml)

<table>
<thead>
<tr>
<th>ABCD² score</th>
<th>LpPLA₂-A&lt;143</th>
<th>LpPLA₂-A ≥143</th>
<th>P</th>
<th>LpPLA₂-M&lt;208</th>
<th>LpPLA₂-M ≥208</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 3</td>
<td>5/36 (13.9%)</td>
<td>2/11 (18.2%)</td>
<td>0.66</td>
<td>8/43 (18.6%)</td>
<td>2/16 (12.5%)</td>
<td>0.71</td>
</tr>
<tr>
<td>4 to 5</td>
<td>10/53 (18.9%)</td>
<td>10/19 (52.6%)</td>
<td>0.008</td>
<td>12/62 (19.4%)</td>
<td>10/21 (47.6%)</td>
<td>0.02</td>
</tr>
<tr>
<td>6 to 7</td>
<td>3/13 (23.1%)</td>
<td>3/4 (75.0%)</td>
<td>0.12</td>
<td>5/15 (33.3%)</td>
<td>3/5 (60.0%)</td>
<td>0.35</td>
</tr>
</tbody>
</table>

### Table 4. No. of Patients With Composite End Point in ABCD² Categories Stratified by High-Sensitivity CRP (CRP, ug/dL) Levels

<table>
<thead>
<tr>
<th>ABCD² Score</th>
<th>CRP&lt;351</th>
<th>CRP≥351</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 3</td>
<td>9/49 (18.4%)</td>
<td>1/10 (10.0%)</td>
<td>1.0</td>
</tr>
<tr>
<td>4 to 5</td>
<td>17/63 (27.0%)</td>
<td>5/20 (25.0%)</td>
<td>1.0</td>
</tr>
<tr>
<td>6 to 7</td>
<td>5/9 (55.6%)</td>
<td>3/11 (27.3%)</td>
<td>0.36</td>
</tr>
</tbody>
</table>
multiple time points within the first month after stroke onset, suggesting this may not be a major concern. To our knowledge, similar data are not currently available for Lp-PLA₂ however.

In conclusion, our results suggest a potential clinical role for measurement of Lp-PLA₂, but not CRP, for short-term risk stratification of patients with acute TIA. Further, our results support the idea that Lp-PLA₂ reflects the presence of unstable atherosclerotic plaque.

Sources of Funding
This project was supported by an American Heart Association Fellow-to-Faculty Transition Award (to B.C.). The blood assays for hs-CRP and Lp-PLA₂ were supported by diaDexus Inc.

Disclosures
None.

References
Lipoprotein-Associated Phospholipase A2 and C-Reactive Protein for Risk-Stratification of Patients With TIA

Brett L. Cucchiara, Steve R. Messe, Lauren Sansing, Larami MacKenzie, Robert A. Taylor, James Pacelli, Qaisar Shah and Scott E. Kasner

*Stroke*. 2009;40:2332-2336; originally published online May 21, 2009; doi: 10.1161/STROKEAHA.109.553545

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2009 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://stroke.ahajournals.org/content/40/7/2332

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