**PULSE PRESSURE IS MORE RELEVANT THAN SYSTOLIC AND DIASTOLIC BLOOD PRESSURE IN PATIENTS WITH TYPE 2 DIABETES AND CARDIOVASCULAR DISEASE**

**ABSTRACT**

**Background and aims**. The parameters evaluated during 24-hour ambulatory blood pressure monitoring were reported to be predictors of cardiovascular events. We aimed to investigate mean blood pressure, blood pressure variability and pulse pressure during 24-hour ambulatory blood pressure monitoring in type 2 diabetes patients and to establish their relationship with the presence of atherosclerotic cardiovascular disease (CVD).

**Methods**. The observational study included type 2 diabetes patients randomly selected and distributed in 2 study groups depending on the presence of atherosclerotic cardiovascular disease: CVD(-), n=90, and CVD(+), n=87. Daytime, nighttime and 24-hour systolic and diastolic blood pressure were monitored and mean blood pressure, blood pressure variability and pulse pressure were calculated.

**Results.** The study groups were comparable as age, male percentage, smoking status, body mass index and abdominal circumference. Diabetes and hypertension duration were significantly higher in the CVD(+) group. Mean systolic and diastolic blood pressure, blood variability, dipper prevalence did not differ between study groups. Pulse pressure was significantly higher in the CVD(+) group compared to CVD(-) group (daytime pulse pressure 56.2±13.1 vs. 50.6±11.3 mmHg, p=0.003; nighttime pulse pressure 56.5±14.2 vs. 50.7±12.4 mmHg, p=0.005; 24-hour pulse pressure 54.7±13.6 vs. 49.0±12.0 mmHg, p=0.003).

**Conclusions.** Ambulatory pulse pressure was significantly higher in patients with type 2 diabetes and atherosclerotic cardiovascular disease compared to those without cardiovascular disease, although mean systolic and diastolic blood pressure and blood pressure variability were similar.

**Keywords**: diabetes mellitus, cardiovascular disease, ambulatory blood pressure monitoring, pulse pressure.

**Background and aims**

It is well known from a number of large randomized controlled trials the importance of arterial blood pressure (BP) as a determinant of cardiovascular risk [1]. The results of the United Kingdom Prospective Diabetes Study (UKPDS) have demonstrated the importance of systolic BP as a risk factor for cardiovascular events [2]. Pulse pressure (PP) is defined as the difference between systolic and diastolic BP and it is dependent on arterial wall elastic properties [3]. The Framingham Heart Study demonstrated that PP was the strongest predictor of coronary heart disease risk in individuals older than 50 years of age [4], although a meta-analysis suggests that systolic BP may be more predictive than PP [5]. A recent meta-analysis found that an increase of 10 mmHg in PP to be positively associated with the risk of stroke occurrence [6]. The importance of PP in determining cardiovascular risk is due to the fact that PP is a marker of large artery stiffness, an independent predictor of cardiovascular risk [7]. Evidence showing that PP is an independent predictor of atherosclerotic cardiovascular disease (CVD) have not led to a change in current guidelines that continue to focus on reducing BP rather than on reducing PP [8].

Evidence showed that widened PP is a powerful independent predictor of incident CVD in patients with type 2 diabetes, but there are not many studies that have investigated the predictive value of PP as a risk factor for CVD in patients with type 2 diabetes [1,9,10]. Some studies showed that PP was higher in type 2 diabetes patients than in nondiabetic patients, and PP was positively associated with cardiovascular mortality in type 2 diabetes patients [11]. Also, PP was associated with micro- and macrovascular complications of type 2 diabetes. This association can be explained by the fact that type 2 diabetes is associated with premature arterial stiffening. As the large arteries stiffen, systolic BP increases as a consequence; but diastolic BP actually falls, leading to the increase in PP [1,12].

Office BP measurement can be easily used to evaluate hypertension control. However, 24-hour ambulatory blood pressure monitoring (ABPM) provides information on circadian changes in BP and can estimate mean BP, BP variability, PP and many other parameters derived from BP [13]. Also, 24-hour ABPM correlates better with cardiovascular outcome than clinic BP levels do [14]. Given this data, we aimed to investigate mean BP, BP variability and PP evaluated during 24-hour ABPM in type 2 diabetes patients and to establish their relationship with the presence of atherosclerotic CVD.

**Methods**

***Patients***

The observational study included type 2 diabetes patients randomly selected from Clinical Centre of Diabetes, Nutrition and Metabolic Diseases in Cluj-Napoca, Romania, between July 2013 and

February 2014. The patients were distributed in two study groups depending on the presence of atherosclerotic cardiovascular disease: absent CVD(-), n=90, and present CVD(+), n=87. Patients were not included if they were previously diagnosed with unstable cardiovascular disease, secondary hypertension, inflammatory diseases, malignancies, renal or hepatic failure. Atherosclerotic cardiovascular disease was defined as the presence of coronary heart disease, peripheral arterial disease or cerebrovascular disease presumed to be of atherosclerotic origin [15].

In accordance with the World Medical Association Declaration of Helsinki revised in 2000, Edinburgh, and institutional guidelines, the protocol was approved by the local Ethics Committee of the Iuliu Haţieganu University of Medicine and Pharmacy Cluj-Napoca, Romania. All patients were aware of the investigational nature of the study and provided written informed consent before any study procedure.

***Study protocol***

The study protocol was previously described [16].

***24-hours ambulatory blood pressure monitoring***

The 24-hour ABPM technique was previously described [16].Mean BP, BP variability and PP were calculated during daytime, nighttime and 24-hour periods. BP variability was estimated as standard deviation of mean BP [17]. PP was calculated as the difference between systolic and diastolic BP [18].

***Statistical analysis***

Data analysis was performed using the R 2.15.1 software for Windows. Kolmogorov–Smirnov test was used to test the normal distribution of all continuous variables. Data were expressed as mean ± standard deviation. ANOVA test was used to compare the groups’ parametric variables. Chi-square test was applied in order to verify the differences in frequency for nominal variables between the groups. A value of p<0.05 was considered statistically significant.

**Results**

***Characteristics of the study groups***

The characteristics of the study participants are presented in Table I.

**Table I**. Baseline characteristics of the study groups.

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | CVD(-) group (n=90) | CVD(+) group (n=87) | *p*-value |
| Age (years) | 59.7±7.1 | 61.3±7.2 | 0.152 |
| Male gender n, (%) | 41 (45.6) | 33 (37.9) | 0.307 |
| Smoking status n, (%) | 19 (21.1) | 14 (16.1) | 0.430 |
| Diabetes duration (years) | 8.2±7.5 | 12.5±8.5 | 0.001 |
| Hypertension duration (years) | 6.4±5.8 | 11.1±6.6 | <0.001 |
| Systolic BP at admission (mmHg) | 139.6±20.9 | 142.5±19.5 | 0.336 |
| Diastolic BP at admission (mmHg) | 82.3±10.7 | 79.8±11.0 | 0.108 |
| Heart rate at admission (beats/minute) | 78.1±14.3 | 77.2±14.0 | 0.664 |
| Body mass index (kg/m2) | 31.5±5.0 | 32.2±4.9 | 0.317 |
| Waist circumference (cm) | 107.2±11.9 | 109.5±11.9 | 0.208 |
| Values are means +/− standard deviation or numbers and percentages. CVD, atherosclerotic cardiovascular disease; BP, blood pressure. |

We found no significant differences in age, gender, smoking status, systolic and diastolic BP at admission, heart rate at admission, body mass index and waist circumference between the two study groups. Significantly higher durations of diabetes and hypertension were observed in the CVD(+) group.

The patients included in the CVD(+) group presented one or more manifestations of atherosclerotic CVD in different percentages. Most patients (n=75, 86.2%) were diagnosed with ischemic heart disease, while history of stroke (n=21, 24.1%), history of acute myocardial infarction (n=17, 19.5%) and peripheral arterial disease (n=19, 21.8 %) were present in lower numbers of patients.

***24-hours ambulatory blood pressure monitoring***

When analysing 24-hour ABPM parameters, we observed that mean systolic and diastolic BP during the daytime, nighttime and 24-hour periods were higher in the type 2 diabetes CVD(+) group compared to the type 2 diabetes CVD(-) group, but the difference did not reach statistical significance (Table II). Systolic and diastolic BP at admission were statistically significant higher than ambulatory systolic and diastolic BP monitored during daytime, nighttime and 24-hour periods (p<0.001).

**Table II**. Mean systolic and diastolic blood pressure during 24-hours ambulatory blood pressure monitoring in the study groups.

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | CVD(-) group (n=90) | CVD(+) group (n=87) | *p*-value |
| Daytime mean systolic BP (mmHg) | 129.5±14.3 | 133.4±13.7 | 0.064 |
| Nighttime mean systolic BP (mmHg) | 123.2±17.0 | 127.4±16.1 | 0.092 |
| 24-hour mean systolic BP (mmHg) | 126.3±15.1 | 130.4±14.2 | 0.066 |
| Daytime mean diastolic BP (mmHg) | 78.9±10.1 | 77.2±8.9 | 0.242 |
| Nighttime mean diastolic BP (mmHg) | 72.4±10.7 | 71.0±9.7 | 0.335 |
| 24-hour mean diastolic BP (mmHg) | 77.4±9.9 | 75.7±8.8 | 0.246 |
| Values are means +/− standard deviation; CVD, atherosclerotic cardiovascular disease; BP, blood pressure. |

We found higher systolic BP variability and lower diastolic BP variability in the type 2 diabetes CVD(+) group compared to type 2 CVD(-) group, without reaching statistical significance (Table III).

**Table** **III.** Systolic and diastolic blood pressure variability during 24-hour ambulatory blood pressure monitoring in the study groups.

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | CVD(-) group (n=90) | CVD(+) group (n=87) | *p*-value |
| Daytime systolic BP variability (mmHg) | 10.5±3.4 | 10.9±4.0 | 0.547 |
| Nighttime systolic BP variability (mmHg) | 9.5±3.6 | 10.3±4.2 | 0.170 |
| 24-hour systolic BP variability (mmHg) | 11.1±3.3 | 11.6±3.9 | 0.329 |
| Daytime diastolic BP variability (mmHg) | 8.0±2.1 | 7.6±2.5 | 0.241 |
| Nighttime diastolic BP variability (mmHg) | 7.4±2.4 | 7.4±2.2 | 0.943 |
| 24-hour diastolic BP variability (mmHg) | 8.6±2.0 | 8.3±2.3 | 0.296 |
| Values are means +/− standard deviation. CVD, atherosclerotic cardiovascular disease; BP, blood pressure. |

PP, calculated as the difference between systolic BP and diastolic BP, was statistically significant higher during daytime, nighttime and 24-hour periods in the type 2 diabetes CVD(+) group compared to type 2 diabetes CVD(-) group, as can be seen in Table IV. Also, PP at admission was statistically significant higher in the type 2 diabetes CVD(+) group compared to type 2 diabetes CVD(-) group. When comparing PP at admission with daytime PP (p<0.001), nighttime PP (p<0.001) and 24-hour PP (p<0.001), we found statistically significant higher values of PP at admission.

**Table** **IV.** Pulse pressure during 24-hours ambulatory blood pressure monitoring in the study groups.

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | CVD (-) group (n=90) | CVD (+) group (n=87) | *p*-value |
| Daytime pulse pressure (mmHg) | 50.6±11.3 | 56.2±13.1 | 0.003 |
| Nighttime pulse pressure (mmHg) | 50.7±12.4 | 56.5±14.2 | 0.005 |
| 24-hour pulse pressure (mmHg) | 49.0±12.0 | 54.7±13.6 | 0.003 |
| Pulse pressure at admission (mmHg) | 57.1±15.1 | 62.7±15.5 | 0.016 |
| Values are means +/− standard deviation or numbers and percentages CVD, atherosclerotic cardiovascular disease. |

Regarding the distribution of patients in the two study groups according to dipper or non-dipper status, we found that 18% of patients in the CVD(+) group were dippers compared to 16% of patients in the CVD(-) group. There was no evidence of a correlation between the dipping index and the presence of CVD (p= 0.625).

BP control as recommended by hypertension guideline published by European Society of Hypertension and European Society of Cardiology in year 2013 (8), was less satisfactory in the CVD(+) group than in the CVD(-) group during the daytime, nighttime and 24-hour periods, although the results did not reach statistical significance (Table V).

**Table V.** Blood pressure control following European Society of Hypertension and European Society of Cardiology recommendations in year 2013.

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | CVD(-) group (n=90) | CVD(+) group (n=87) | *p*-value |
| Daytime BP control (<135/85mmHg) | 51 (56.7%) | 41 (47.1%) | 0.206 |
| Nighttime BP control (<120/70mmHg) | 38 (42.2%) | 30 (34.5%) | 0.293 |
| 24-hour BP control (<130/80mmHg) | 38 (42.2%) | 35 (40.2%) | 0.789 |
| Values are means +/− standard deviation or numbers and percentages. CVD, atherosclerotic cardiovascular disease; BP, blood pressure. |

**Discussions**

The most important observation of our study was that ambulatory PP was statistically significant higher during daytime, nighttime and 24-hour periods in patients with type 2 diabetes and atherosclerotic cardiovascular disease compared to patients with type 2 diabetes without atherosclerotic cardiovascular disease. While, the mean systolic and diastolic BP, as well as BP variability during daytime, nighttime and 24-hour were comparable between the two groups. This demonstrates that ambulatory PP was more relevant than mean BP and BP variability in patients with type 2 diabetes and atherosclerotic cardiovascular disease. Our finding is in agreement with other studies [1,7,19], although there are results that suggest that PP is much less informative than systolic and diastolic BP [5], but these results don’t refer to ambulatory PP. Other evidence suggests that the magnitude of association between mean BP, PP and CVD is similar among these BP indices [20]. Therefore, the assessment of PP may assist in risk stratification and monitoring therapeutic response [1] and if PP is lowered a marked cardiovascular risk reduction could to be achieved [7]. However, systolic BP cannot be replaced with brachial artery PP as a single measure of cardiovascular risk [19]. Thus, the assessment of risk in diabetes patients should begin with measuring the increase in systolic BP and then continue with stratifying the risk according to the PP range [21]. ABPM has been described in literature as a strong predictor of cardiovascular morbidity [22], being independently associated with future cardiovascular events in patients with type 2 diabetes [23]. The importance of ABPM over 24 hours was also demonstrated by our study, with the obtained parameters being more relevant than the isolated values of BP measured in the medical office. The best example is represented by the results obtained in the 24-hour ambulatory PP evaluation, as described above.

Even though mean systolic BP during daytime, nighttime and over 24 hour periods was higher in the diabetes CVD(+) group compared to the CVD(-) group, these results did not reach statistical significance. Conversely, diastolic BP values were non-significantly lower in the CVD (+) group compared to the CVD(+) group. These results confirm the need for 24 hour ABPM and PP measurement in patients with type 2 and CVD. Similarly, it was observed that systolic BP variability was non-significantly higher in the diabetes CVD(+) group, while diastolic BP variability was non-significantly lower in the diabetes CVD(+) group compared to diabetes CVD(-) group. BP variability was described as a risk factor for cardiovascular events and was directly correlated with subclinical inflammation [16,24] and subclinical myocardial function [25]. However, as in the case of mean systolic and diastolic BP, BP variability was similar in the two groups, highlighting the relevance of PP measurement in patients with type 2 diabetes and CVD.

Also, we found that PP at admission was statistically significant higher than 24-hour ambulatory PP, while mean systolic and diastolic BP were statistically significant higher than mean BP during daytime, nighttime and 24-hour periods. Our results indicating the presence of white-coat hypertension in the study population are confirmed by a previous study reporting that increased PP in the clinic is positively associated with the presence of white-coat hypertension [26]. White-coat hypertension is a benign condition; moreover, it seems that patients with white-coat hypertension are frequently treated for high office BP, and thus, lower BP might be responsible for lower incidence of cardiovascular events [27]. The opposite condition, that we might have expected to find in our study, is masked hypertension, which prone to cardiovascular events, particularly in the presence of diabetes and obesity. Since 24-hour ABPM remains the gold standard for diagnosing masked and white coat hypertension, it is important to consider it for effective diagnosis and control of hypertension, regardless the presence of atherosclerotic CVD [28].

Non-dippers are defined as patients with an overnight mean BP reduction less than 10% of mean daytime BP. Many reports say that non-dippers have an increased risk for cardiovascular or cerebrovascular disease [29]. We would have expected the proportion of patients with non-dipper status to be higher among patients with present CVD. Instead, the percentage was higher in those without CVD (74% vs. 69%), but the results were not statistically significant. A possible explanation would be the time of the day when the antihypertensive medication was administered. It has been reported that the administration of antihypertensive medication during the evening was associated with higher prevalence of dipper profile [30].

It is well known that older adults with diabetes have a higher risk for developing atherosclerotic CVD than young adults with diabetes and elderly adults without diabetes [31]. The results obtained in this study confirm this data, the group of patients with CVD(+) had a longer duration of diabetes compared to those without CVD, statistically significant result. It has also been confirmed by this study that hypertension is a risk factor for CVD, the duration of the hypertension being significantly longer in the diabetes CVD(+) group, as the groups were comparable in age and gender distribution.

Most patients (86.2%) who had atherosclerotic cardiovascular disease were diagnosed with ischemic heart disease; much smaller percentages presented other clinical manifestation of atherosclerotic cardiovascular disease. This is probably due to the predilection of atherosclerosis in the coronary arteries [32].

**Conclusions**

We found that ambulatory pulse pressure was significantly higher in patients with type 2 diabetes and atherosclerotic cardiovascular disease compared to type 2 diabetes without atherosclerotic cardiovascular disease, although mean systolic and diastolic blood pressure and blood pressure variability were similar. Our results suggest that pulse pressure might be more relevant to cardiovascular disease risk than mean blood pressure and blood pressure variability in type 2 diabetes patients. Also, our findings emphasise the importance of 24-hour ambulatory pulse pressure monitoring in type 2 diabetes.

**References**

1. Cockcroft JR, Wilkinson IB, Evans M, et al. Pulse pressure predicts cardiovascular risk in patients with type 2 diabetes mellitus. Am J Hypertens. 2005;18(11):1463-7.
2. Turner RC, Millns H, Neil HA, et al. Risk factors for coronary artery disease in non-insulin dependent diabetes mellitus: United Kingdom Prospective Diabetes Study (UKPDS: 23). BMJ. 1998;316(7134):823-8.
3. Alfie J, Waisman GD, Galarza CR, Cámera MI. Contribution of stroke volume to the change in pulse pressure pattern with age. Hypertension. 1999;34(4 Pt 2):808-12.
4. Franklin SS, Khan SA, Wong ND, et al. Is pulse pressure useful in predicting risk for coronary heart Disease? The Framingham heart study. Circulation. 1999;100(4):354–60.
5. Lewington S, Clarke R, Qizilbash N, Peto R, Collins R, Prospective Studies Collaboration. Age-specific relevance of usual blood pressure to vascular mortality: a meta-analysis of individual data for one million adults in 61 prospective studies. Lancet (London, England). 2002;360(9349):1903–13.
6. Liu F-D, Shen X-L, Zhao R, et al. Pulse pressure as an independent predictor of stroke: a systematic review and a meta-analysis. Clin Res Cardiol. 2016;105(8):677–86.
7. Guerin AP, Blacher J, Pannier B, Marchais SJ, Safar ME, London GM. Impact of aortic stiffness attenuation on survival of patients in end-stage renal failure. Circulation. 200;103(7):987-92.
8. Mancia G, et al. 2013 ESH/ESC Guidelines for the management of arterial hypertension: the Task Force for the management of arterial hypertension of the European Society of

Hypertension (ESH) and of the European Society of Cardiology (ESC). J Hypertens.

2013;31(7):1281-357.

1. Nilsson PM, Cederholm J, Eeg-Olofsson K, Eliasson B, Zethelius B, Gudbjörnsdóttir S. Pulse pressure strongly predicts cardiovascular disease risk in patients with type 2 diabetes from the Swedish National Diabetes Register (NDR). Diabetes Metab. 2009;35(6):439–46.
2. Schram MT, Kostense PJ, Van Dijk RA, et al. Diabetes, pulse pressure and cardiovascular mortality: the Hoorn Study. J Hypertens. 2002;20(9):1743–51.
3. Bobby D, Vinodha R, Kumudha P . Assessment of pulse pressure in type 2 diabetes mellitus. International Journal of Current Research. 2016; 8(2):26494-26497.
4. Safar ME, Nilsson PM, Blacher J, Mimran A. Pulse Pressure, Arterial Stiffness, and End-Organ Damage. Curr Hypertens Rep. 2012;14(4):339–44.
5. Grossman E. Ambulatory Blood Pressure Monitoring in the Diagnosis and Management of Hypertension. Diabetes Care. 2013;36(Suppl 2):S307-S311.
6. Ohkubo T, et al. Prediction of stroke by ambulatory blood pressure monitoring versus screening blood pressure measurements in a general population: the Ohasama study.

J Hypertens. 2000;18(7):847-54.

1. American Diabetes Association. 9. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes-2018. Diabetes Care. 2018;41(Suppl 1):S86–104.
2. Ciobanu DM, Bala CG, Veresiu IA, Mircea PA, Roman G. High-sensitivity C-reactive protein is associated with 24-hour ambulatory blood pressure variability in type 2 diabetes and control subjects. Rev Rom Med Lab. 2016;24(1):65–73.
3. Stevens SL, Wood S, Koshiaris C, et al. Blood pressure variability and cardiovascular disease: systematic review and meta-analysis. BMJ. 2016;354:i4098.
4. Darne B, Girerd X, Safar M, Cambien F, Guize L. Pulsatile versus steady component of blood pressure: a cross-sectional analysis and a prospective analysis on cardiovascular mortality. Hypertension. 1989;13(4):392–400.
5. Zoppini G, Verlato G, Zamboni C, et al. Pulse Pressure and Mortality from Cerebrovascular Diseases in Type 2 Diabetic Patients: The Verona Diabetes Study. Cerebrovasc Dis. 2007;23(1):20–6.
6. Kengne AP, Czernichow S, Huxley R, et al. Blood Pressure Variables and Cardiovascular Risk New Findings From ADVANCE. Hypertension. 2009;54(2):399-404.
7. Safar ME: Pulse pressure, heart rate, and drug treatment of hypertension. Curr Hypertens Rep. 2004;6:190–194.
8. Madin K, Iqbal P. Twenty four hour ambulatory blood pressure monitoring: a new tool for determining cardiovascular prognosis. Postgrad Med J. 2006;82(971):548–51.
9. Eguchi K, Pickering TG, Hoshide S, et al. Ambulatory Blood Pressure Is a Better Marker Than Clinic Blood Pressure in Predicting Cardiovascular Events in Patients With/Without Type 2 Diabetes. Am J Hypertens. 2008;21(4):443–50.
10. Pierdomenico S, Lapenna D, Ditommaso R, et al. Blood Pressure Variability and Cardiovascular Risk in Treated Hypertensive Patients. Am J Hypertens. 2006;19(10):991–7.
11. Ciobanu AO, Gherghinescu CL, Dulgheru R, et al. The impact of blood pressure variability on subclinical ventricular, renal and vascular dysfunction, in patients with hypertension and diabetes. Maedica (Buchar). 2013;8(2):129–36.
12. Yoon HJ et al; Korean Hypertension Research Network. Can pulse pressure predict the white-coat effect in treated hypertensive patients? Clin Exp Hypertens. 2012;34(8):555-60
13. Pierdomenico SD, Cuccurullo F. Prognostic value of white-coat and masked hyper- tension diagnosed by ambulatory monitoring in initially untreated subjects: an updated meta analysis. Am J Hypertens. 2011;24:52–58.
14. Franklin SS, O'Brien E, Staessen JA. Masked hypertension: understanding its

complexity. Eur Heart J. 2017;38(15):1112-1118.

1. Akasaki Y, Ohishi M. Dipper, non-dipper pattern. Nihon Rinsho, Japanese Journal of Clinical Medicine. 2014;72(8):1400–3.
2. Hermida RC, Ayala DE, Mojon A, Fernandez JR. Bedtime Dosing of Antihypertensive Medications Reduces Cardiovascular Risk in CKD. J Am Soc Nephrol. 2011;22(12):2313–21.
3. Korytkowski MT, Forman DE. Management of Atherosclerotic Cardiovascular Disease Risk Factors in the Older Adult Patient with Diabetes. Diabetes Care. 2017;40(4):476–84.
4. Frangos SG, Gahtan V, Sumpio B. Localization of Atherosclerosis. Arch Surg. 1999;134(10):1142.