Effect of Estimated Glomerular Filtration Rate Decline on the Efficacy and Safety of Clopidogrel With Aspirin in Minor Stroke or Transient Ischemic Attack

CHANCE Substudy (Clopidogrel in High-Risk Patients With Acute Nondisabling Cerebrovascular Events)

Yilun Zhou, MD, PhD*; Yuesong Pan, MD*; Yu Wu, MD, PhD*; Xingquan Zhao, MD, PhD; Hao Li, PhD; David Wang, DO; S. Claiborne Johnston, MD, PhD; Liping Liu, MD, PhD; Chunxue Wang, MD, PhD; Xia Meng, MD, PhD; Yilong Wang, MD, PhD; Yongjun Wang, MD; on behalf of the CHANCE Investigators†

Background and Purpose—Patients with chronic kidney disease (CKD) are at a particularly high risk for ischemic and bleeding events. Limited data exist as to the efficacy and safety of clopidogrel in stroke patients with renal dysfunction. Therefore, we sought to assess the impact of decreased kidney function on clinical outcomes for stroke patients on clopidogrel–aspirin treatment.

Methods—Patients in the CHANCE trial (Clopidogrel in High-Risk Patients With Acute Nondisabling Cerebrovascular Events) were randomized to clopidogrel–aspirin or aspirin-alone treatment. The primary efficacy outcome was new stroke during 90 days, whereas bleeding was the safety outcome. Patients were stratified according to estimated glomerular filtration rate.

Results—Dual clopidogrel–aspirin therapy was associated with a marked reduction in new strokes compared with the therapy of aspirin alone in patients with normal renal function (hazard ratio, 0.77; 95% confidence interval, 0.60–0.98; P=0.02) and mild CKD (hazard ratio, 0.60; 95% confidence interval, 0.45–0.79; P<0.01), whereas in patients with moderate CKD, no significant benefit from clopidogrel therapy was detected (hazard ratio, 1.00; 95% confidence interval, 0.43–2.35; P=0.99). There was no clear difference in bleeding episodes by treatment assignment across categories of renal impairment.

Conclusions—Clopidogrel plus aspirin could decrease new stroke in patients with normal kidney function and mild CKD, but no extra benefit was observed in those with moderate CKD. Bleeding risk from the dual therapy did not seem to increase in mild or moderate CKD patients.

Clinical Trial Registration—URL: http://www.clinicaltrials.gov. Unique identifier: NCT00979589.

Key Words: chronic kidney disease ◼ clopidogrel ◼ stroke

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Original Contribution

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From the Department of Nephrology, Beijing Tiantan Hospital (Y.Z., Y.W.); Department of Neurology, Beijing Tiantan Hospital (Y.P., X.Z., H.L., L.L., C.W., X.M., Yilong Wang, Yongjun Wang), and Department of Epidemiology and Health Statistics, School of Public Health (Y.P.), Capital Medical University, China; China National Clinical Research Center for Neurological Diseases, Beijing, China (Y.P., X.Z., H.L., L.L., C.W., X.M., Yilong Wang, Yongjun Wang); Center of Stroke, Beijing Institute for Brain Disorders, China (Y.P., X.Z., H.L., L.L., C.W., X.M., Yilong Wang, Yongjun Wang); Beijing Key Laboratory of Translational Medicine for Cerebrovascular Disease, China (Y.P., X.Z., H.L., L.L., C.W., X.M., Yilong Wang, Yongjun Wang); INI Stroke Network, OSF Healthcare System, University of Illinois College of Medicine, Peoria (D.W.); and Dell Medical School, University of Texas at Austin (S.C.J.).

†A list of all CHANCE Investigators is given in the online-only Data Supplement.

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*Drs Zhou, Pan, and Wu contributed equally.

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Correspondence to Yilong Wang, MD, PhD, Department of Neurology, Beijing Tiantan Hospital, Capital Medical University, No 6 Tiantanxili, Dongcheng District, Beijing 100050, China, E-mail yilong528@gmail.com or Yongjun Wang, MD, Department of Neurology, Beijing Tiantan Hospital, Capital Medical University, No 6 Tiantanxili, Dongcheng District, Beijing 100050, China, E-mail yongjunwang1962@gmail.com

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stroke plus CKD are not available, although there have been a few investigations in the field of acute coronary syndrome (ACS). CKD is characterized as a state with a prothrombotic tendency where excessive platelet activation and dysfunction plays a pivotal role. On the contrary, the risk of all-cause major hemorrhage increased in a graded fashion across all stages of CKD.\(^6\) Bleeding complications may occur in patients even with a normal coagulation profile or elevated coagulation factors.\(^2\) Therefore, assessment of the efficacy and safety of dual antiplatelet therapy with clopidogrel and aspirin for treating and preventing cerebrovascular diseases in the setting of CKD is of great significance.\(^2,9\)

The CHANCE trial (Clopidogrel in High-Risk Patients With Acute Nondisabling Cerebrovascular Events) was designed to determine the protection effect against stroke and bleeding risk of combination therapy of clopidogrel plus aspirin compared with aspirin alone among patients with minor stroke or transient ischemic attack (TIA).\(^10,11\) On the basis of the CHANCE trial, we aimed to investigate whether declined eGFR would be associated with altered efficacy and safety of dual antiplatelet therapy.

**Methods**

**Study Population**
CHANCE was a randomized, double-blind, placebo-controlled clinical trial conducted at 114 clinical centers in China. Details about the CHANCE study design and results have been published elsewhere.\(^10–12\)

Within 24 hours after the onset of minor ischemic stroke or high-risk TIA, patients were randomly assigned to either clopidogrel plus aspirin (clopidogrel at an initial dose of 300 mg, followed by 75 mg per day for 90 days, plus aspirin at a dose of 75 mg per day for the first 21 days) or placebo plus aspirin (75 mg per day for 90 days) group.

Between October 2009 and July 2012, the CHANCE trial enrolled 5170 eligible patients, who met the following inclusion criteria: age ≥40 years; diagnosis of an acute minor ischemic stroke or high-risk TIA; and ability to start the study drug within 24 hours after symptom onset. Acute minor stroke was defined as the National Institutes of Health Stroke Scale value ≤3 at the time of randomization. High-risk TIA was defined as a neurological deficit lasting <24 hours caused by focal brain ischemia plus a moderate-to-high risk of stroke recurrence (ABCD2 [scores assessing the risk of stroke on the basis of age, blood pressure, clinical features, duration of TIA, and presence or absence of diabetes mellitus]) at the time of randomization ≥4). Other eligibility criteria were provided in the study protocol.\(^10\) Venous blood samples were obtained at randomization and were sent for laboratory analysis of creatinine concentration. It should be noted that patients with severe renal dysfunction, defined as serum creatinine >1.5 times of upper limit of normal value, were excluded.

The trial was approved by the ethics committee at each study center. Written informed consent was obtained from all the participants or their legal proxies. This study was registered at ClinicalTrials.gov (registration number NCT00979589).

**Calculation of eGFR**

eGFR was calculated by the CKD-EPI China equation with adjusted coefficient of 1.1 for the Chinese population:\(^13\) eGFR\(_{\text{CKD-EPI,CN}}\) = 141 × min (SCr/k,1) × max (SCr/k,1)\(^1–0.329\) × 0.993\(^\text{age}\) × 1.018 (if female) × 1.1, where SCr is serum creatinine, k is 0.7 for females and 0.9 for males, \(\alpha\) is −0.329 for females and −0.411 for males, min is the minimum of SCr/k or 1, and max indicates the maximum of SCr/k or 1. Patients were divided into the following groups: eGFR ≥90 mL/min per 1.73 m\(^2\) (normal renal function), 60 to 89 mL/min per 1.73 m\(^2\) (mild CKD), and <60 mL/min per 1.73 m\(^2\) (moderate CKD) based on the NKF-KDOQI guidelines (National Kidney Foundation Kidney Disease Outcomes Quality Initiative).\(^14,15\)

**Table 1. Baseline Characteristics According to eGFR Category**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>eGFR &lt;60 mL/min per 1.73(^2) (n=354)</th>
<th>eGFR 60–89 mL/min per 1.73(^2) (n=2064)</th>
<th>eGFR ≥90 mL/min per 1.73(^2) (n=2732)</th>
<th>(P) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, median (IQR), y</td>
<td>73.35 (65.59–77.15)</td>
<td>69.00 (60.15–75.02)</td>
<td>57.52 (51.29–64.12)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Female sex, n (%)</td>
<td>158 (44.63)</td>
<td>698 (33.82)</td>
<td>887 (32.47)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Medical history, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic stroke</td>
<td>88 (24.86)</td>
<td>473 (22.92)</td>
<td>465 (17.02)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>TIA</td>
<td>18 (5.08)</td>
<td>64 (3.10)</td>
<td>91 (3.33)</td>
<td>0.16</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>13 (3.67)</td>
<td>49 (2.37)</td>
<td>34 (1.24)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Angina</td>
<td>20 (5.65)</td>
<td>84 (4.07)</td>
<td>79 (2.89)</td>
<td>0.008</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>10 (2.82)</td>
<td>37 (1.79)</td>
<td>32 (1.17)</td>
<td>0.027</td>
</tr>
<tr>
<td>Known atrial fibrillation</td>
<td>13 (3.67)</td>
<td>60 (2.91)</td>
<td>23 (0.84)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>1 (0.28)</td>
<td>11 (0.53)</td>
<td>2 (0.07)</td>
<td>0.010</td>
</tr>
<tr>
<td>Hypertension</td>
<td>278 (78.53)</td>
<td>1395 (67.59)</td>
<td>1715 (62.77)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>85 (24.01)</td>
<td>431 (20.88)</td>
<td>572 (20.94)</td>
<td>0.39</td>
</tr>
<tr>
<td>NIHSS, median (IQR)</td>
<td>2.00 (0.00–3.00)</td>
<td>1.00 (0.00–2.00)</td>
<td>2.00 (0.00–2.00)</td>
<td>0.21</td>
</tr>
<tr>
<td>eGFR (mL/min per 1.73(^2)), median (IQR)</td>
<td>52.45 (45.81–56.68)</td>
<td>80.06 (71.81–85.76)</td>
<td>100.25 (94.99–106.15)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Table 1. Baseline Characteristics According to eGFR Category

<table>
<thead>
<tr>
<th>Qualifying event, n (%)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor stroke</td>
<td>258 (72.88)</td>
<td>1494 (72.38)</td>
<td>1964 (71.89)</td>
<td>0.89</td>
</tr>
<tr>
<td>TIA</td>
<td>96 (27.12)</td>
<td>570 (27.62)</td>
<td>768 (28.11)</td>
<td>...</td>
</tr>
</tbody>
</table>

eGFR indicates estimated glomerular filtration rate; IQR, interquartile range; NIHSS, National Institutes of Health Stroke Scale; and TIA, transient ischemic attack.
Efficacy and Safety Outcomes
The primary efficacy outcome was a new stroke event (ischemic or hemorrhagic) within 90 days. The secondary efficacy outcome was a combined vascular event (ischemic stroke, hemorrhagic stroke, myocardial infarction, or vascular death). The safety outcome was mild-to-severe bleeding event. Mild bleeding referred to bleeding not requiring transfusion and not causing hemodynamic compromise requiring intervention (eg, subcutaneous bleeding, mild hematomas, and oozing from puncture sites). Moderate hemorrhage was defined as bleeding that required transfusion of blood but did not lead to hemodynamic compromise requiring intervention. Severe hemorrhage was defined as fatal or intracranial hemorrhage or other hemorrhage causing hemodynamic compromise that required blood or fluid replacement, inotropic support, or surgical intervention, according to the GUSTO definition (Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries). All reported efficacy and safety outcomes were confirmed by a central adjudication committee that was blinded to the study group assignments.

Statistical Methods
Categorical variables were presented as percentages, whereas continuous variables were presented as medians with interquartile ranges. The study population was divided according to levels of kidney function. Comparisons across groups were calculated by 1-way ANOVA or Kruskal–Wallis test. Kaplan–Meier methods were used to estimate event rates between subgroups based on kidney function and were compared with a log-rank test. Hazard ratios and their corresponding 95% confidence intervals were estimated using Cox proportional hazards models to assess the efficacy and safety of treatment stratified by renal function categories. To exclude impact of confounding factors, baseline characteristics, including age, sex, current or previous smoking, medical history of hypertension, ischemic stroke, TIA, myocardial infarction, angina, congestive heart failure, known atrial fibrillation, valvular heart disease, and hypertension (Table 1).

Clinical Outcomes

Ninety-Day Efficacy Outcomes
As shown in Table 2 and Figure, at 90 days, combination therapy of clopidogrel and aspirin reduced the incidence of new stroke compared with aspirin alone in patients with normal kidney function (8.6% versus 11.2%; hazard ratio, 0.74; 95% confidence interval, 0.58–0.95; P < 0.02) and mild CKD group (7.5% versus 10.1%; hazard ratio, 0.59; 95% confidence interval, 0.44–0.78; P < 0.001). Similarly, in normal renal function group and mild CKD group, clopidogrel–aspirin therapy was associated with significant lower rates of combined vascular events in comparison with the aspirin group.

However, in patients with moderate CKD, no significant benefit from clopidogrel therapy was found again. The new stroke events occurred in 10.1% of patients in the aspirin therapy group and in 9.4% of patients in the clopidogrel–aspirin therapy group (hazard ratio, 1.00; 95% confidence interval, 0.43–2.35; P = 0.99).

Ninety-Day Safety Outcomes
As shown in Table 3, in the subgroup of patients with normal renal function, mild CKD, and moderate CKD, moderate or

Table 2. Effects of Combination Therapy of Clopidogrel and Aspirin on 90-d Efficacy Outcomes Based on eGFR Levels

<table>
<thead>
<tr>
<th>eGFR, mL/min per 1.73²</th>
<th>Outcome</th>
<th>Aspirin Event Rate, %</th>
<th>Clopidogrel–Aspirin Event Rate, %</th>
<th>Crude</th>
<th>Multivariable Adjusted*</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥90 (n=2732)</td>
<td>Stroke</td>
<td>147 (10.70)</td>
<td>117 (8.62)</td>
<td>HR (95% CI)</td>
<td>P Value (95% CI)</td>
</tr>
<tr>
<td></td>
<td>Ischemic stroke</td>
<td>144 (10.48)</td>
<td>115 (8.47)</td>
<td>0.77 (0.60–0.99)</td>
<td>0.036</td>
</tr>
<tr>
<td></td>
<td>Combined vascular events†</td>
<td>149 (10.84)</td>
<td>118 (8.69)</td>
<td>0.77 (0.60–0.98)</td>
<td>0.032</td>
</tr>
<tr>
<td>60–89 (n=2064)</td>
<td>Stroke</td>
<td>135 (13.08)</td>
<td>77 (7.46)</td>
<td>0.60 (0.45–0.79)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Ischemic stroke</td>
<td>130 (12.60)</td>
<td>72 (6.98)</td>
<td>0.58 (0.43–0.77)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>Combined vascular events†</td>
<td>136 (13.18)</td>
<td>80 (7.75)</td>
<td>0.60 (0.46–0.80)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>&lt;60 (n=354)</td>
<td>Stroke</td>
<td>17 (10.12)</td>
<td>17 (9.14)</td>
<td>1.06 (0.50–2.25)</td>
<td>0.88</td>
</tr>
<tr>
<td></td>
<td>Ischemic stroke</td>
<td>17 (10.12)</td>
<td>16 (8.60)</td>
<td>1.06 (0.50–2.25)</td>
<td>0.88</td>
</tr>
<tr>
<td></td>
<td>Combined vascular events†</td>
<td>18 (10.71)</td>
<td>17 (9.14)</td>
<td>0.99 (0.47–2.07)</td>
<td>0.97</td>
</tr>
</tbody>
</table>

Cl indicates confidence interval; eGFR, estimated glomerular filtration rate; and HR, hazard ratio.

*Adjusted for age, sex, current or previous smoking, medical history of hypertension, ischemic stroke, TIA, myocardial infarction, angina, congestive heart failure, known atrial fibrillation, valvular heart disease, National Institutes of Health Stroke Scale score at 1 d after randomization, and qualifying event.
†Combined vascular events were composed of ischemic stroke, hemorrhagic stroke, myocardial infarction, and vascular death.
severe hemorrhage occurred in 3 patients (0.22%), 3 patients (0.29%), and 1 patient (0.54%), respectively, on clopidogrel–aspirin therapy and in 4 patients (0.29%), 4 patients (0.38%), and 0 patient on aspirin therapy. There was no significant interaction between eGFR subgroup and antiplatelet therapy in their effects on mild, moderate, and severe bleeding events.

Discussion

There are 2 major findings in this post hoc analysis of the CHANCE trial. First, clopidogrel plus aspirin compared with aspirin alone in patients with normal renal function and mild renal insufficiency resulted in a significant reduction in new stroke events and combined vascular events at 90 days of follow-up, but this benefit was not apparent in moderate CKD patients. Second, clopidogrel did not seem to increase bleeding more in mild or moderate CKD patients than it did in those with normal renal function.

In patients with normal renal function and mild renal insufficiency, our results were in accordance with those of the overall cohort of the CHANCE study. The significance of this subgroup study is that even in mild CKD, the combination of clopidogrel and aspirin was superior to aspirin alone for reducing the risk of stroke among patients with minor stroke or TIA in the first 90 days. However, no extra benefit from clopidogrel therapy was observed in those with moderate CKD. To our knowledge, there were no trials that have evaluated the effect of clopidogrel in terms of decreasing the risk of cerebrovascular events in patients with CKD. As opposed to our results, subgroup analysis of the CURE trial (Clopidogrel in Unstable angina to prevent Recurrent Events) showed that clopidogrel add-on resulted in a similar beneficial effect in all 3 groups stratified according to eGFR (<64, 64–81.2, and >81.3 mL/min). Post hoc analysis of the CREDO trial (Clopidogrel for the Reduction of Events During Observation) suggested that clopidogrel did not decrease mortality or improve cardiovascular outcomes in mild or moderate CKD patients with ACS after percutaneous coronary intervention.

The reasons why no benefit of clopidogrel was observed in patients with moderate CKD in the present study were not absolutely clear. Clopidogrel resistance might partly account for this result. Clopidogrel induces antiplatelet effect to be highly variable, and the individuals who have poor antiplatelet effects are defined as clopidogrel resistant. Clopidogrel resistance is a multifactorial phenomenon, and the underlying mechanisms involve clinical, cellular, and genetic aspects. Previous studies have shown that patients with CKD exhibited significantly higher platelet activation and on-treatment residual ADP-inducible platelet reactivity than patients without renal insufficiency. Moreover, a low response to clopidogrel might be an independent predictor of the poorer outcomes in these CKD patients. Nowadays, the use of higher than usual clopidogrel doses (600 mg as loading dose and 150 mg as maintenance dose), longer therapy duration (beyond 12 months), or alternative more potent thienopyridine agents such as prasugrel or ticagrelor have been proposed as ways to overcome the clopidogrel resistance in CKD. However, patients with CKD also have higher bleeding tendency. So special consideration should be given to balance the benefit–risk ratio among CKD patients.

Several previous studies demonstrated that in patients with ACS, CKD increased gastrointestinal bleeding or serious
bleeding in clopidogrel users. Although in another study conducted in patients with end-stage renal disease undergoing dialysis, no association was found between increased hemorrhagic risks and use of aspirin or clopidogrel. In our trial, clopidogrel did not seem to increase bleeding more in mild or moderate CKD patients than it did in those with normal renal function. Although the exact mechanism underlying the conflicting results were not absolutely elucidated, and possible explanations for the difference were as follows. First, populations targeted in these studies were highly heterogeneous, and the definitions and assessment of bleeding outcomes were different. Second, compared with previous studies including patients with more severe strokes, our trial targeted a population at a relative low risk for bleeding. Third, compared with studies conducted in patients with ACS including percutaneous coronary intervention, the treatment paradigm was different in the CHANCE trial. In patients with ACS, the dual antiplatelet therapy was lasted for at least 9 to 12 months under normal circumstances. However, in our trial, clopidogrel plus aspirin was administered for just 21 days, followed by clopidogrel alone for a total of 90 days.

There were several limitations in the study. First, because the patients with creatinine >1.5 times the upper normal limit were excluded from the CHANCE trial and the eGFR of the patients enrolled ranged from 31.8 to 146.2 mL/min per 1.73 m², it would be difficult to make generalizations to patients with more severe renal insufficiency such as stage 4 or 5 CKD. Second, the sample size was imbalanced between the defined CKD subgroups, in particular, much less patients in the moderate renal dysfunction group (n=354). Therefore, cautions are needed when we interpret the efficacy and safety of dual antiplatelet treatment in the defined CKD patients plus stroke based on statistical analyses in this study. However, because specific recommendations for antiplatelet therapy in patients with CKD plus ischemic stroke are not available, the present study may provide some valuable information for this special population. A prospective and well-designed study in CKD with stroke would be needed for further evaluation. Third, we did not perform the platelet function test such as residual ADP-inducible platelet reactivity; thus, we could not directly evaluate the relationship between clopidogrel resistance and CKD. However, many investigations have confirmed this relationship in ACS and stroke.

To sum up, the present study is the first to investigate the effect of renal function on efficacy of clopidogrel in the setting of cerebrovascular events. In this cohort of patients with minor ischemic stroke or high-risk TIA in CHANCE, dual antiplatelet therapy was associated with improved outcomes in patients with normal renal function and mild CKD, whereas in those with moderate CKD, no extra benefit was observed. With respect to safety, bleeding risk of the dual therapy did not seem to increase with declined eGFR. Taken together, these observations support the use of dual antiplatelet therapy among patients with minor ischemic stroke or TIA with normal to mild renal insufficiency. While for those with moderate to severe CKD, further studies would be needed to explore how to optimize antiplatelet treatment according to renal function to improve the clinical outcomes.

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Disclosures

None.

References

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