cannot have it both ways. In front-runner institutions like the Cleveland Clinic, we should not criticize the report-card process, but rather should try to define and validate the standards we intend to follow. In our profession, which is very costly and which is going to go through great upheaval in the next several years, physicians must take the lead. I can guarantee that if it is done by the government, the local chamber of commerce, or the local newspaper, it is going to be done very poorly.

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Correction

A table in the article "Lipid-regulating and antiatherosclerotic therapy: current options and future approaches" (Cleveland Clinic Journal of Medicine 1996; 63:31–41) contained an error. In Table 6 on page 37, the values for the effects of the various drugs on HDL-C and LDL-C were reversed through an editing error. The corrected table appears below.

TABLE 6APPROVED DRUGS FOR DYSLIPIDEMIA*

Bile-acid seguestran		
Lipid effects: ^T	LDL-C: HDL-C: TG:	↓ 15%–30% ↑ 3%–5% ↑ or no effect
Drugs and daily dose:	Cholestyramine Colestipol	4–24 g 5–30 g
HMG-CoA reductase Lipid effects:	inhibitors LDL-C: HDL-C: TG:	↓ 20%–40% ↑ 5%–15% ↓ 10%–20%
Drugs and daily dose:	Fluvastatin Lovastatin Pravastatin Simvastatin	20–40 mg 10–80 mg 10–40 mg 5–40 mg
Nicotinic acid (NA) Lipid effects:	LDL-C: HDL-C: TG:	↓ 10%-25% ↑ 15%-35% ↓ 20%-50%
Drugs and daily dose:	Crystalline NA	1.5–6 g
Fibric-acid derivativ Lipid effects:	es [‡] LDL-C: HDL-C: TG:	↓ 10%–15% (may↑ ↑ 10%–15% ↓ 20%–50%
Drugs and daily dose:	Gemfibrozil Clofibrate Fenofibrate	1200 mg 2000 mg 300 mg

*Adapted from information in the second Adult Treatment Panel report, reference 24, and Yeshurun and Gotto, reference 25 *LDL-C, low-density lipoprotein cholesterol; HDL-C,

'LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; TG, triglyceride 'Clofibrate is not considered a first-line agent because of associated toxicity; fenofibrate is approved but not currently available in the United States