

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 anti-atherosclerotic 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 6
APPROVED DRUGS FOR DYSLIPIDEMIA*

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