

are paying now, although mostly for care of end-stage complications. In addition, a recent study⁷ has shown that increases in worker productivity may offset the increase in the cost of providing intensive glycemic control.

REFERENCES

1. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993; 329:977-986.
2. The Diabetes Control and Complications Trial Research Group. Lifetime benefits and costs of intensive therapy as practiced in the Diabetes Control and Complications Trial. *JAMA* 1996; 276:1409-1415.
3. Klein R. Hyperglycemia and microvascular and macrovascular disease in diabetes. *Diabetes Care* 1995; 18:258-268.
4. Ohkubo Y, Kishikawa H, Araki E, et al. Intensive insulin therapy prevents progression of diabetic microvascular complications in Japanese patients with non-insulin-dependent diabetes mellitus: a randomized prospective 6-year study. *Diabetes Res Clin Pract* 1996; 28:103-117.
5. Eastman, RC, Javitt JC, Herman, WH, et al. Model of complications of NIDDM: I. Model construction and assumptions. *Diabetes Care* 1997; 20:725-734.
6. Eastman, RC, Javitt JC, Herman, WH, et al. Model of complications of NIDDM: II. Analysis of the health benefits and cost-effectiveness of treating NIDDM with the goal of normoglycemia. *Diabetes Care* 1997; 20:735-744.
7. Testa M, Simonson D. Health economic benefits of improved glycemic control in NIDDM. *Diabetes* 1997; 46(Suppl 1):36A.

ADDRESS: Richard C. Eastman, MD, National Institute of Diabetes and Digestive and Kidney Diseases, Bldg 31 Rm 9A16, 31 Center Dr MSC 2560, National Institutes of Health, Bethesda, MD 20892-2560.

CORRECTION

The special supplement "Clinical practice guidelines: renal cell carcinoma"¹ contained an error. On page SI-29, a dosage of rHuIFN- α cited from preliminary results of a study by S. Negrier et al² was reported as 6×10^6 IU SC three times each week for both monotherapy and combination therapy. While this was the correct dosage for rHuIFN- α in combination with rHuIL-2, the correct dosage of rHuIFN- α as monotherapy should read 18×10^6 IU SC three times each week.

REFERENCES

1. Bukowski RM, Novick RM. Clinical practice guidelines: renal cell carcinoma. *Cleve Clin J Med* 1997; 64(Suppl 1):SI-1-SI-48.
2. Negrier S, Escudier B, Lasset C, et al. The FNCLCC Crecy trial: interleukin 2 (IL2) + interferon (IFN) is the optimal treatment to induce responses in metastatic renal cell carcinoma (MRCC) [abstract]. *Proc Am Soc Clin Oncol* 1996; 15:248.

DEDICATED TO LIFELONG LEARNING

CLEVELAND CLINIC JOURNAL OF MEDICINE

CME
2
CREDIT HOURS

MEDICAL GRAND ROUNDS

Low back pain:
Living with ambiguity
D. MAZANEK

The economics
of intensive glycemic control:
Is it worth the expense?
K.C. EASTMAN

CLINICAL REVIEWS

The elderly driver:
What physicians need to know
K.J. FOLEY

Panic disorder in primary care:
A cause of unexplained
symptoms
D.J. MEDINA AND D.A. MALONE

INTERNAL MEDICINE BOARD REVIEW

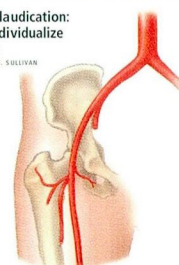
A 68-year-old woman
with high serum protein
and no symptoms
H. ABDEL-RAZED AND R. BOWELL

CURRENT DRUG THERAPY

Carvedilol for heart failure:
Renewed interest
in beta blockers
J.B. YOUNG

CLINICAL REVIEW

Vascular claudication:
How to individualize
treatment
D.M. GARY AND T.M. SULLIVAN



Dear Doctor:

As editors, we'd like you to look into every issue, every page of the *Cleveland Clinic Journal of Medicine*. We'd like to know...

1. How many ISSUES do you look into per YEAR?*

Here's our goal:

☐ None ☐ 1-33% ☐ 34-66% ☒ 67-100%

2. How many PAGES do you look into per ISSUE?

Here's our goal:

☐ None ☐ 1-33% ☐ 34-66% ☒ 67-100%

We put it in writing...
please put it in writing for us.
We want to hear from you.

E-mail: ccjm@cesmtp.ccf.org

WWW: <http://www.ccf.org/ed/ccjhome.htm>

Cleveland Clinic Journal of Medicine
The Cleveland Clinic Foundation, EE37
9500 Euclid Avenue
Cleveland, Ohio 44195

Phone: 216.444.2661 Fax: 216.444.9385

10 issues per year