

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.

REFERENCES

1. Ellerbeck EF, Jencks SF, Radford MJ, et al. Quality of care for Medicare patients with acute myocardial infarction. A four-state pilot study from the Cooperative Cardiovascular Project. *JAMA* 1992; 273:1509–1514.
2. Gunnar RM, Bourdillon PDV, Dixon DW, et al. Guidelines for the early management of patients with acute myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic and Therapeutic Cardiovascular Procedures (Subcommittee to Develop Guidelines for the Early Management of Patients with Acute Myocardial Infarction). *JACC* 1990; 16:249–292.
3. Hilborne LH, Leape LL, Kahan JP, et al. Percutaneous transluminal coronary angioplasty: a literature review and rating of appropriateness and necessity. Santa Monica, Calif: RAND; 1991. JRA-01.
4. Vogel RA, Lauer MA, Ziskind AA. A new revascularization appropriateness score for coronary angioplasty and bypass surgery. *Clin Res* 1994; 42:290A. Abstract.
5. Lauer MA, Ziskind AA, Lemmon CC, Vogel RA. Prospective assessment of revascularization appropriateness scoring systems: a comparison of RAND expert panel ratings, ACC/AHA guidelines, and the University of Maryland revascularization appropriateness score. *JACC* 1995; 25:344A. Abstract.
6. Ziskind AA, Lauer MA, Lemmon CC, Vogel RA. Prospective application of RAND expert panel ratings, ACC/AHA guidelines, and the University of Maryland revascularization appropriateness score (RAS): Only RAS predicts clinical outcome. *JACC* 1995; 25:344A. Abstract.
7. Hannan EL, Kilburn H Jr, Racz M, Shields E, Chassin MR. Improving the outcomes of coronary artery bypass surgery in New York State. *JAMA* 1994; 271:761–766.
8. Clough JD, Kay R, Gombeski WR, Nickelson DE, Loop FD. Mortality of patients transferred to a tertiary care hospital. *Cleve Clin J Med* 1993; 60:449–454.

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