Errata

Huang ES, O'Grady M, Basu A, Winn A, John P, Lee J, Meltzer D, Kollman C, Laffel L, Tamborlane W, Weinzimer S, Wysocki T, the Juvenile Diabetes Research Foundation Continuous Glucose Monitoring Study Group. The cost-effectiveness of continuous glucose monitoring in type 1 diabetes. Diabetes Care 2010;33:1269–1274

In the RESEARCH DESIGN AND METHODS section in the print version of the article listed above, the acronym JDRF has been incorrectly expanded as Juvenile Diabetes Research Federation. The correct expansion of the acronym JDRF is Juvenile Diabetes Research Foundation. The online version reflects these changes.

Gogitidze Joy N, Hedrington MS, Briscoe VJ, Tate DB, Ertl AC, Davis SN. Effects of acute hypoglycemia on inflammatory and pro-atherothrombotic biomarkers in individuals with type 1 diabetes and healthy individuals. Diabetes Care 2010;33:1529–1535

In the print version of the article listed above, the legend symbols for hypoglycemia and euglycemia are transposed in the "Nondiabetic Subjects" panel in Figs. 1 and 2. The correct legend symbols are as follows: ⊷, euglycemia; and ⊶, hypoglycemia. The online version reflects these changes.

Pignone M, Alberts MJ, Colwell JA, Cushman M, Inzucchi SE, Mukherjee D, Rosenson RS, Williams CD, Wilson PW, Kirkman MS. Aspirin for primary prevention of cardiovascular events in people with diabetes: a position statement of the American Diabetes Association, a scientific statement of the American Heart Association, and an expert consensus document of the American College of Cardiology Foundation. Diabetes Care 2010;33:1395–1402

Because of an error in data transcription, the data for the effect of aspirin on stroke from the Japanese Primary Prevention of Atherosclerosis with Aspirin for Diabetes (JPAD) trial were incorrect in the article's Table 1 and meta-analysis. For the results of the meta-analysis, the sentences "For stroke, our random-effects meta-analysis of the nine trials found a reduction in the risk of stroke of 15% (RR 0.85, 95% CI 0.66–1.11) that was not statistically significant. There was some heterogeneity ($\chi^2 = 12.48$, $P = 0.131$, $I^2 = 35.9\%$)." should read "For stroke, our random-effects meta-analysis of the nine trials found a reduction in the risk of stroke of 10% (RR 0.90, 95% CI 0.71–1.13) that was not statistically significant. There was some heterogeneity ($\chi^2 = 11.0$, $P = 0.20$, $I^2 = 27.2\%$)." The data have also been corrected in Fig. 1 and its legend and Table 1. The online version reflects these changes.

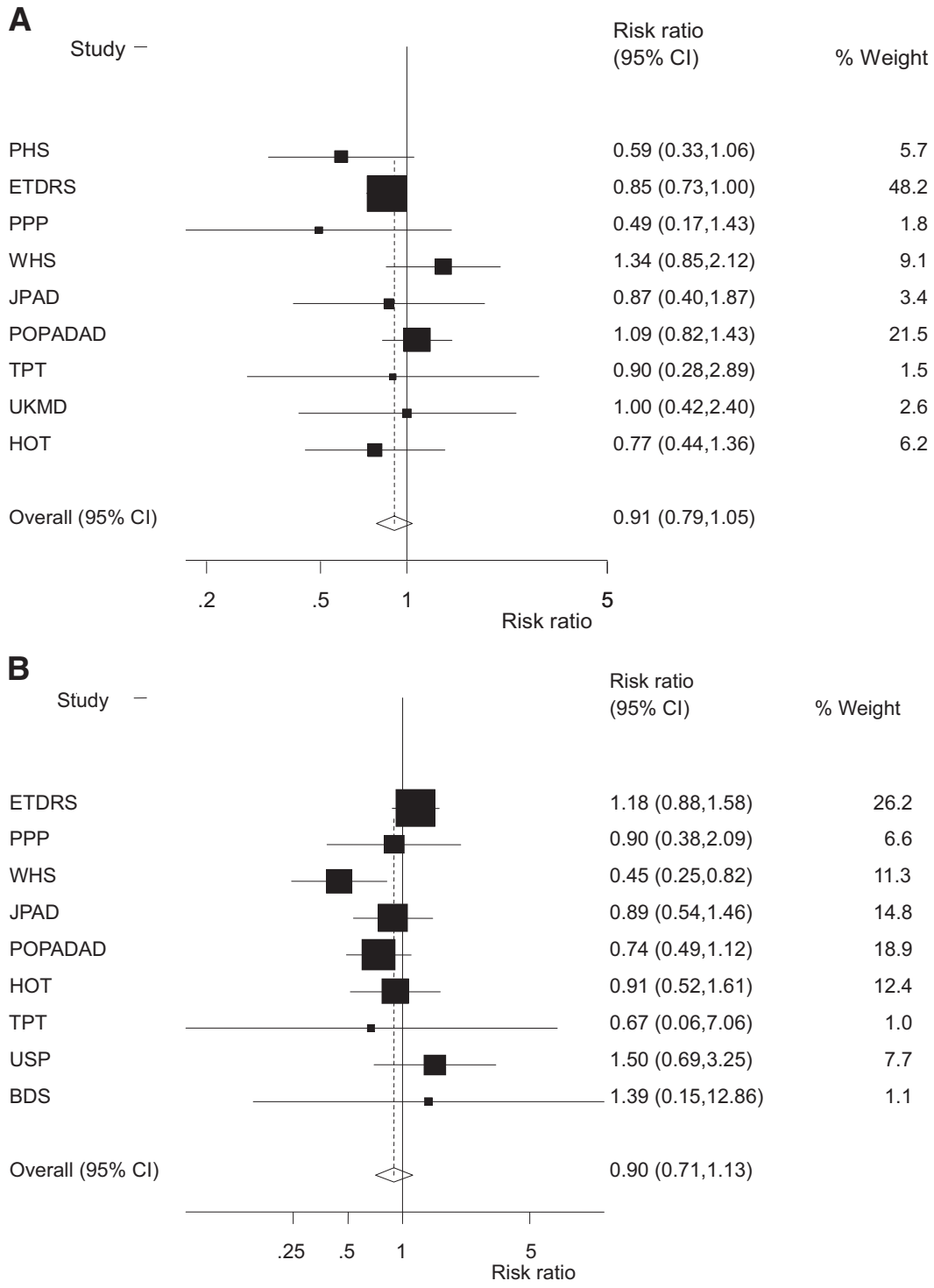

Figure 1—*Meta-analysis of trials examining the effects of aspirin on risk of CVD events in patients with diabetes.* A*: Effect of aspirin on CHD events. Tests for heterogeneity:* $\chi^2 = 8.71$, P = *0.367,* $I^2 = 8.2\%$. B*: Effect of aspirin on risk of stroke in patients with diabetes. Tests for heterogeneity:* $\chi^2 = 11.0$, P = *0.20,* $I^2 = 27.2\%$. *CI, confidence interval; ETDRS, Early Treatment of Diabetic Retinopathy Study; HOT, Hypertension Optimal Treatment; JPAD, Japanese Primary Prevention of Atherosclerosis with Aspirin for Diabetes; PHS, Physicians' Health Study; POPADAD, Prevention of Progression of Arterial Disease and Diabetes; PPP, Primary Prevention Project; TPT, Thrombosis Prevention Trial; and WHS, Women's Health Study.*

Table 1 —*Comparison of primary prevention trials of aspirin that enrolled patients with diabetes* (N = *11,787*)

Study/year (ref.)	Aspirin dose (study design)	Follow-up (years)	Number enrolled with diabetes	% Female	Age (years) (minimum/ mean)	CHD endpoint	CHD endpoint event rate (control vs. aspirin)	10-year extrapolated CHD event rates[i]	RR (95% CI)[ii]	Stroke events for aspirin vs. control: RR (95% CI)
PHS DM/1989 (12)	325 mg every other day (2 × 2 factorial design with 50 mg beta carotene)	5.0	533	0	>40/NA	Fatal + nonfatal MI	10.5% vs. 6.2%[iii] (27/258 vs. 17/275)	21% vs. 12.4%	0.59 (0.33–1.06)	16 vs. 10: 1.50 (0.69–3.25)
ETDRS/1992 (18)	650 mg daily	5.0	3,711	44	>18/NA	Fatal + nonfatal MI	15.3% vs. 13.0% (283/1,855 vs. 241/1,856)	30.6% vs. 26.0%	0.85 (0.73–1.00)	92 vs. 78: 1.18 (0.88–1.58)
PPP DM/2003[iv] (16)	100 mg daily (2 × 2 design with 30 mg vitamin E)	3.7	1,031	52	>50/64	Fatal + nonfatal MI	2.0% vs. 1.0% (10/512 vs. 5/519)	5.4% vs. 2.7%	0.49 (0.17–1.43)	10 vs. 11: 0.90 (0.38–2.09)
WHS DM/2005 (17)	100 mg every other day (2 × 2 factorial design with 600 IU Vitamin E every other day)	10.1	1,027	100	>45/55	Fatal + nonfatal MI[v]	5.9% vs. 7.9% (29/494 vs. 42/533)	5.9% vs. 7.9%	1.34 (0.85–2.12)	15 vs. 31: 0.45 (0.25–0.82)
JPAD/2008 (10)	81–100 mg daily (open label treatment assignment, blinded end-point assessment)	4.4	2,539	46	>30/65	Fatal + nonfatal MI	1.1% vs. 1.0% (14/1,277 vs. 12/1,262)	2.5% vs. 2.3%	0.87 (0.40–1.87)	28 vs. 32: 0.89 (0.54–1.46)
POPADAD/2008 (9)	100 mg daily (2 × 2 factorial design including anti-oxidants)	6.7	1,276	56	>40/60	CHD death + nonfatal MI	12.9% vs. 13.9% (82/638 vs. 89/638)	19.3% vs. 20.7%	1.09 (0.82–1.44)	37 vs. 50: 0.74 (0.49–1.12)
TPT DM/1998 (data from ATT) (5)	75 mg daily	6.7	68	0	>45/58	MCE	15.4% vs. 13.8% (6/39 vs. 4/29)	23.0% vs. 20.6%	0.90 (0.28–2.89)	1 vs. 2: 0.67 (0.06–7.06)
BMD/1988 (data from ATT) (5)	500 mg daily	5.6	101	0	>50/NA	MCE	18.8% vs. 18.8% (6/32 vs. 13/69)	33.48% vs. 33.6%	1.00 (0.42–2.40)	3 vs. 1: 1.39 (0.15–12.86)
HOT DM/1998 (data from ATT) (5)	75 mg daily (co-randomized to one of three diastolic BP goals)	3.8	1,501	47	>50/62	MCE	3.6% vs. 2.8% (27/749 vs. 21/752)	9.5% vs. 7.3%	0.77 (0.44–1.36)	22 vs. 24: 0.91 (0.52–1.61)

DM, diabetes mellitus; MCE, major coronary event (CHD death + nonfatal MI + sudden death); NA, not available. [i]10-year extrapolated CHD event rate calculated by (10 ÷ study duration) × event rate. [ii]Calculated based on event counts. [iii]Values slightly different from original PHS report based on updated ICD-9 coding information obtained by the ATT trialists. [iv]Data used from 2003 PPP diabetic substudy (16); number with diabetes is discrepant from original PPP publication (15) due to continued enrollment and follow-up of diabetic patients beyond the original study period. [v]Event rates slightly different than original 2005 report due to 11 extra MI/CHD deaths (6 in aspirin group and 5 in placebo) reported to the ATT study group vs. original publication.