type of diagnosis, 5604 exact matches were found in the CCSS cohort. There were 422 SPCs among the matched SEER survivors. We found statistically significantly higher incidence of SPCs in SEER survivors than among their CCSS matches (IR = 1.15, 95% CI = 1.06 to 1.27). The incidence ratio was unchanged when Canadians (n = 1017 individuals) were excluded from the analysis (IR = 1.13, 95% CI = 1.04 to 1.24). When we additionally matched on first course radiation treatment and geographic region (San Francisco, Atlanta, Seattle), SPC incidence remained statistically significantly higher in SEER than in CCSS (IR = 1.24, 95% CI = 1.02 to 2.81).

We could not determine if this elevated risk was due to differences in childhood cancer treatment between SEER and CCSS survivors, as SEER collects only limited information about the first course of treatment. In contrast to SPC rates, the rates of all-cause mortality were not statistically significantly different between these groups (IR = 0.71, 95% CI = 0.54 to 1.03).

In a matched comparison of long-term childhood cancer survivors in SEER and the CCSS cohort, a large sample of survivors treated at North American academic medical centers, we found no evidence of an outmigration bias in the incidence of SPCs in SEER.

STEPHANIE A. KOVALCHIK
RUTH M. PFEIFFER

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Erratum: "Diabetes and cardiovascular disease during androgen deprivation therapy: observational study of veterans with prostate cancer" by Keating et al. [J. Natl Cancer Inst 2009; 102(1): 39–46].

In the original analyses, a programming error resulted in overestimation of the number of men with diagnoses of diabetes and heart disease. However, after the error was corrected, the outcomes were affected only minimally and did not change the conclusions of the study. In the following, each original section is followed by the corrected text.

Abstract results, p. 39

Original text. "Overall, 14 597 (39%) of the 37 443 patients were treated with androgen deprivation therapy. Treatment with GnRH agonists was associated with statistically significantly increased risks of incident diabetes (for GnRH agonist therapy, 159.4 events per 1000 person-years vs 87.5 events for no androgen deprivation therapy, difference = 71.9, 95% confidence interval [CI] = 71.6 to 72.2; adjusted hazard ratio [aHR] = 1.28, 95% CI = 1.19 to 1.38), incident coronary heart disease (aHR = 1.19, 95% CI = 1.10 to 1.28), myocardial infarction (12.8 events per 1000 person-years for GnRH agonist therapy vs 7.3 for no androgen deprivation therapy, difference = 5.5, 95% CI = 5.4 to 5.6; aHR = 1.28, 95% CI = 1.08 to 1.52), sudden cardiac death (aHR = 1.35, 95% CI = 1.18 to 1.54), and stroke (aHR = 1.22, 95% CI = 1.10 to 1.36). Combined androgen blockade was statistically significantly associated with an increased risk of incident coronary heart disease (aHR = 1.27, 95% CI = 1.05 to 1.53), and orchiectomy was associated with coronary heart disease (aHR = 1.40, 95% CI = 1.04 to 1.87) and myocardial infarction (aHR = 2.11, 95% CI = 1.27 to 3.50)."

Corrected text. "Overall, 13,620 (36%) of the 37443 patients were treated with androgen deprivation therapy. Treatment with GnRH agonists was associated with statistically significant increased risks of incident diabetes (36.1 events per 1000 person years on GnRH agonist therapy [95% confidence interval [CI] = 32.8 to 39.3] vs 21.1 events [95% CI = 20.0 to 22.3] on no androgen deprivation therapy; adjusted hazard ratio [aHR] = 1.48, 95% CI = 1.31 to 1.67), incident coronary heart disease (aHR = 1.17, 95% CI = 1.06 to 1.30), myocardial infarction (12.5 events per 1000 person years on GnRH agonist therapy [95% CI = 10.8 to 14.1] vs 7.3 on no androgen deprivation therapy [95% CI = 6.8 to 8.1]; aHR = 1.21, 95% CI = 1.01 to 1.44), sudden cardiac death (aHR = 1.28, 95% CI = 1.05 to 1.57), and stroke (aHR = 1.18, 95% CI = 1.02 to 1.36). Combined androgen blockade was statistically significantly associated with an increased risk of diabetes (aHR = 1.40, 95% CI = 1.01 to 1.93) and incident coronary heart disease (aHR = 1.27, 95% CI = 1.05 to 1.53) and orchiectomy was associated with coronary heart disease (aHR = 1.48, 95% CI = 1.00 to 2.20), myocardial infarction (aHR = 1.98, 95% CI = 1.15 to 3.41), and stroke (aHR = 1.81, 95% CI = 1.15 to 2.84)."

Patients and Methods, p. 40.

Original text. "The 15 087 (40.3%) men with prevalent diabetes and the 14 375 (29.5%) men with coronary heart disease were excluded from analyses of

incident diabetes or coronary heart disease, respectively."

Corrected text. "The 7941 (21.2%) men with prevalent diabetes and the 6477 (17.3%) men with coronary heart disease were excluded from analyses of incident diabetes or coronary heart disease, respectively."

Results, p.41–42

Original text. "Overall, 14 597 (39%) of the 37 443 men received some form of androgen deprivation therapy during follow-up (Table 1), primarily with GnRH agonists (14 037 or 37.5%). Few were treated with bilateral orchiectomy (308 or 0.8%) or oral antiandrogen monotherapy (1229 or 3.3%) at any time. Use of combined androgen blockade (for more than 6 weeks at the start of GnRH agonist therapy) was also infrequent (1838 or 4.9%). Overall rates of androgen deprivation therapy were highest for men diagnosed in 2001 because they had the longest duration of follow-up.

After prostate cancer diagnosis, 847 (2.3%) of the 37 443 men had a myocardial infarction, 1337 (3.6%) had sudden cardiac death or life-threatening ventricular arrhythmia, and 1188 (3.2%) had an ischemic stroke or transient ischemic attack during follow-up. Among the 22 356 men without prevalent diabetes, 4967 (22.2%) developed diabetes, and among the 23 068 without prevalent coronary heart disease, 4775 (20.7%) developed coronary heart disease.

The unadjusted rates per 1000 person-years for developing diabetes, coronary heart disease, myocardial infarction, sudden cardiac death, or stroke during treatment or no treatment with androgen deprivation therapy are included in Table 2. We found higher unadjusted rates for each outcome for men who were receiving GnRH agonists therapy or orchiectomy than for men who were not (Table 2). For example, rates of incident diabetes were 159.4 (95% confi dence interval [CI] = 150.6 to 158.3) per 1000 person-years for men on GnRH agonist treatment vs 87.5 (95% CI = 84.6 to 90.4) per 1000 person-years for men on no therapy, and rates of myocardial infarction were 12.8 (95% CI = 11.1 to 14.4) per 1000 person-years for men on GnRH agonist treatment vs 7.3 (95% CI = 6.4 to 7.9) per 1000 person-years for men on no therapy. Higher rates of diabetes, coronary heart disease, and sudden cardiac death were observed during periods when men were on combined androgen blockade (Table 2). Higher rates of diabetes and coronary heart disease were observed for men during periods on oral antiandrogen monotherapy (Table 2).

By use of Cox proportional hazards models that adjusted for patient and tumor characteristics, we found that current use of a GnRH agonist, compared with no androgen deprivation therapy, was associated with a statistically significantly increased risk of developing incident diabetes (adjusted hazard ratio [aHR] = 1.28, 95% CI = 1.19 to 1.38), incident coronary heart disease (aHR = 1.19, 95% CI = 1.10 to 1.28), myocardial infarction (aHR = 1.28, 95% CI = 1.08 to 1.52), sudden cardiac death (aHR = 1.35, 95% CI = 1.18 to 1.54), and stroke (aHR = 1.22, 95% CI = 1.10 to 1.36) (Table 3). Orchiectomy was statistically signifi cantly associated with an increased risk of incident coronary heart disease (aHR = 1.40, 95% CI = 1.04 to 1.87) and myocardial infarction (aHR = 2.11, 95% CI = 1.27 to 3.50). Oral antiandrogen use via combined androgen blockade, compared with no androgen deprivation therapy, was associated with an increased risk of incident coronary heart disease (aHR = 1.27, 95% CI = 1.05 to 1.53) but not with risk for diabetes, myocardial infarction, sudden cardiac death, or stroke. Oral antiandrogen monotherapy was not associated with any outcome examined.

When we repeated analyses by comparing ever use of androgen deprivation therapy with no androgen deprivation therapy, we found that, after adjustment for patient and tumor characteristics, ever use of androgen deprivation therapy was associated with diabetes (aHR = 1.28, 95% CI = 1.20 to 1.37, P <.001), coronary heart disease (aHR = 1.17, 95% CI = 1.09 to 1.25, P <.001), sudden cardiac death (aHR = 1.44, 95% CI = 1.28 to 1.64, P <.001), and stroke (aHR = 1.17, 95% CI = 1.03 to 1.33, P =.02). The risk for myocardial infarction was no longer statistically significant (aHR = 1.11, 95% CI = 0.95 to 1.30, P =.18) in this analysis, indicating that the association with myocardial infarction may be more directly related to current use of androgen deprivation therapy than any use."

Corrected text. Overall, 13620 (36%) of the 37443 men received some form of androgen deprivation therapy during follow-up (Table 1), primarily with GnRH agonists (13065 or 34.9%). Few were treated with bilateral orchiectomy (268 or 0.7%) or oral antiandrogen monotherapy (1230 or 3.3%) at any time. Use of combined androgen blockade (for more than 6 weeks at the start of GnRH agonist therapy) was also infrequent (1829 or 4.9%). Overall rates of androgen deprivation therapy were highest for men diagnosed in 2001 because they had the longest duration of follow-up.

After prostate cancer diagnosis, 832 (2.2%) of the 37443 men had a myocardial infarction, 593 (1.6%) had sudden cardiac death or life-threatening ventricular arrhythmia, and 1231 (2.7%) had an ischemic stroke or transient ischemic attack during follow-up. Among the 29502 men without prevalent diabetes, 1787 (6.1%) developed diabetes and among the 30,966 without prevalent coronary heart disease, 2559 (8.3%) developed coronary heart disease.

The unadjusted rates per 1000 person-years for developing diabetes, coronary heart disease, myocardial infarction, sudden cardiac death, or stroke during treatment or no treatment with androgen deprivation therapy are included in Table 2. We found higher unadjusted rates for each outcome for men who were receiving GnRH agonist therapy than for men who were not (Table 2). For example, rates of incident diabetes were 36.1 (95% confidence interval [CI] = 32.8 to 39.3) per 1000 person-years for men on GnRH agonist treatment vs 21.1 (95% CI = 20.0 to 22.3) per 1000 person-years for men on no therapy and rates of myocardial infarction were 12.5 (95% CI = 10.8 to 14.1) per 1000 person-years for men on GnRH agonist treatment versus 7.4 (95% CI = 6.8 to 8.1) per 1000 person-years for men on no therapy. Higher rates of coronary heart disease, myocardial infarction, sudden cardiac death, and stroke were seen for men treated with orchiectomy. Higher rates of diabetes and coronary heart disease were observed during periods when men were on combined androgen blockade (Table 2). Higher rates of coronary heart disease were observed for men during periods on oral antiandrogen monothearpy (Table 2).

By use of Cox proportional hazards models that adjusted for patient and tumor

Original Table 1, p. 42

Table 1. Patient characteristics and receipt of androgen deprivation therapy*

Characteristic	No. (%)	% who received ADT during follow-up
Total	37443 (100)	39.0
Age at diagnosis, y		
≤55	4110 (11)	23.6
56–60	5369 (14)	24.9
61–65	6412 (17)	33.0
66–70	8036 (21)	39.5
71–75	7173 (19)	46.7
>75	6343 (17)	57.6
Race or ethnicity		
White	24979 (67)	38.1
Black	8896 (24)	39.2
Hispanic	2138 (6)	50.1
Other or unknown	1430 (4)	36.3
Marital status		
Married	20578 (55)	39.4
Unmarried	16040 (43)	38.5
Unknown	825 (2)	38.4
Census division		
New England	1483 (4)	40.4
Mid Atlantic	3949 (11)	35.4
East North Central	3751 (11)	37.1
West North Central	3156 (9)	38.1
Pacific	3507 (10)	26.2
Mountain	2273 (6)	36.4
West South Central	5288 (15)	40.5
East South Central	3010 (9)	44.8
South Atlantic	8680 (25)	45.4
Median household income in zip code of residence at diagnosis		
Quartile 1 (lowest)	8852 (24)	43.5
Quartile 2	8855 (24)	40.9
Quartile 3	8849 (24)	37.3
Quartile 4 (high)	8850 (24)	34.1
Unknown	2037 (5)	39.8
% high school graduates in census tract of residence at diagnosis		
Quartile 1 (lowest)	8852 (24)	40.6
Quartile 2	8849 (24)	42.1
Quartile 3	8854 (24)	38.1
Quartile 4 (high)	8846 (24)	34.9
Unknown	2042 (5)	39.8
Tumor grade (Gleason score)		
Well differentiated (2-4)	1552 (4)	28.8
Moderately differentiated (5-7)	22626 (60)	31.4
Poorly differentiated or undifferentiated (8-10)	11688 (31)	54.7
Unknown	1577 (4)	41.5
DCG comorbidity score		
Quartile 1 (lowest)	9418 (25)	36.3
Quartile 2	9315 (25)	37.9
Quartile 3	9353 (25)	39.9
Quartile 4 (high)	9357 (25)	41.8
Year of diagnosis		
2001	9240 (25)	45.1
2002	9479 (25)	41.0
2003	9387 (25)	37.6
2004	9337 (25)	32.3
Primary treatment received in the 6 months after diagnosis		
Radical prostatectomy	9025 (24)	15.2
Radiation therapy	13490 (37)	44.3
Neither	14478 (39)	48.8
Prevalent diabetes		
No	22356 (60)	33.3
Yes	15087 (40)	47.4
Prevalent coronary heart disease		
No	26387 (70)	34.9
Yes	11056 (30)	48.7

*DCG = Diagnostic Cost Groups.

Corrected Table 1

Table 1. Patient characteristics and receipt of androgen deprivation therapy*

Characteristic	No. (%)	% who received ADT during follow-up
Total	37443 (100)	36.4
Age at diagnosis, y		
≤55	4110 (11)	22.7
56–60	5369 (14)	23.9
61–65	6412 (17)	30.0
66–70	8036 (21)	35.6
71–75	7173 (19)	43.4
>75	6343 (17)	55.3
Race or ethnicity		
White	24979 (67)	35.2
Black	8896 (24)	37.1
Hispanic	2138 (6)	48.3
Other or unknown	1430 (4)	34.1
Marital status		
Married	20578 (55)	36.3
Unmarried	16040 (43)	36.5
Unknown	825 (2)	36.0
Census division		
New England	1483 (4)	36.5
Mid Atlantic	3949 (11)	33.4
East North Central	3751 (11)	35.0
West North Central	3156 (9)	35.7
Pacific	3507 (10)	24.6
Mountain	2273 (6)	32.9
West South Central	5288 (15)	15.1
East South Central	3010 (9)	41.6
South Atlantic	8680 (25)	42.7
Median household income in zip code of residence at diagnosis		
Quartile 1 (lowest)	8852 (24)	40.9
Quartile 2	8855 (24)	38.1
Quartile 3	8849 (24)	34.7
Quartile 4 (high)	8850 (24)	31.7
Unknown	2037 (5)	36.4
% high school graduates in census tract of residence at diagnosis		
Quartile 1 (lowest)	8852 (24)	37.9
Quartile 2	8849 (24)	39.3
Quartile 3	8854 (24)	35.4
Quartile 4 (high)	8846 (24)	32.8
Unknown	2042 (5)	36.4
Tumor grade (Gleason score)		
Well differentiated (2-4)	1552 (4)	25.1
Moderately differentiated (5-7)	22626 (60)	28.4
Poorly differentiated or undifferentiated (8-10)	11688 (31)	52.9
Unknown	1577 (4)	39.0
DCG comorbidity score		
Quartile 1 (lowest)	9537 (25)	28.1
Quartile 2	9295 (25)	37.4
Quartile 3	9355 (25)	38.4
Quartile 4 (high)	9347 (25)	41.7
Year of diagnosis		
2001	9240 (25)	41.9
2002	9479 (25)	37.9
2003	9387 (25)	35.1
2004	9337 (25)	30.7
Primary treatment received in the 6 months after diagnosis		
Radical prostatectomy	9025 (24)	12.5
Radiation therapy	13490 (37)	41.5
Neither	14478 (39)	46.3
Prevalent diabetes		
No	29502 (79)	35.3
Yes	7941 (21)	40.5
Prevalent coronary heart disease		
No	30966 (83)	35.4
Yes	6477 (17)	41.1

*DCG = Diagnostic Cost Groups; ADT = androgen deprivation therapy.

Original Table 2, p.43

Table 2. Unadjusted rate of incident diabetes, coronary heart disease, myocardial infarction, sudden death, and stroke associated with androgen deprivation therapy*

	Incident diabetes		Incident CHD		Myocardial infarction		Sudden cardiac death		Stroke	
Treatment	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†
No androgen deprivation therapy	87.5 (84.6 to 90.4)	-	81.4 (78.7 to 84.2)	-	7.3 (6.4 to 7.9)	-	11.5 (10.7 to 12.3)	-	10.8 (10.0 to 11.5)	-
GnRH agonist	159.4 (150.6 to 168.3)	<.001	144.0 (135.7 to 152.2)	<.001	12.8 (11.1 to 14.4)	<.001	21.6 (19.4 to 23.7)	<.001	18.5 (16.5 to 20.5)	<.001
Orchiectomy	190.4 (137.6 to 243.2)	<.001	210.5 (150.9 to 270.0)	<.001	24.3 (12.4 to 36.3)	.005	23.3 (11.5 to 35.1)	.05	26.2 (13.8 to 38.7)	.015
Combined androgen blockade	144.6 (117.2 to 172.0)	<.001	157.7 (129.4 to 186.0)	<.001	10.2 (5.2 to 15.2)	.26	20.1 (13.0 to 27.2)	.02	14.8 (8.8 to 20.9)	.19
Oral antiandrogen	126.8 (82.9 to 170.8)	.08	143.2 (97.1 to 189.4)	.009	11.2 (2.3 to 20.1)	.40	18.8 (7.2 to 30.5)	.22	14.9 (4.6 to 25.2)	.43

* Rate = number of events per 1000 person-years; CHD = coronary heart disease; GnRH = gonadatropin releasing hormone.

† *P* values were based on two-sample z tests that evaluated whether the rate of each outcome for men during treatment with any of the treatments differed from the rate under no androgen deprivation therapy, accounting for censoring. Patients with prevalent diabetes and coronary heart disease did not contribute data to the rates for incident diabetes and coronary heart disease, respectively. All statistical tests were two-sided.

Corrected Table 2

Table 2. Unadjusted rate of incident diabetes, coronary heart disease, myocardial infarction, sudden death, and stroke associated with androgen deprivation therapy*

	Incident diabetes		Incident CHD		Myocardial infarction		Sudden cardiac death		Stroke	
Treatment	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†	Rate (95% CI)	*P* value†
No androgen deprivation therapy	21.1 (20.0 to 22.3)	-	29.7 (28.3 to 31.0)	-	7.4 (6.8 to 8.1)	-	5.3 (4.7 to 5.8)	-	11.3 (10.5 to 12.2)	-
GnRH agonist	36.1 (32.8 to 39.3)	<.001	47.4 (43.7 to 51.1)	<.001	12.5 (10.8 to 14.1)	<.001	9.3 (7.8 to 10.7)	<.001	18.7 (16.7 to 20.8)	<.001
Orchiectomy	30.3 (14.4 to 46.2)	.26	61.3 (33.7 to 84.8)	.009	23.7 (11.3 to 36.1)	.01	15.1 (5.2 to 25.0)	.05	34.7 (19.5 to 50.0)	.002
Combined androgen blockade	34.5 (23.8 to 45.2)	.01	52.7 (39.8 to 65.7)	<.001	10.2 (5.2 to 15.2)	.28	8.3 (3.8 to 12.8)	.19	14.7 (8.7 to 20.8)	.26
Oral antiandrogen	30.3 (13.2 to 47.5)	.29	56.2 (33.2 to 79.2)	.02	11.1 (2.2 to 20.-)	.42	12.8 (3.3 to 22.3)	.12	16.6 (5.8 to 27.4)	.34

* Rate = number of events per 1000 person-years; CHD = coronary heart disease; GnRH = gonadatropin releasing hormone.

† *P* values were based on two-sample z tests that evaluated whether the rate of each outcome for men during treatment with any of the treatments differed from the rate under no androgen deprivation therapy, accounting for censoring. Patients with prevalent diabetes and coronary heart disease did not contribute data to the rates for incident diabetes and coronary heart disease, respectively. All statistical tests were two-sided.

characteristics, we found that current use of a GnRH agonist, compared with no androgen deprivation therapy, was associated with a statistically significantly increased risk of developing incident diabetes (adjusted hazard ratio [aHR] = 1.48, 95% CI = 1.31 to 1.67), incident coronary heart disease (aHR = 1.17, 95% CI = 1.06 to 1.30), myocardial infarction (aHR = 1.21, 95% CI = 1.01 to 1.44), sudden cardiac death (aHR = 1.28, 95% CI = 1.05 to 1.57), and stroke (aHR = 1.18, 95% CI = 1.02 to 1.36) (Table 3). Orchiectomy was statistically significantly associated with an increased risk of incident coronary heart disease (aHR = 1.48, 95% CI = 1.00 to 2.20) and myocardial infarction (aHR = 1.98, 95% CI = 1.15 to 3.41). Oral antiandrogen use via combined androgen blockade, compared with no androgen deprivation therapy, was associated with an increased risk of incident diabetes (aHR = 1.40, 95% CI = 1.01 to 1.93) and coronary heart disease (aHR = 1.29, 95% CI = 1.00 to 1.66), but not with risk for myocardial infarction, sudden cardiac death, or stroke. Oral antiandrogen monotherapy was not associated with any outcome examined.

When we repeated analyses by comparing ever use of androgen deprivation therapy with no androgen deprivation therapy, we found that, after adjustment for patient and tumor characteristics, ever use of androgen deprivation therapy was associated with diabetes (adjusted hazard ratio [aHR] = 1.45, 95% confidence interval [CI] = 1.30 to 1.62, *P*<.001), coronary heart disease (aHR = 1.13, 95% CI = 1.03 to 1.23, *P*=.008), sudden cardiac death (aHR = 1.26, 95% CI = 1.05 to 1.52, *P*=.01), and stroke (aHR = 1.21, 95% CI = 1.06 to 1.37, *P* =.005). The risk for myocardial infarction was no longer statistically significant (aHR = 1.11, 95% CI = 0.95 to 1.30, *P* =.20) in this analysis, indicating that the association with myocardial infarction may be more directly related to current use of androgen deprivation therapy than any use.

Peter Albertsen, author of the accompanying editorial, "Does the Benefit Justify the Risk?", [J. Natl Cancer Inst 2009; 102(1): 4-5], has

Original Table 3, p.44

Table 3. Association between androgen deprivation therapy and diabetes, coronary heart disease, myocardial infarction, sudden death, and stroke*

	Adjusted hazard ratio (95% CI)				
Treatment	**Diabetes**	**Coronary heart disease**	**Myocardial infarction**	**Sudden cardiac death**	**Stroke**
No androgen deprivation therapy	Reference	Reference	Reference	Reference	Reference
GnRH agonist	1.28 (1.19 to 1.38)	1.19 (1.10 to 1.28)	1.28 (1.08 to 1.52)	1.35 (1.18 to 1.54)	1.21 (1.05 to 1.40)
Orchiectomy	1.16 (0.87 to 1.54)	1.40 (1.04 to 1.87)	2.11 (1.27 to 3.50)	1.29 (0.76 to 2.18)	1.49 (0.92 to 2.43)
Combined androgen blockade	1.17 (0.96 to 1.42)	1.27 (1.05 to 1.53)	1.03 (0.62 to 1.71)	1.22 (0.85 to 1.76)	0.93 (0.61 to 1.42)
Oral antiandrogen	1.02 (0.72 to 1.45)	1.10 (0.80 to 1.53)	1.05 (0.47 to 2.35)	1.06 (0.57 to 1.99)	0.86 (0.43 to 1.73)

* Cox proportional hazards models were adjusted for age, race or ethnicity (white, black, Hispanic, or other or unknown), marital status (married, unmarried, or unknown), Census division, zip code level measures of income and education (categorized in quartiles), tumor grade (well differentiated, moderately differentiated, poorly differentiated, or unknown), comorbidity score, year of diagnosis, stage (regional or local), primary therapy (radical prostatectomy or radiation therapy), prostate-specific antigen level at diagnosis (categorized in quintiles or unknown), cholesterol level at baseline (categorized in quintiles or unknown), baseline statin use, baseline finasteride use, prevalent coronary heart disease, prevalent diabetes, and development of new diabetes, coronary heart disease or myocardial infarction, sudden cardiac death, and stroke during follow up, except that the diabetes, coronary heart disease, and sudden death models do not control for past occurrences of the same condition. The diabetes and coronary heart disease models excluded patients with prevalent diabetes and coronary heart disease, respectively. GnRH = gonadotropin-releasing hormone; CI = confidence interval.

Corrected Table 3

Table 3. Association between androgen deprivation therapy and diabetes, coronary heart disease, myocardial infarction, sudden death, and stroke*

	Adjusted hazard ratio (95% CI)				
Treatment	**Diabetes**	**Coronary heart disease**	**Myocardial infarction**	**Sudden cardiac death**	**Stroke**
No androgen deprivation therapy	Reference	Reference	Reference	Reference	Reference
GnRH agonist	1.48 (1.31 to 1.67)	1.17 (1.06 to 1.39)	1.21 (1.01 to 1.44)	1.28 (1.05 to 1.57)	1.18 (1.02 to 1.36)
Orchiectomy	1.36 (0.79 to 2.31)	1.48 (1.00 to 2.20)	1.98 (1.15 to 3.41)	1.70 (0.86 to 3.34)	1.81 (1.15 to 2.84)
Combined androgen blockade	1.40 (1.01 to 1.93)	1.29 (1.00 to 1.66)	0.99 (0.59 to 1.64)	1.05 (0.60 to 1.87)	0.91 (0.60 to 1.39)
Oral antiandrogen	1.33 (0.75 to 2.36)	1.30 (0.85 to 1.20)	0.98 (0.43 to 2.19)	1.48 (0.69 to 3.14)	0.89 (0.46 to 1.73)

* Cox proportional hazards models were adjusted for age, race or ethnicity (white, black, Hispanic, other or unknown), marital status (married, unmarried or unknown), Census division, zip code level measures of income and education (categorized in quartiles), tumor grade (well differentiated, moderately differentiated, poorly differentiated or unknown), comorbidity score, year of diagnosis, stage (regional, local), primary therapy (radical prostatectomy or radiation therapy), PSA at diagnosis (categorized in quintiles or unknown), cholesterol level at baseline (categorized in quintiles, or unknown), baseline statin use, baseline finasteride use, prevalent coronary heart disease, prevalent diabetes, and development of new diabetes, coronary heart disease or myocardial infarction, sudden cardiac death, and stroke during follow up, except that the diabetes, coronary heart disease, and sudden death models do not control for past occurrences of the same condition. The diabetes and coronary heart disease models excluded patients with prevalent diabetes and coronary heart disease, respectively. GnRH = gonadotropin-releasing hormone; CI = confidence interval.

given permission to correct the following text from the original editorial:

"Although ADT was more common among men with poorly differentiated disease, more than 25% of the men with well-differentiated disease (Gleason 2 – 4) and more than 30% of men with moderately differentiated disease were treated. We do not know whether these treatments have prolonged survival, but Keating et al. confirm that this approach has the potential for substantial unintended side effects. Almost 25% of the men treated with ADT developed diabetes and 20% developed coronary heart disease. These rates are considerably higher than those found among men who did not receive ADT."

Corrected text. "Although ADT was more common among men with poorly differentiated disease, approximately 25% of the men with well-differentiated disease (Gleason 2 – 4) and almost 30% of the men with moderately differentiated disease were treated. We do not know whether these treatments have prolonged survival, but Keating et al. confirm that this approach has the potential for substantial unintended side effects. The rates of diabetes and coronary heart disease were considerably higher in men treated with ADT than in men who did not receive ADT."

The authors regret these errors.

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