In the article by Stone et al, “2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines,” which published online November 12, 2013, and appears in the supplement to the June 24, 2014, issue of the journal (Circulation. 2014;129[suppl 2]:S1–S45), several corrections were needed.

These corrections have been made to the print version and to the current online version of the article, which is available at http://circ.ahajournals.org/lookup/doi/10.1161/01.cir.0000437738.63853.7a.

1. On the title page, the American Academy of Physician Assistants has been added as an endorsing organization.
2. On the title page, the first footnote paragraph now reads “This document was approved by the American College of Cardiology Board of Trustees and the American Heart Association Science Advisory and Coordinating Committee in November 2013. The Academy of Nutrition and Dietetics affirms the value of this guideline.” The footnote previously did not refer to the Academy of Nutrition and Dietetics.
3. On the title page, Robert A. Guyton, MD, FACC, was listed as a member of the ACC/AHA Task Force. His name has been removed from the list of Task Force members.
4. Throughout the article, mathematical symbols have been changed as follows:
   • “triglycerides >500 mg/dL” has been changed to “triglycerides ≥500 mg/dL”
   • “ALT >3 X ULN” has been changed to “ALT ≥3 times ULN”
   • “non–HDL-C level >220 mg/dL” has been changed to “non–HDL-C level ≥220 mg/dL”
   • “high-sensitivity C-reactive protein >2 mg/L” has been changed to “high-sensitivity C-reactive protein ≥2 mg/L”
5. Throughout the article, callouts to the “Full Panel Report Supplement” have been hyperlinked to the report.
6. Throughout the article, the Web-based calculator links have been updated to:
   • http://my.americanheart.org/cvriskcalculator
7. In Section 1.2, the last paragraph, the American Academy of Physician Assistants has been added as an endorsing organization.
8. In Section 2, Table 3, titled “Expanded Discussion of What’s New in the Guideline,” is now Appendix 5. The respective callouts in the text have been updated.
9. In Section 2, a new Table 3 has been inserted. Its updated title is, “Summary of Key Recommendations for the Treatment of Blood Cholesterol to Reduce ASCVD Risk in Adults.”
   The following callout sentence has been added to the text: “A summary of the major recommendations for the treatment of cholesterol to reduce ASCVD risk is provided in Table 3.”
10. In Section 2.1, end of the first paragraph, the following sentence has been added: “Drug therapy for lifestyle-related risk factors such as hypertension is often needed and smoking should be avoided.”
11. In Section 2.2,
   • second paragraph, the second sentence read, “…or 4) without clinical ASCVD or diabetes with LDL-C 70 to 189 mg/dL and estimated 10-year ASCVD risk >7.5%...” It has been changed to read, “…and 4) primary prevention in individuals without diabetes and with estimated 10-year ASCVD risk ≥7.5%, 40 to 75 years of age who have LDL-C 70 to 189 mg/dL.”
   • second paragraph, the following text has been added to the end of the paragraph:
     “Moderate evidence supports the use of statins for primary prevention in individuals with 5% to <7.5% 10-year ASCVD risk, 40 to 75 years of age with LDL-C 70 to 189 mg/dL.”

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Selected individuals with <5% 10-year ASCVD risk, or <40 or >75 years of age may also benefit from statin therapy. Clinicians and patients should engage in a discussion of the potential for ASCVD risk-reduction benefits, adverse effects, drug–drug interactions, and consider patient preferences for treatment. This discussion also provides the opportunity to re-emphasize healthy-lifestyle habits and address other risk factors.

- penultimate paragraph, the following text has been added to the end of the paragraph:
  “In primary prevention, additional factors may influence ASCVD risk in those for whom a risk-based decision is unclear. These include a primary LDL-C ≥160 mg/dL or other evidence of genetic hyperlipidemias, family history of premature ASCVD with onset <55 years of age in a first-degree male relative or <65 years of age in a first-degree female relative, high-sensitivity C-reactive protein ≥2 mg/L, coronary artery calcium score ≥300 Agatston units or ≥75th percentile for age, sex, and ethnicity (for additional information, see http://www.mesa-nhlbi.org/CACReference.aspx), ankle-brachial index <0.9, and elevated lifetime risk of ASCVD.”

12. In Section 3.1, the third bullet read, “…to lower LDL-C.” It has been changed to read, “…to reduce ASCVD risk.”

13. In Table 4, in the “Primary Prevention in Individuals ≥21 Years of Age With LDL-C ≥190 mg/dL” section, recommendation 4, the Class IIb level of evidence recommendation color has been changed from yellow to orange.

14. In Section 4.5, the first paragraph, the last sentence, “…or whose LDL-C <70 mg/dL…” has been added so the sentence now reads, “In persons with diabetes who are <40 years of age or >75 years of age, or whose LDL-C <70 mg/dL, statin therapy…”

15. In Section 4.6, the second paragraph, in the first and the penultimate sentences, the LDL-C level, which was >70 mg/dL, has been changed to ≥70 mg/dL.

16. Figure 2 has been edited and clarified to more closely align with published recommendations.
   - The 3 center diamonds have been colored green to correspond with Class I recommendations.
   - The top white box has been edited to read “Heart-healthy lifestyle habits are the foundation of ASCVD prevention (See 2013 AHA/ACC Lifestyle Management Guideline).”
   - In the second white box on the left, “Age >21 y…” has been changed to “Age ≥21 y…”
   - A second green box has been added under the 3 gray boxes on the left that says, “Regularly monitor adherence to lifestyle and drug therapy with lipid and safety assessments (See Fig 5).”
   - In the bottom half of the figure, stemming from the third diamond, “Diabetes”:
     - On the left side of the figure, a white box has been added that reads, “DM age <40 or >75 or LDL-C <70 mg/dL.”
     - Under the diamond, a green Primary Prevention box has been added with 4 boxes breaking off to indicate categories of ASCVD risk.
     - An orange box has been added regarding additional factors under the boxes indicating categories of ASCVD risk.
     - A yellow Clinician-Patient Discussion box has been added.
     - Two gray boxes have been added on the right indicating the decision on whether or not to add statin therapy.
   - The footnotes have been modified according to updates in the figure.

17. In Section 4.6, the last paragraph, reference 11 has been cited as follows: “For an individual <40 years of age, the 10-year horizon might not be optimal for predicting lifetime risk of ASCVD (see “2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk”).”

18. In Table 9, for the subheading “Safety of Fibrates,” the following footnote has been added to recommendation 3, second bullet: “Consult the manufacturer’s prescribing information as there are several forms of fenofibrate available.”

19. In Section 10, under the list “Four Statin Benefit Groups,” the following has been added to No. 4: “This requires a clinician-patient discussion.”

20. After the references, “Key Words” have been added: “AHA Scientific Statements cardiovascular disease cholesterol hydroxymethylglutaryl-CoA reductase inhibitors/statins primary prevention secondary prevention diabetes mellitus drug therapy risk assessment risk reduction behavior patient compliance hypercholesterolemia lipids biomarkers, pharmacological.”
21. In Appendix 1, the information for Susan T. Shero has been added.

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<th>Panel Member</th>
<th>Employment</th>
<th>Consultant</th>
<th>Speaker’s Bureau</th>
<th>Ownership/Partnership/Principal</th>
<th>Personal Research</th>
<th>Expert Witness</th>
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22. In Appendix 2,
- For Robert S. Rosenson, LipoScience was added to the Ownership/Partnership/Principal column.
- The following has been added to the footnote: “This table represents the relationships of reviewers with industry and other entities that were self-disclosed at the time of peer review. It does not necessarily reflect relationships with industry at the time of publication. To review the NHLBI and ACC/AHA’s current comprehensive policies for managing relationships with industry and other entities, please refer to http://www.nhlbi.nih.gov/guidelines/cvd_adult/coi-rwi_policy.htm and http://www.cardiosource.org/Science-And-Quality/Practice-Guidelines-and-Quality-Standards/Relationships-With-Industry-Policy.aspx.”

23. In Appendix 4, mathematical symbols have been changed in several Evidence Statements in ways that make the text more concise but do not alter the meaning.

24. In Appendix 4, for Evidence Statement No. 57, the penultimate bullet, the word “elevated” has been added to the beginning of the statement, “Elevated levels of uric acid, serum glutamic oxaloacetic transaminase, alkaline phosphatase, and glucose.”

25. Appendix 5, which was formerly Table 3, has been created. The following changes have been made:
- In the subheading “Focus on ASCVD Risk Reduction: 4 Statin Benefit Groups,” under the list “Four statin benefit groups,” No. 4, the following sentence has been added: “This requires a clinician-patient discussion.”
- In the subheading “Focus on ASCVD Risk Reduction: 4 Statin Benefit Groups,” under letter C, “Treat level of ASCVD risk” header, “…class III or IV heart failure” has been changed to “…NYHA class II to IV heart failure.”
- In the subheading “A New Perspective on LDL-C and/or Non−HDL-C Goals,” the second bullet, “dose” has been changed to “intensity” in 2 instances.
- In the third bullet, under letter B, the subheading “FH with LDL-C >190 mg/dL…” has been changed to “Familial hypercholesterolemia with LDL-C ≥190 mg/dL…”
- In the subheading “Global Risk Assessment for Primary Prevention,” in the third bullet, the following text has been added: “…prevention of ASCVD. Other factors such as LDL-C ≥160 mg/dL may also be considered. This gives…”
Correction

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