for the management of acute coronary syndromes without ST-segment elevation, the CURE trial[2] showed that the rate of death from cardiovascular causes, nonfatal infection or stroke was reduced in 12 562 patients during the average 9-month follow-up period from 11.4% in the group who received aspirin alone to 9.3% in the group treated with clopidogrel plus aspirin. This is a 2.1% absolute risk reduction or a 20% relative risk reduction, with 95% confidence intervals (0.72–0.90) showing a highly significant benefit. Major bleeding increased from 2.7% in the patients who received aspirin to 3.7% in the patients who received aspirin plus clopidogrel: this is an absolute increase of 1% but a relative increase of hazard of 38%. However, few of these bleeds were sufficiently serious to require transfusion and there was no significant increase in life-threatening hemorrhage.

Expressed in terms of numbers to treat to observe both the benefits and hazards, the CURE trial showed that for every 1000 patients treated with clopidogrel and aspirin compared with aspirin alone, 28 major cardiovascular events would be prevented in 23 patients at the cost of 9 serious hemorrhages, of which only 6 would require transfusion.

In high-risk patients with an acute coronary syndrome, outcomes can be improved by more efficacious antithrombotic and antiplatelet treatment. Unfortunately, such treatment does come with a small but important increase in hemorrhagic side effects. By carefully selecting patients, as well as determining the optimal duration of treatment, we can enhance the benefits of such treatment and minimize the risks.

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References

1. Fitchett D, Goodman S, Langer A. New advances in the management of acute coronary syndromes: 1. Matching treatment to risk. *CMAJ* 2001;164(9):1309-16.
2. Yusuf S, Zhao F, Mehta SR, Chrolavicius S, Tognoni G, Fox KK; the Clopidogrel in Unstable Angina to Prevent Recurrent Events Trial Investigators. Effects of clopidogrel in addition to aspirin in patients with acute coronary syndromes without ST-segment elevation. *N Engl J Med* 2001;345(7):494-502.

Correction

There is an error in the reference numbering in a research article by Michael Mondloch and associates.[1] In Tables 2 and 3, the numbering for references 12 to 26 should be increased by 1 (i.e., these references should be numbered 13 to 27).

Reference

1. Mondloch MV, Cole DC, Frank JW. Does how you do depend on how you think you'll do? A systemic review of the evidence for a relation between patients' recovery expectations and health outcomes. *CMAJ* 2001;165(2):174-9.