for almost half the total cost of care.⁵ In ATHENA, it can be demonstrated that the reduction in AF-related hospitalizations was not simply due to fewer cardioversions, but also to a decrease in the severity of recurrent atrial fibrillation episodes.

If we conclude that reasons for cardiovascular hospitalization in ATHENA were pre-specified, it would be also interesting to clearly characterize and pre-specify the reasons for non-cardiovascular hospitalizations. For example, it is well known that during the development of dronedarone the problem of liver toxicity has not been clearly observed. In the DIONYSOS (Dronedaronne vs. Amiodarone for the Maintenance of Sinus Rhythm in Patients with Atrial Fibrillation) trial,⁶ the rate of elevation of alanine aminotransferase levels in the dronedarone group was higher than in the previous trials, but similar to that observed in the case of amiodarone. It is known that in the ATHENA trial, cardiovascular mortality but not total mortality, was significantly decreased. Thus, it would have been interesting to analyse the reasons for non-cardiovascular hospitalizations in ATHENA.

Reservations have been made about the relevance of hospitalizations in the trials analysing the effects of antiarrhythmic drugs in atrial fibrillation. Indeed, it remains difficult to accurately characterize the reason for hospitalization in a multicentre trial, considering that there are different clinical practices in different countries. Nevertheless, it is plausible to assume that if the reasons for

hospitalization are clearly pre-specified, hospitalization could be considered a relevant endpoint.

Conflict of interest: J.Y.L. received research grants from Sanofi-Aventis and was the principal investigator of DIONYSOS.

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Corrigendum

doi:10.1093/europace/eur232

Corrigendum to: 'Efficacy of adjunctive ablation of complex fractionated atrial electrograms and pulmonary vein isolation for the treatment of atrial fibrillation: a meta-analysis of randomized controlled trials' [*Europace* 2010;**13**:193–204, doi:10.1093/europace/euq384]. Melissa H. Kong, Jonathan P. Piccini, and Tristram D. Bahnson.

In the results section, under 'Secondary Endpoints' the mean procedural, fluoroscopy, and RF energy times were incorrectly reported. The correct times should be as follows:

Mean Procedural time for PVI v. PVI + CFAE: 202.9 +/- 71.3 min v. 278.5 +/- 84.9 min
 Mean Fluoroscopy time for PVI v. PVI + CFAE: 59.5 +/- 22.2 min v. 79.3 +/- 29.2 min
 Mean RF Energy time for PVI v. PVI + CFAE: 69.7 +/- 33.4 min v. 92.8 +/- 39.2 min

The *p* values and the conclusions are not affected. The authors apologize for this error.

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