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In Reply We appreciate the interest of Chidambaram and Goh in our article.[1] As they point out, our trial population included men and women (mean [SD] age, 50.6 [11.4] years) who had a moderate risk of future myocardial infarction based on their risk score and who were free of cardiovascular disease. Thus, our findings that a digital health intervention consisting of goal setting and regular email or text messages was not effective in reducing risk factors applies to this population and may not be generalizable to older South Asian individuals at higher risk, ie, with established cardiovascular disease or with a higher mean risk score. As has been seen in the TEXT ME trial,[2] patients with established cardiovascular disease may "feel their risk" such that they are more motivated (because of their recent cardiac hospitalization) to make risk factor changes in response to a frequent text intervention.

Chidambaram and Goh also ask whether the intervention period in our study[1] was too short (1 year) for people to make risk factor changes. We chose this period after conducting a pilot study that was 6 months in duration because we thought it was a realistic period of time to motivate and assist participants to make and sustain dietary and activity behaviors and because the period was more pragmatic than high-intensity short-term trials in which extreme behavior change observed in the first 6 months of an intervention tapers off over time.[3] The glycated hemoglobin A_{1c} levels and stress did decrease by 2.2% and 38.0%, respectively, in the intervention group after 1 year, but importantly, the levels from the control group decreased by a similar 1.7% and 31.4%. This emphasizes why the randomized trial design is essential to prove an intervention is effective over and above usual change, which could have been biased in the case of self-reported stress.

We disagree with Chidambaram and Goh that pharmacotherapy is ineffective in primary prevention. Certainly, the recent HOPE-3 trial[4] shows the additive benefit of lowering blood pressure and lipid levels in people with an intermediate INTERHEART risk score without established cardiovascular disease.

Finally, we agree that a digital health intervention offers a low-cost and potentially scalable intervention to assist a high-risk population to change and sustain optimal health behaviors over time. The digital health intervention should be further evaluated in different risk groups with a variety of messaging formats to assess the effect of timing, frequency, content, and intensity of messaging on promoting risk factor changes.

Sonia S. Anand, MD, PhD, FRCPC
Catherine Middleton, BA, MBA, PhD
Scott Leear, BSc, PhD

Author Affiliations: Department of Medicine, McMaster University, Hamilton, Ontario, Canada (Anand); Ryerson University, Toronto, Ontario, Canada (Middleton); Simon Fraser University, Burnaby, British Columbia, Canada (Leear).

Corresponding Author: Sonia Anand, MD, PhD, FRCPc, Department of Medicine, McMaster University, 1280 Main St W, MDCL 3204, Hamilton, ON L8S 4K1, Canada (anands@mcmaster.ca).

Published Online: November 30, 2016. doi:10.1001/jamacardio.2016.4246

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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CORRECTION

Error in Author Affiliation and Results: In the Research Letter by Rosinger et al titled "Trends in Total Cholesterol, Triglycerides, and Low-Density Lipoprotein in US Adults, 1999-2014," published online November 30, 2016,[1] there was an error in the author affiliations and an error in the Results section. Dr Rosinger should have the affiliation "Epidemic Intelligence Service, Centers for Disease Control and Prevention, Atlanta, Georgia," and Drs Rosinger, Carroll, Lacher, and Ogden should have the affiliation "Division of Health and Nutrition Examination Surveys, National Center for Health Statistics, Centers for Disease Control and Prevention, Hyattsville, Maryland."
Additionally, in the first paragraph of the Results section, in the second sentence, the age-adjusted mean total cholesterol level in 2013/2014 should have been 189 mg/dL, not 89 mg/dL. This article was corrected online.

1. Rosinger A, Carroll MD, Lacher D, Ogden CL. Trends in total cholesterol, triglycerides, and low-density lipoprotein in US adults, 1999-2014 [published online November 30, 2016]. *JAMA Cardiol*. doi:10.1001/jamacardio.2016.4396

Incorrectly Spelled Author Name: In the Original Investigation titled "Types of Myocardial Infarction Among Human Immunodeficiency Virus–Infected Individuals in the United States," published in this issue of *JAMA Cardiology*,[1] an author's name was misspelled in the byline. The name of the 25th author, which was given as Mathew Feinstein, MD, should have appeared as Matthew J. Feinstein, MD. This article was corrected online.

1. Crane HM, Paramsothy P, Drozd DR, et al; Centers for AIDS Research Network of Integrated Clinical Systems (CNICS) Cohort. Types of myocardial infarction among human immunodeficiency virus–infected individuals in the United States [published online January 4, 2017]. *JAMA Cardiol*. doi:10.1001/jamacardio.2016.5139

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