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C-reactive protein: a critical update

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Corrigendum

Original citation: J. Clin. Invest.111:1805–1812 (2003). doi:10.1172/JCI18921. Citation for this corrigendum: J. Clin. Invest.112:299 (2003). doi:10.1172/JCI18921C1. The authors wish to correct an error that appeared in the text. The corrected paragraph appears below. However, it is critically important to recognize that the CRP response is nonspecific and is triggered by many disorders unrelated to cardiovascular disease (Table 2). In using CRP for assessment of cardiovascular risk, it is therefore essential to clearly establish true base-line CRP values that are not distorted by either trivial or serious intercurrent pathologies. If the initial CRP result is in the low-risk range, less than 1 mg/l, a single measurement is sufficient, but if it is in the higher-risk range, greater than about 2.5 mg/l, two or more serial samples taken at intervals of 1 week or more should be retested until a stable base-line value is seen. If the CRP value persistently remains above 10 mg/l, indicating the presence of a significant acute-phase response, a full history and physical examination of the patient is indicated, ideally together with relevant investigations, to determine the cause and alleviate it if possible. Interestingly, chronic inflammatory conditions, such as rheumatoid arthritis and hemodialysis for end-stage renal failure, that are characterized by persistently elevated CRP concentrations in some individuals, are associated with premature cardiovascular disease.

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