

national training objectives for the interventional rotation. The purpose of this survey was not to suggest that on certification cardiac surgeons could be given privileges for cardiac catheterization with this limited training; however, it is essential that we optimize training experiences to give them the best repertoire of skills to innovate and collaborate in what we perceive will be a rapidly evolving specialty. This would ultimately lead to a new model for the delivery of cardiovascular health care.

Funding Sources

This project was funded with internal funds from the Division of Cardiac Surgery.

Disclosures

The authors have no conflicts of interest to disclose.

References

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Supplementary Material

To access the supplementary material accompanying this article, visit the online version of the *Canadian Journal of Cardiology* at www.onlinecjc.ca and at <http://dx.doi.org/10.1016/j.cjca.2015.07.007>.

Erratum



In the article, “The 2014 Canadian Cardiovascular Society Heart Failure Management Guidelines Focus Update: Anemia, Biomarkers, and Recent Therapeutic Trial Implications” by Moe et al., published in the January issue (*Can J Cardiol* 2015; 31:3-16), there is an error on page 12. The recommendation on combined angiotensin/neprilysin inhibition in HFrEF should state an EF of $\leq 40\%$. A corrected recommendation is provided here.

Recommendation

1. We recommend that in patients with mild to moderate HF, an EF $\leq 40\%$, an elevated NP level or hospitalization for HF in the past 12 months, a serum potassium < 5.2 mmol/L, and an eGFR ≥ 30 mL/min and treated with appropriate doses of guideline-directed medical therapy should be treated with LCZ696 in place of an ACE inhibitor or an angiotensin receptor blocker, with close surveillance of serum potassium and creatinine (Conditional Recommendation; High-Quality Evidence).