

recognition of melanoma is improving in the United States.³

We certainly agree with Drs Sung and Kimball that primary care physicians could benefit from additional education related to dermatologic conditions in medical school, residency, and continuing medical education programs. Tele dermatology supported by primary care physicians who have additional training and experience with dermatologic evaluation may provide better results than those reported in current studies. Until we can provide additional primary care training for the identification of skin diseases, we agree with Warshaw et al,⁴ who concluded that “tele dermatology may still be superior to dermatologic care provided by nondermatologists.”

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CORRECTIONS

In the article “**Overreliance on Symptom Quality in Diagnosing Dizziness: Results of a Multicenter Survey of Emergency Physicians**,” which appeared in the November 2007 issue of *Mayo Clinic Proceedings* (2007;82(11):1319-1328), an author’s name was listed incorrectly. Paris Lovett should have been listed as Paris B. Lovett.

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In the article “**The New Oral Anticoagulants in Clinical Practice**” published in the May 2013 issue of *Mayo Clinic Proceedings* (2013;88(5):495-511), there is an error in the statement related to apixaban and its efficacy in preventing ischemic strokes when compared with warfarin.

On page 509, in the “Choosing an Oral Anticoagulant” section at the last line, it reads as follows: “On the other hand, in patients with a history of ischemic strokes while taking warfarin, dabigatran and apixaban may be suitable alternatives as they are the only NOAs with a lower rate of ischemic stroke than warfarin.”

However, even though the primary outcome of systemic embolism or ischemic and hemorrhagic stroke

reduction of apixaban was superior when compared with warfarin, 1.27%/y in the apixaban group vs 1.60%/y in the warfarin group (hazard ratio [HR], 0.79; 95% CI, 0.66-0.95; $P < .001$ for noninferiority; $P = .01$ for superiority), this was primarily due to hemorrhagic rather than ischemic stroke reduction. The rate of hemorrhagic stroke was 0.24%/y in the apixaban group vs 0.47%/y in the warfarin group (HR, 0.51; 95% CI, 0.35-0.75; $P < .001$), and the rate of ischemic or uncertain type of stroke was 0.97%/y in the apixaban group and 1.05%/y in the warfarin group (HR, 0.92; 95% CI, 0.74-1.13; $P = .42$). Thus, apixaban did not significantly reduce the risk of ischemic stroke compared with warfarin.

Therefore, the sentence should read: “On the other hand, in patients with a history of ischemic strokes while taking warfarin, dabigatran may be a suitable alternative as it is the only NOA with a lower rate of ischemic stroke than warfarin.”

<http://dx.doi.org/10.1016/j.mayocp.2013.05.016>

In the article “**Management of Newly Diagnosed Symptomatic Multiple Myeloma: Updated Mayo Stratification of Myeloma and Risk-Adapted Therapy (mSMART) Consensus Guidelines 2013**,” which appeared in the April 2013 issue of *Mayo Clinic Proceedings* (2013;88(4):360-76), an author’s name was listed incorrectly. Keith Stewart should have been listed as A. Keith Stewart.

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