Furthermore, Linos and Bassett suggest that the WHO recommendation of less than 10% of calories from sugar may be more reasonable than the criteria of the IOM. Such a judgment call was beyond the scope of our article. Even though the WHO report recommends reducing the added sugar consumption to less than 10% of total daily energy intake, the report noted, “The overall quality of the available evidence for adults was considered to be moderate.”

Also, the population studied by Yang et al1 was from the United States. Therefore, we applied the IOM criteria in our example. We noted the wide disparity in conclusions drawn based on the use of the WHO vs the IOM criteria and called for a consensus to adopt a single criterion for defining excessive sugar consumption.

The authors mention that the IOM set a maximal level of sugar intake at 25%, and that is not a “recommendation.” We extracted language directly from the study by Yang et al, which stated, “The Institute of Medicine recommended no more than 25% calories from added sugar based on the NHANES III study.” Yang et al used the phrase “IOM recommendations” on multiple occasions, which we adopted for consistency.

The authors correctly note that the percentage of the population that report consuming more than 25% of total intake from added sugars was not entirely stable over time. While the percentages during the 1988-1994 and 2005-2010 study periods were similar (10.3% and 9.9%), the percentage increased to 16.6% during the interim period (1999-2004). Nonetheless, these percentages represent a small proportion of the population if the IOM criterion is used.

The authors mention the responsibility of health departments in developing health policies around obesity for children and communities. The study by Yang et al,1 the focus of our article, studied adults, which precludes inferences about children. The WHO report also stated: “The overall quality of the available evidence for an association between a reduction of free sugars intake and reduced body weight in children was considered to be moderate, whereas the quality of the evidence for an association between an increase in free sugars intake and increased body weight was considered to be low.”

We agree about the charge of health departments to protect public health. However, because health policies can have intended and unintended consequences,4 they should be guided by sound evidence. In our view, the study by Yang et al1 does not provide compelling evidence for developing a health policy for adults around sugar intake and cardiovascular disease risk, for the reasons detailed in our article.

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CORRECTION

Incorrect Row Labels in Table 2: In the Research Letter entitled “Association of Aflatoxin With Gallbladder Cancer in Chile” published in the May 26, 2015, issue of JAMA (2015;313[20]:2075-2077. doi:10.1001/jama.2015.4559), the first 3 rows of Table 2 were incorrectly labeled. In row 1, column 1, “Controls with gallstones vs” should be deleted. In row 2, column 1 will no longer be indented and this will become row 1 and read “Controls with gallstones vs community controls.” In row 3, column 1 will no longer be indented and will become row 2 and read “Patients with gallbladder cancer vs controls with gallstones.” This article was corrected online.

Incorrect Date in Figure Title: In the Research Letter entitled “Acute Gastroenteritis Hospitalizations Among US Children Following Implementation of the Rotavirus Vaccine” published in the June 9, 2015, issue of JAMA (2015;313[22]:2282-2284. doi:10.1001/jama.2015.5571), the date range in the Figure title should be “January 2000 Through December 2012.” This article was corrected online.

Omission of a Word: In the Original Contribution entitled “Association of Perioperative β-Blockade With Mortality and Cardiovascular Morbidity Following Major Noncardiac Surgery” published in the April 24, 2013, issue of JAMA (2013;309[16]:1704-1713. doi:10.1001/jama.2013.4135), the first subcategory of Table 2, the eighth subcategory of eTable 4, the third subcategory of eTable 6, and the 12th subcategory of eTable 8 in the Supplement should have read “Preoperative or in-patient medications.” This article was corrected online.

Incorrect Labels in Text and in Table 1 Column Headings: In the Research Letter entitled “Cannabinoid Dose and Label Accuracy in Edible Medical Cannabis Products” published in the June 23/30, 2015, issue of JAMA (2015;313[24]:2491-2493. doi:10.1001/jama.2015.6613), there are incorrect labels in the text and in Table 1. The first paragraph of the Results section should be “Of 75 products purchased (47 different brands), 17% were accurately labeled, 23% were underlabeled, and 60% were overlabeled with respect to THC content (Table 1).” The greatest likelihood of obtaining underlabeled products was in Los Angeles and overlabeled products in Seattle (y2 = 12.94, P = .01).” In the second paragraph of the Results section, the third sentence should be “Four products were underlabeled and 9 were overlabeled for CBD.” In Table 1, the column 3 heading should be “Underlabeled” and the column 4 heading should be “Overlabeled.” This article was corrected online.