scale and the NRS, we believe this demonstrates the validity of the emoji scale to assess pain perceptions. An important benefit of the emoji scale lies in its inherent Unicode encoding, which encompasses almost all the living languages of the world into a default 16-bit code for digital applications. For example, a loud crying face emoji corresponds to the Unicode character U+1F6D2, which can then be easily adapted into Unicode operating systems including electronic medical records or used in telehealth and mobile health technology. With the advent of the COVID-19 pandemic, the use of telehealth in medical practice has increased 38 times the pre-COVID-19 baseline level.6 We believe that emojis may have additional implications for digital patient communications due to the increasing use and scope of virtual and hybrid health care delivery models.

In addition, while the FPS-R is free of charge for clinical, educational, and research purposes, this scale requires pre-approved permission and a possible royalty fee for commercial use. An emoji-based VAS, in contrast, is the only face scale option that is open-source, meaning that it is modifiable and freely available for all uses.

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Conflict of Interest Disclosures: Dr He reported receiving nonfinancial support from Emojination as an unpaid volunteer during the conduct of the study; being on the advisory board for Covid Act Now; being co-founder of ConductScience Inc; serving on the American College of Emergency Physicians Supply Chain Task Force; receiving research funding from the Foundation for Opioid Response Efforts (FORE); and receiving personal fees from Withings Inc, Task Force; receiving research funding from the Foundation for Opioid Audit and Feedback on Prevention of Acute Kidney Injury in Patients Undergoing Coronary Angiography: A Randomized Clinical Trial;1,2 published in the September 6, 2022, issue of JAMA, data were incorrectly placed. In the Results section, Primary Outcome section, first paragraph, the sentences should have been “Over the 2-year duration of the trial, there were 310 AKI events after 4327 procedures (7.2%) performed by physicians in the intervention group compared with 299 AKI events after 3493 procedures (8.6%) performed by physicians in the control group (Table 2). In the primary analysis accounting for clustering and adjusted for time, the intervention resulted in a significant odds reduction in AKI (time-adjusted OR, 0.72 [95% CI, 0.56 to 0.93], P = .01; time-adjusted risk difference, −2.3% [95% CI, −6.6% to −0.1%]) with a consistent effect over the duration of the trial (P = .72 for treatment × time interaction).” This article was corrected online.1


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