to allocate the available monetary resources toward elimination of existing cases rather than surveillance for DHS. A robust cost-effectiveness analysis would determine the incorporation of this patient-benefitting exercise in NLEP.

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In Reply We thank Dr Bishnoi and colleagues for their interest in our study and for sharing with us the current epidemic status of leprosy and the focus of the disease control activities in India.

India has the highest prevalence of leprosy, with 126,164 new patients diagnosed in 2017 (0.67 cases per 100,000 population), accounting for nearly 60% of the total number of newly diagnosed patients in the world (data from National Leprosy Eradication Programme). We also agree that leprosy control activities should unmistakably focus on sustaining the elimination status. However, based on the dapsone hypersensitivity syndrome (DHS) incidence rate of 0.8% to 1.6% among patients with leprosy in India that was cited by Dr Vinay and colleagues, the annual incidence of patients with DHS may range from 1000 to 2000. A worldwide DHS mortality rate of 9.9% has been reported. Therefore, a screening policy prior to initiation of dapsone should be gradually implemented to prevent the occurrence of DHS and associated mortality in patients with leprosy in the future.

Although the association between DHS and HLA-B*13:01 has been confirmed in some populations, it has not yet been investigated in India. Generally, the association of HLA allele and cutaneous adverse drug reactions (cADRs) is specific to a particular polymorphism. However, the exception could be observed in cADRs as well, such as the different HLA alleles associated with carbamazepine-induced cADRs in different populations (HLA-B*15:02 allele in a Han Chinese population and HLA-A*31:01 in Japanese and European populations). Given of the existing diversity of multiethnic populations in India, the correlation between the HLA-B*13:01 allele and DHS should be first validated before further preemptive screening is implemented.

We are also very concerned about the question of whether modified multidrug therapy (MDT) without dapsone would likely pose the potential risk of inducing rifampicin resistance. When it comes to alternative drug regimens, a combination of rifampicin and clofazimine for treating leprosy is recommended by the World Health Organization in cases of severe adverse events attributed to dapsone. The treatment efficacy of a modified therapeutic regimen appeared to be satisfactory for patients with paucibacillary and multibacillary leprosy based on our preliminary observation. However, relapse of leprosy can occur 2 to 5 years or even 10 years after treatment; thus, long-term follow-up is required. We plan to perform a comparative study about the percentage of relapses with standard MDT vs modified MDT owing to DHS to reach a conclusion.

We agree with the opinion of Dr Bishnoi and colleagues that practical difficulties lead to a long way ahead to perform preemptive HLA-B*13:01 screening for preventing DHS in India. We hope our study empowers clinicians by providing a valuable tool to personalize leprosy treatment with a view to minimize drug toxic effects to guide a comprehensive management strategy in line with patient goals.

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CORRECTION

Error in the Author Affiliations: In the Viewpoint titled “Eliminating Copayments for Skin Cancer Screening—A Public Health Policy With Insufficient Evidence” published online August 16, 2019, Dr Pignone’s affiliation was incorrect. The correct affiliation is 1. Adamson AS, Pignone MP. Eliminating copayments for skin cancer screening—a public health policy with insufficient evidence [published online August 16, 2019]. JAMA Dermatol. 2019. doi:10.1001/jamadermatol.2019.2797