to unnecessary morbidity and mortality. Multiple studies already show benefits to screening high-risk individuals. Failure to train clinicians now and to begin widespread screening and treatment programs means time and lives are lost.

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In Reply We thank Terlizzi et al for their comments on our cohort study and insightful review of the current literature, which highlights the importance of anal dysplasia screening in high-risk individuals and the subsequent treatment of high-grade lesions to prevent the progression to anal cancer. We agree with their impassioned call to begin screening for and treating high-grade anal dysplasia in at-risk populations to address the alarming rise in anal cancer incidence in the US. However, we encourage clinicians to use a shared decision-making model with their patients given the lack of the highest-quality evidence on anal dysplasia screening and treatment, which is reflected by the absence of national guidelines on the subject from organizations, such as the US Preventive Services Task Force or the US Centers for Disease Control and Prevention. We also agree with Terlizzi et al that it is critical to begin training more clinicians to perform high-resolution anoscopies—analogous to colposcopies—because many communities in the US lack clinicians who are trained to perform these procedures, thereby making it difficult for many patients with abnormal anal cytology results to receive follow-up.

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CORRECTION

Errors in Abstract, Key Points, Figures, and a Table: In the article titled “Efficacy and Safety of Bimekizumab in Moderate to Severe Hidradenitis Suppurativa: A Phase 2, Double-blind, Placebo-Controlled Randomized Clinical Trial,” published online August 18, 2021, and also in the November 2021 print issue of JAMA Dermatology, a number of errors have been corrected. In the Findings section of the Key Points and Results section of the Abstract, the number of participants who completed the study has been amended to 73. In Table 1, the row labeled “DLQI” and “All participants” has been relabeled “AN count, mean (SD),” and the mean (SD) in the last column has been changed to “17.7 (14.8);” 16 values in the bimekizumab, placebo, and adalimumab columns for all categories of musculoskeletal and connective tissue disorders were in the wrong location; and footnote b, pertaining to the column headed “All participants,” has been amended from “Full analysis set” to “Full analysis set except for age, sex, BMI, and prior history of musculoskeletal and connective tissue disorders, which constitute the safety set; there were no differences in participant numbers between the safety set and full analysis sets.” In Figure 2, the labels of 3 panels have been corrected: Panel B: “HSCR respondents, NRT;” Panel C: “HSCR1 responsiveness, NRT;” and Panel D: “HSCR2 responsiveness, NRT” (HSCR indicates Hidradenitis Suppurativa Clinical Response, with the subscript numbers representing the percentage of symptom improvement from baseline; NRT indicates nonresponder imputation). Also in Figure 2, in the Response Rate column of the table in Panel A, the NRT for placebo was amended to “5/20.” In Figure 3, in the Panel C table, the NRT total No. (%) of patients taking bimekizumab at week 6 was corrected to read “9/39 (23).” The changes do not affect the interpretation of the data or the authors’ conclusions. This article has been corrected online.