Regarding concern for the impracticality of customizing DIF panels based on indication in high-volume laboratories, we offer a flow diagram (Figure) that we believe allows for a streamlined approach for DIF case triaging by technical staff. We concur that educating submitting clinicians regarding DIF limitations in particular clinical settings (ie, connective tissue disease, porphyria, and LP), the need for DIF biopsies to be submitted with a biopsy for HE, and improving clinician-pathologist communication are key areas that will reduce the need for the full antibody panel, followed by a reduction in unnecessary DIF biopsies. Given the ever ballooning cost of health care in the US, it is imperative that the medical community choose wisely when spending health care dollars. The authors point out a key illustration of this when they suggest the proposed streamlining of the DIF protocol is an apt example of choosing wisely that should be done now rather than waiting until we exist in a perfectly optimized state of clinician-pathologist communication.

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CORRECTION

Errors in Table 1: In the Original Investigation titled “Assessing the Potential for Patient-led Surveillance After Treatment of Localized Melanoma (MEL-SELF): A Pilot Randomized Clinical Trial,” published online on November 24, 2021, in JAMA Dermatology, there were 2 minor errors in Table 1. The number of participants with 1 melanoma was adjusted from a total of 77 to 76, and for 3 melanomas, from 10 to 11. The respective percentages were adjusted as well. These changes did not affect the results of the data analysis. This article was corrected online.


Error in Author Surname: In the Letter titled “Treatment With Dupilumab for Refractory Cutaneous B-Cell Pseudolymphoma,” the second author’s surname was spelled “Duvicy” but should be “Duvic.” This article was corrected online on May 11, 2022.