at time of DOAC initiation or a PPI prescription filled up to 1 month after DOAC initiation. Among 82,625 users of warfarin, 20,124 (24%) had an active PPI prescription, while for 31,647 users of dabigatran it was 6769 (21%), for 35,252 users of rivaroxaban it was 8591 (24%), and for 17,751 users of apixaban it was 4615 (26%). Estimates of the risk of fracture, with adjustment for PPI use, were virtually identical to those reported in our article. The hazard ratio (HR) for risk of hip fracture comparing DOACs with warfarin was 0.91 (95% CI, 0.78-1.07); after adjustment for PPIs it was 0.92 (95% CI, 0.78-1.07). Adjustment for PPI use was not associated with increased risk of fractures (without PPI adjustment: HR, 0.87; 95% CI, 0.79-0.96; with PPI adjustment: HR, 0.87; 95% CI 0.78-0.97) or all fractures (without PPI adjustment: HR 0.93; 95% CI, 0.88-0.98; with PPI adjustment: HR 0.93; 95% CI, 0.89-0.98). Adjustment for PPI use also did not attenuate the findings when we compared individual DOACs vs warfarin. In summary, although a hypothesis worthy of consideration, we found no evidence that our findings were explained by differential use of PPIs.

Pamela L. Lutsey, PhD
Faye L. Norby, MPH
Alvaro Alonso, MD, PhD

Author Affiliations: Division of Epidemiology and Community Health, University of Minnesota School of Public Health, Minneapolis (Lutsey, Norby); Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta, Georgia (Alonso).

Corresponding Author: Pamela L. Lutsey, PhD, Division of Epidemiology and Community Health, University of Minnesota School of Public Health, 1300 S Second St, Ste 300, Minneapolis, MN 55454 (lutsey@umn.edu).

Conflict of Interest Disclosures: Dr Lutsey reported receiving grants from the National Institutes of Health (NIH) during the conduct of the study. Dr Alonso reported receiving grants from the NIH and American Heart Association during the conduct of the study. No other disclosures were reported.


CORRECTION

Errors in Survey Description: In the Research Letter titled “Health Insurance for Asian Americans, Native Hawaiians, and Pacific Islanders Under the Affordable Care Act,” published online April 30, 2018, and in the August 2018 print issue, there were errors in the description of a survey. The first sentence of the Methods section should have read as follows: “The American Community Survey (ACS)—the nation’s largest household survey—collects data on health insurance, race/ethnicity, and other demographic information from questionnaires sent to around 295,000 households monthly, with an approximate response rate of 95%.” The article has been corrected online. been corrected online.


Incorrect Data in Text: In the Editorial entitled “Statins for Primary Prevention: The Debate Is Intense, But the Data Are Weak” published in the January 2017 issue of JAMA Internal Medicine, incorrect data were reported in the text. In the first sentence of the second paragraph on the first page, the absolute benefit for use of statins should have been reported as 0.20%, rather than 0.43%, for cardiovascular mortality. This article was corrected online.


Incorrect Axis Label in Figure: In the Original Investigation titled “Risk of Hospitalization for Serious Adverse Gastrointestinal Events Associated With Sodium Polystyrene Sulfonate Use in Patients of Advanced Age,” published online first June 10, 2019, and printed August 5, 2019, the y-axis in the Figure was mislabeled. The correct label should read “Event-Free Probability.” This article has been corrected online.


Errors in Abstract and Figure 2A: In the Original Investigation titled “Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States: A Difference-in-Differences Analysis” published in the February 2020 issue, the fourth sentence of the Results paragraph of the abstract should have read as follows: “Five years after a plant closure, mortality rates had increased by 8.6 opioid overdose deaths per 100,000 individuals (95% CI, 2.6-14.6; P = .006) in exposed counties compared with unexposed counties, an 85% higher increase relative to the mortality rate that would have been expected had exposed counties followed the same outcome trends as unexposed counties.” Also, the y-axis label for Figure 2A should have read “Unadjusted Mortality Rate per 100,000, %.” This article was corrected online.