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 rate of fracture, with adjustment for PPI use, were virtually identical to those reported in our article.1 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 imputant 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).1 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.

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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 Data in Text: Estimates of the risk of fracture, with adjustment for PPI use, were virtually identical to those reported in our article.1 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 imputant 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).1 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.