tricular areas. Although it is not typical for patients with adult MLD, we think that the diagnosis of MLD cannot be excluded, considering the heterogeneity of imaging manifestations in patients with MLD. Other clinical data should be considered together for final diagnosis.

Second, residual ARSA activity is highly variable between patients with MLD with similar presentations and for individual patients at repeated testing because of the limitations of assays and the contributions of other genetic or environmental factors. The levels of ARSA activity in patients with MLD from East Asia seem much higher than that of patients with MLD from other areas. In a review that included 11 patients with MLD from East Asia, the levels of ARSA activity ranges from 14.50% to 30.75% of the normal controls. In addition, Lorioli et al have described a presymptomatic patient with MLD with an ARSA activity equal to 50% of normal values, which is similar to a carrier in this family. Therefore, we still advised the patient in our case report (a Chinese patient) to undergo an ARSA gene test although his ARSA activity was half of the normal lower limit.

Considering the presence of ARSA pseudodeficiency and the variety of the ARSA activity among patients with MLD, the diagnosis or exclusion of MLD should be based not only on the ARSA activity but also on other clinical data, such as genetic analyses. Moreover, other causes of leukoencephalopathies, including cobalamin C disease, should be considered even though lower ARSA enzyme activity was found.

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Published Online: June 18, 2018. doi:10.1001/jamaneurol.2018.1518

Conflict of Interest Disclosures: None reported.


CORRECTION

Misspelled Surname: In the Editorial titled “Deaths in Epilepsy: What We Are Missing,” published online April 9, 2018, in JAMA Neurology, the surname of the first author of the Original Investigation being commented on was inadvertently misspelled. The first author’s surname should have appeared as “Gorton” throughout the Editorial and in reference 1. This article was corrected online.

1. Devinsky O, Singh A, Friedman D. Deaths in epilepsy: what we are missing [published online April 9, 2019]. JAMA Neurol. doi:10.1001/jamaneurol.2018.0002

Error in Text: In the Review titled “Use of Vitamins and Dietary Supplements by Patients With Multiple Sclerosis: A Review,” published online April 23, 2018, there was an error in the last sentence of the second paragraph of the section on vitamin C. The vitamin C upper limit should be 2000 mg, not 2 mg. This article was corrected online.


Errors in Red and White Blood Cell Counts: In the Original Investigation titled “Chronic Meningitis Investigated via Metagenomic Next-Generation Sequencing,” published online April 16, 2018, the red and white blood cell counts in cerebrospinal fluid were off by 1000 000 and 1000, respectively. This article was corrected online.


Error in Results Section of the Abstract: In the Original Investigation titled “Chemotherapy-Induced Peripheral Neuropathy in Long-Term Survivors of Childhood Cancer: Clinical, Neurophysiological, Functional, and Patient-Reported Outcomes,” published online May 14, 2018, there was an error in the Results section of the Abstract. The third sentence should read, “Clinical abnormalities consistent with peripheral neuropathy were common, seen in 53 of 100 participants (53.0%) treated with ...” This article was corrected online.


Errors in the Table and Results: In the Research Letter titled “Timolol Eyedrops in the Treatment of Acute Migraine Attacks: A Randomized Crossover Study,” published online on May 14, 2018, there were errors in the Table and the Results section. In the Table, the mean (SD) and percentage for migraine attacks with a severity of none or mild at 2 hours for the placebo group was “57 (34)” and not “67 (30).” In the Results section, “Thirty-seven of 55 migraines (67%) had a severity of none or mild at 2 hours while using timolol compared with 58 of 77 (78%) with placebo” has been corrected to “The average percentage of headaches with a severity of none or mild at 2 hours while using timolol compared with 58 of 77 (78%) with placebo” has been corrected to “The average percentage of headaches with a severity of none or mild at 2 hours while using timolol compared with 58 of 77 (78%) with placebo” has been corrected to “The average percentage of headaches with a severity of none or mild at 2 hours while using timolol compared with 58 of 77 (78%) with placebo.” This article was corrected online.