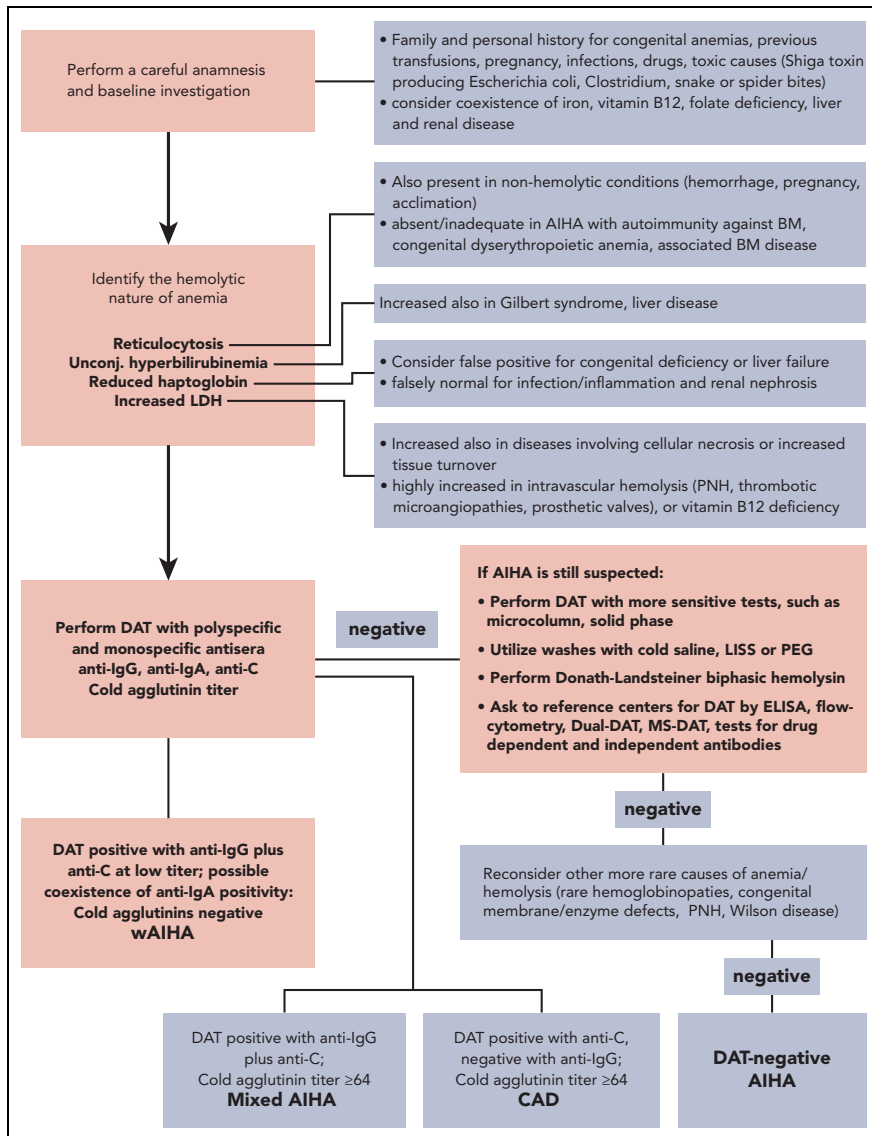


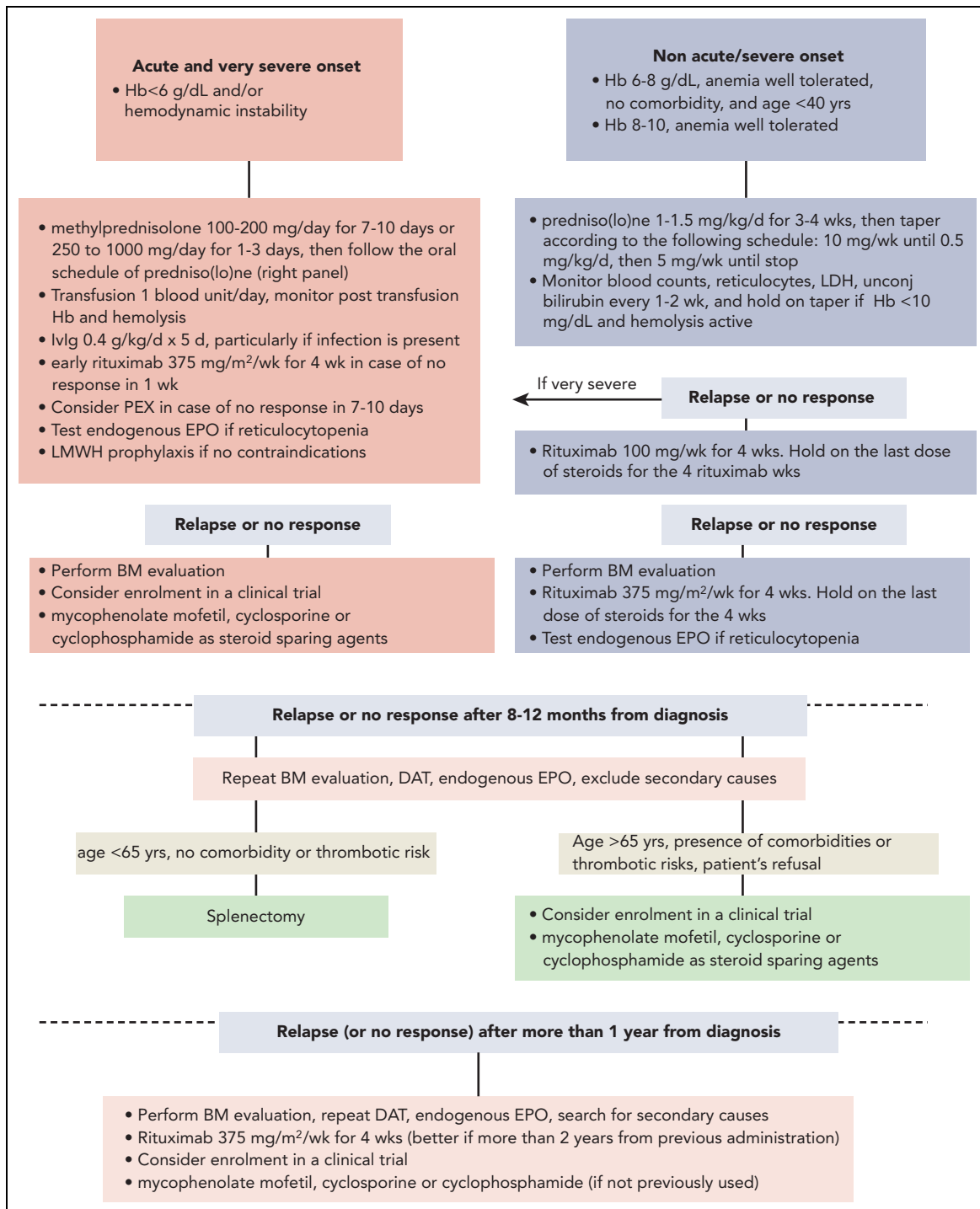
**Barcellini W, Fattizzo B. How I treat warm autoimmune hemolytic anemia. *Blood*. 2021;137(10):1283-1294.**

Page 1284: In Figure 1, in the box labeled "Identify the hemolytic nature of anemia," there should be separate leader lines connecting "Reticulocytosis," "Unconj. hyperbilirubinemia," "Reduced haptoglobin," and "Increased LDH" to the respective boxes on the right side of the figure. In the pink box on the right side of the figure, "Persisting the suspect of AIHA" should read "If AIHA is still suspected." At the bottom of the figure, "Cold agglutinin titer > 1:40" should read "Cold agglutinin titer ≥64" in both boxes where it appears. The corrected Figure 1 is shown below.



**Figure 1. Diagnostic algorithm of AIHA.** The DAT or Coombs test is the cornerstone of diagnosis, and allows the distinction of the different forms of AIHA. wAIHA is the most common form, accounting for 60% to 70% of all cases; the DAT is positive with anti-IgG antisera (70% of all wAIHA) or anti-IgG plus C at low titer. Cold agglutinin disease (CAD; 20% to 25% of all AIHAs) is characterized by DAT positivity with anti-C antisera and high titer of cold agglutinins. In mixed forms (5% to 10% of all AIHAs), the DAT is positive for IgG plus C, and cold agglutinins are present at high titer. The atypical forms (~10% of all AIHAs) include DAT<sup>+</sup>, IgA, and warm IgM-driven AIHAs. Finally, it is necessary to record the very rare form named paroxysmal cold hemoglobinuria (1% to 3% of all AIHAs) sustained by the biphasic Donath-Landsteiner hemolysin. ELISA, enzyme-linked immunosorbent assay; LISS, low-ionic salt solution; MS-DAT, mitogen-stimulated DAT; PEG, polyethylene glycol; PNH, paroxysmal nocturnal hemoglobinuria.

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**Figure 2. Therapeutic flow-chart of wAIHA.** This figure illustrates the therapy lines of wAIHA. Responses include complete responses (CR) and partial responses (PR); CR is defined by normalization of Hb and hemolytic markers (unconjugated bilirubin, LDH, haptoglobin, and reticulocytes); PR is defined by Hb >10 g/dL or at least an increase by >2 g/dL, with or without biochemical resolution of hemolysis; lack of response or relapse is defined as Hb <10 g/dL or at least 2 g/dL decrease with alteration of hemolytic markers. EPO, erythropoietin; LMWH, low-molecular-weight heparin; PEX, plasma exchange.

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