An 80-year-old woman presented to the emergency department with vertigo, right hand incoordination, and postural instability 5 months after rituximab treatment for chronic lymphocytic leukemia. Physical examination revealed dysarthria, horizontal nystagmus, gait ataxia, and right upper and lower limb dysmetria. Brain magnetic resonance imaging showed a T2 hyperintense (Figure, A) and T1 hypointense (Figure, B) lesion in the right cerebellar white matter that demarcates the dentate nucleus (delineated with a dashed line in A and B). The dentate nucleus is best identified on susceptibility-weighted images (arrowhead in C).

This imaging finding corresponds to the “shrimp sign”: white matter lesion that preserves the curvilinear-shaped dentate nucleus, giving a shrimp-like appearance. HIV serologic testing was negative, and JC virus DNA was detected in the CSF, establishing the diagnosis of HIV-negative progressive multifocal leukoencephalopathy (PML). Rituximab was discontinued, and she showed no radiologic and clinical progression after 1-year follow-up. The “shrimp sign” is a reliable indicator of infratentorial PML in patients with cerebellar ataxia.

**Author Contributions**

F.J. Varela: drafting/revision of the manuscript for content, including medical writing for content; major role in the acquisition of data; study concept or design; analysis or interpretation of data. H. Chaves: drafting/revision of the manuscript for content, including medical writing for content; major role in the acquisition of data; analysis or interpretation of data. M. Rossi: drafting/revision of the manuscript for content, including medical writing for content.
content; major role in the acquisition of data; study concept or design; analysis or interpretation of data.

**Study Funding**
No targeted funding reported.

**Disclosure**
The authors report no relevant disclosures. Go to Neurology.org/N for full disclosures.

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**Can an Intervention Be Cost-effective Following a Negative Clinical Trial?**

*Nurology*® 2023;101:918-919. doi:10.1212/WNL.0000000000207838

In the Editorial “Can an Intervention Be Cost-effective Following a Negative Clinical Trial?” by Ney and van der Goes,¹ the authors have revised the second sentence of the fourth paragraph to read as follows:

In frequentist statistical evaluations, a *p*-value is the probability of obtaining the observed effect or a more extreme effect given the null hypothesis is true. An a priori set level of significance (alpha or type 1 error rate, i.e., probability of rejecting the null hypothesis when it is true) is used as a threshold to determine whether an observed *p*-value is low enough to reject the null hypothesis, commonly set at 5%. *p*-Values are affected by effect size, sample size, and statistical power, where a type II error (false-negative rate, i.e., probability of failing to reject a null hypothesis that is false) of 10%–20% is usually deemed reasonable.

The authors regret the misleading statement previously published.

**Reference**

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**Teaching NeuroImage: Bilateral Nucleus Tractus Solitarius Lesions in Neurogenic Respiratory Failure**

*Nurology*® 2023;101:918-919. doi:10.1212/WNL.0000000000207608

In the Resident & Fellow Section Teaching NeuroImage “Bilateral Nucleus Tractus Solitarius Lesions in Neurogenic Respiratory Failure” by Parayil Sankaran et al.,¹ the second author’s name should be spelled “Saskia B. Wortmann.” The article has been replaced by a corrected version. The authors regret the error.

**Reference**
Teaching NeuroImage: Shrimp Sign in Ataxic Cerebellar Progressive Multifocal Leukoencephalopathy
Francisco J. Varela, Hernan Chaves and Malco Rossi

Neurology 2023;101;918-919 Published Online before print August 31, 2023
DOI 10.1212/WNL.0000000000207868

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