

In light of these potential biases, which can only be ruled out by a careful nasal examination, these authors' conclusions have to be taken with great caution until a more objective assessment confirms this interesting finding.

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Disclosures: The authors report no disclosures.

Reply from the Authors: We appreciate Drs. Landis and Burkhard's reflections on our article. The article by Gudziol et al.² states that "when patients recognized improvement of olfactory sensitivity, olfactory testing also revealed improvement of the ("Sniffin' Sticks") test scores," and then contrasts their positive correlation with a negative correlation published by Landis et al.³ However, both of these observations are irrelevant since no one knows if they apply in PD. We merely suggested that self perception may be a useful measure.

Our discussion detailed many shortcomings of our study. We suspect there are more, but not those suggested in the correspondence by Drs. Landis and Burkhard. First, this was a case-controlled trial to determine if there was an increased prevalence of rhinorrhea. It was not a definitive study. Performing nasal endoscopy on every subject in a first-ever study is both injudicious and costly (over \$170 each) and would have raised the cost of our unfunded study from \$0 to about \$30,000.

A visual analogue quantitative scale would be less helpful than our method of a yes/no choice. It would have made statistical analysis of a relatively small sample much less reliable. Our decision not to analyze medication use was based both on our goal to keep this pilot study simple and to enhance our statistical power.

While Drs. Landis and Burkhard's patients with PD have not spontaneously complained about rhinorrhea, we can only report that patients with PD in Rhode Island have. They should keep in mind the old homily, "absence of evidence is not evidence of absence." No PD expert noticed REM sleep behavior disorder or gambling compulsions in PD until they were published as observations (not even case controlled studies). Even olfactory impairment was not noticed in PD until someone recently studied it. In our practice, spontaneous complaints of rhinorrhea far outweigh spontaneous complaints of impaired olfaction or taste.

Drs. Landis and Burkhard advise that our results "be taken with great caution." We concluded our article by stating that, "our observation needs to be confirmed." We hope these authors are now performing a similar survey on their own patients.

Joseph H. Friedman, Kelvin L. Chou, Melissa M. Amick, Warwick, RI

Disclosure: The authors report no disclosures.

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1. Friedman JH, Amick MM, Chou KL. Rhinorrhea and olfaction in Parkinson disease. *Neurology* 2008;70:487-489.
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4. Landis BN, Konnerth CG, Hummel T. A study on the frequency of olfactory dysfunction. *Laryngoscope* 2004; 114:1764-1769.
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CORRECTION

Rhinorrhea and olfaction in Parkinson disease

In the Clinical/Scientific Note "Rhinorrhea and olfaction in Parkinson disease" by J.H. Friedman et al. (*Neurology*[®] 2008;70:487-489), the authors misspelled the name of the first author in reference 5. The correct spelling of the first author should be Gudziol V. The complete corrected reference should read as follows:

5. Gudziol V, Lötsch J, Hähner A, Zahnert T, Hummel T. Clinical significance of results from olfactory testing. *Laryngoscope* 2006;116: 1858-1863.

The authors regret the error.

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CORRECTION

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