The International Panel for NMO Diagnosis (IPND) definition strategy parallels that of the contemporary revised McDonald MS diagnostic criteria, which abandoned the category of probable MS in 2001.⁹ A definitive diagnosis of NMOSD, regardless of AQP4-IgG status, will insure appropriate treatment of patients because MS disease-modifying therapies such as β -interferons, natalizumab, and fingolimod may aggravate NMOSD.¹⁰ These therapies should be avoided in patients with a relapsing course consistent with NMOSD, even if AQP4-IgG seronegative, in favor of immunosuppression. A definitive diagnosis of NMOSD, rather than Prof. Tan's suggested probable NMO, will facilitate—not hinder—insurance coverage for appropriate immunosuppressive treatments.

We agree with Mao et al. that NMOSD occurs at older ages than MS and that nonspecific age-associated degenerative white matter lesions may lead to confusion with MS. We also agree with their recommendation that AQP4-IgG testing in cases with good clinical reason to suspect NMOSD may be of value. A positive AQP4-IgG test lessens the clinical and radiologic requirements for NMOSD diagnosis and these principles guided the development of the diagnostic criteria proposed by the IPND.

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CORRECTION

Association of atrial fibrillation with mortality and disability after ischemic stroke

In the article “Association of atrial fibrillation with mortality and disability after ischemic stroke” by E.R. McGrath et al. (*Neurology* 2013;81:825–832), there is an error in the author byline. The fifth author's name should read ‘Aengus ó Conghaile’ rather than ‘Aengus O’Conghaile’ as originally published. The authors regret the error.

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