

both in direction and in degree of pressure. The patient's fingertip movements will be transmitted through the examiner's underlying fingers, which passively mirror the patient's movements. With this technique, patients feel that they are initiating the palpation — albeit at the direction of the clinician — and thus anticipate the sensation and do not tickle themselves. The examiner's active top hand dictates what is to be palpated and the passive bottom hand feels it.

We found that this technique worked well in all ticklish adults whom we examined in the past year — not just for the palpation of lymph nodes but also for examination for hepatosplenomegaly. We also found in the case of two patients that with this technique we could perform an examination of tender flexures without eliciting a ticklish response. Some patients with auditory hallucinations, passivity experiences (e.g., in schizophrenia), or both reportedly have an impaired sensory prediction of their motor commands and can therefore tickle themselves³; this minority of patients may not benefit from the use of our

technique. We have found that the triple-hand technique is very helpful in the cancer clinic setting but suggest that it has potential usefulness in other areas of clinical and radiologic examination involving ticklish patients. We hope this hands-on approach may tickle some of our colleagues, but not their patients.

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Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

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Hyponatremia among Triathletes in the Ironman European Championship

TO THE EDITOR: Although exercise-associated hyponatremia has been reported in several studies, the effect of participation in long-distance triathlon races on plasma sodium levels is unknown. Prior studies have often been limited by small sample size or by events of shorter duration or distance than those typical of Ironman triathlons.¹⁻³ However, a high incidence of hyponatremia has been reported among marathon runners during races and has been associated with various risk factors.⁴ This report evaluates the rates of hyponatremia in a substantially longer athletic event, an Ironman competition.

From 2005 through 2013, we enrolled a convenience sample of participants in the Ironman European Championship. Participants gave oral consent to undergo routine screening for hyponatremia after finishing a race. A venous blood sample was drawn within 20 minutes after each participant finished a race and was analyzed on site with the use of a blood-gas analyzer. As in prior studies, mild hyponatremia was defined as a plasma sodium level of 135 mmol per liter or less.

Participants with sodium levels of 130 mmol per liter or less were defined as having severe hyponatremia, and those with sodium levels of 120 mmol per liter or less were defined as having critical hyponatremia.

Among the 1089 triathletes who participated in the study, 932 were men and 157 were women. The mean (\pm SD) time in which participants completed the race was 12:39 \pm 1:59 hours (range, 7:59 to 16:20). The mean race time for female participants was 13:15 \pm 1:57 hours and that for male participants was 12:33 \pm 1:58 hours. The mean plasma sodium level at the finish line was 140.5 \pm 4.2 mmol per liter (range, 111 to 152). Among all 1089 athletes, 115 (10.6%) had documented hyponatremia: 95 had mild hyponatremia (8.7%), 17 severe hyponatremia (1.6%), and 3 critical hyponatremia (0.3%). Among the latter 3 athletes, the plasma sodium levels were 120, 119, and 111 mmol per liter, respectively. A multivariate analysis showed a significant association between hyponatremia and participants who were female or who took longer times to complete a

race. The first cases of hyponatremia appeared in the cluster of participants who finished in the 9th hour of the race; cases of critical hyponatremia occurred in the clusters of participants who finished in the 12th and 14th hours of the race.

A previous study involving marathon runners showed that 12 to 13% of participants had hyponatremia and that the incidence of critical hyponatremia was 0.5 to 1%.¹ In contrast, the observed incidence of hyponatremia in long-distance triathlons was 10.6%. The incidence of critical hyponatremia was 0.3% (approximately half the incidence seen among marathoners). Our data show that exercise-associated hyponatremia occurs in a considerable percentage of long-distance triathletes. Female triathletes with a racing time of 9 hours or more appear to be the most susceptible to hyponatremia.

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Disclosure forms provided by the authors are available with the full text of this letter at NEJM.org.

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CORRECTIONS

Subclinical Atrial Fibrillation and the Risk of Stroke (January 12, 2012;366:120-9). In the Stroke or Systemic Embolism subsection of Results (page 123), the first two sentences of the second paragraph included inaccurate hazard ratios, 95% confidence intervals, and P values. In the first sentence, the parenthetical should

have read, “(hazard ratio, 1.77; 95% CI, 1.01 to 3.10; P=0.047),” rather than “(hazard ratio, 1.76; 95% CI, 0.99 to 3.11; P=0.05).” In the second sentence, the parentheticals should have read, “(hazard ratio, 2.99; 95% CI, 1.55 to 5.77; P=0.001),” rather than “(hazard ratio, 2.00; 95% CI, 1.13 to 3.55; P=0.02),” and “(hazard ratio, 4.96; 95% CI, 2.39 to 10.3; P<0.001),” rather than “(hazard ratio, 1.98; 95% CI, 1.11 to 3.51; P=0.02).” The article is correct at NEJM.org.

Chimeric Antigen Receptor–Modified T Cells in Chronic Lymphoid Leukemia (August 25, 2011;365:725-33), Chimeric Antigen Receptor–Modified T Cells for Acute Lymphoid Leukemia (April 18, 2013;368:1509-18), Chimeric Antigen Receptor T Cells for Sustained Remissions in Leukemia (October 16, 2014;371:1507-17). Three articles omitted an acknowledgment of work associated with the chimeric antigen receptor that was used in the studies. The acknowledgments at the end of each article should have included the following sentence: “Drs. Dario Campana and Chihaya Imai and others at St. Jude Children’s Research Hospital designed, developed, and provided under material transfer agreements the chimeric antigen receptor (CAR) that was used in this study.” The articles are correct at NEJM.org.

NOTICES

Notices submitted for publication should contain a mailing address and telephone number of a contact person or department. We regret that we are unable to publish all notices received. Notices also appear on the Journal’s website (NEJM.org/medical-conference). The listings can be viewed in their entirety or filtered by specialty, location, or month.

MATERNAL, FETAL, AND NEONATAL CARE CONFERENCE

The following conference will be held: “XXV European Congress on Perinatal Medicine” (Maastricht, the Netherlands, June 15–18).

Contact MCA Scientific Events, Via Binda 34, 20143 Milan, Italy; or call (39) 2 34934404; or fax (39) 2 34934397; or e-mail luerti@mcascientificevents.eu or direnzo@mcascientificevents.eu; or see <http://www.ecpm2016.eu>.

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