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the health-care team and using local herbal medicines in combination.⁵ As an Ebola outbreak is a public health threat, immediate action is necessary. It is crucial that health-care providers share the patients' cultural backgrounds and that they support informed decision making during quarantine and treatment.

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- 4 Dhillon RS, Kelly JD. Community trust and the Ebola endgame. *N Engl J Med* 2015; **373**: 787–89.
- 5 Adongo PB, Tabong PTN, Asampong E, Ansong J, Robalo M, Adanu RM. Preparing towards preventing and containing an Ebola virus disease outbreak: what socio-cultural practices may affect containment efforts in Ghana? *PLoS Negl Trop Dis* 2016; **10**: e0004852.

Department of Error

Lord C, Charman T, Havdahl A, et al. *The Lancet Commission on the future of care and clinical research in autism*. *Lancet* 2022; **399**: 271–334—In Figure 7 of this Commission, the row of data for Social communication RCTs should have been listed within the Developmental subgroup. This correction has been made to the online version as of Nov 25, 2022.

Yang P, Song L, Zhang Y, et al. *Intensive blood pressure control after endovascular thrombectomy for acute ischaemic stroke (ENCHANTED2/MT): a multicentre, open-label, blinded-endpoint, randomised controlled trial*. *Lancet* 2022; **400**: 1585–96—In table 1 of this Article, the number of participants with a Modified Rankin scale score of 1–2 before stroke onset in the less intensive treatment group should have been “78 (19%)” and the fourth footnote in the legend should have read “Investigators reported the results of brain imaging among randomly assigned patients.” In table 2, in the ordinal analysis of category scores on the mRS, the proportion of participants with a score of 0 (no symptoms at all) in the less intensive treatment group should have read “18%”, the proportion of patients with a score of 5 (severe disability, bed-bound, and incontinent) should have read “11%” for the more intensive treatment group and “8%” for the less intensive treatment group, and the proportion of patients with a score of 6 (death) should have read “16%” for the more intensive treatment group and “15%” for the less intensive treatment group, and in the ordinal analysis of category scores for neurological impairment or death at day 7, the proportion of participants with a score of <5 in the less intensive treatment group should have read “45%”. The final footnote in the legend of table 2 should have read “Adjudicated by an adverse-event committee unaware of treatment allocation according to the definition of an ischaemic event with a different symptom profile, ischaemic location on the imaging report, recanalisation on angiography, or major neurological deterioration (NIHSS score >4) after a stable time period, from the index ischaemic stroke event.” The appendix has also been corrected. These corrections have been made to the online version as of Dec 1, 2022.

Mitjà O, Ogoina D, Titanji BK, et al. *Monkeypox*. *Lancet* 2022; published online Nov 17. [https://doi.org/10.1016/S0140-6736\(22\)02075-X](https://doi.org/10.1016/S0140-6736(22)02075-X)—In this Seminar, the section on Treatment in the unanswered research questions panel should read “Should early initiation of treatment and an extended duration of treatment be recommended for individuals who are highly immunocompromised (eg, HIV with a CD4 count <200)?” This correction has been made to the online version as of Dec 1, 2022, and will be made to the printed version.