

that they too are transmitted via smaller aerosols, which float and build up in indoor air. Many diseases were originally misclassified as transmitted by droplets because of the same flawed reasoning.⁴ Measles, for example, was considered to be transmitted by droplets until the 1980s, when its airborne character was shown beyond doubt.^{2,4}

Scarcity of personal protective equipment for droplet transmission or poor donning-doffing technique could hypothetically explain nosocomial cases, although we know of no studies that have shown this directly. The US Centers for Disease Control and Prevention states that surface transmission is rare.⁵ However, the sheer number of health-care workers affected and the substantial reduction in nosocomial infections after the universal use of masks was introduced in hospitals⁶ makes airborne transmission a more likely explanation. Nosocomial transmission occurs despite personal protective equipment for droplet transmission and eye protection.⁷

Containment measures aimed at reducing droplet transmission, which include use of masks and physical distancing, have indeed reduced transmission of SARS-CoV-2. This is because they are effective against both droplet and aerosol transmission—especially since most aerosol transmission occurs in close proximity (eg, where exhaled cigarette smoke or the smell of garlic breath are strongest).

Lopez and Srigley's response to our Comment¹ shows a logical fallacy: droplets (which quickly fall) dominate transmission at short range; since SARS-CoV-2 is transmitted mainly at short range, it must be transmitted primarily via droplets. The best explanation for the observed transmission pattern of SARS-CoV-2—ie, short-range infection producing most new cases along with shared-room infection producing substantial numbers of cases and

superspreading—is dilution of exhaled aerosols with distance from a person who is infected.⁴

The idea that close proximity transmission is droplet transmission is a basic error of logic that is widely propagated in the scientific literature.⁸ We exhort editors and reviewers to be alert to this bibliographic virus (ie, a claim that gets reproduced from one publication to the next without being independently verified) and take steps to help to stop its transmission.

DF has served on advisory boards for Pfizer, AstraZeneca, Sanofi, and Seqirus vaccines and has provided legal advice to the Elementary Teachers Federation of Ontario and Ontario Nurses' Association. RS has received consulting fees from Sempra Energy and Lysentech; honoraria from the International Antiviral Society—USA; has a patent application submitted for oral anti-coronavirus compounds; has been on a data safety monitoring board for Merck and Vir Biotechnology; has a voluntary (unpaid) leadership role in the Conference on Retroviruses and Opportunistic Infections Foundation Board of Directors and International Antiviral Society—USA; and has stocks or shares in Antiva Biosciences, CytoDyn, and Arcturus. All other authors declare no competing interests.

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NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in hypertension prevalence and progress in treatment and control from 1990 to 2019: a pooled analysis of 1201 population-representative studies with 104 million participants. *Lancet* 2021; **398**: 957–80—In this Article, Marialaura Bonaccio, Maria Benedetta Donati, and Francesco Gianfagna have been added to the NCD Risk Factor Collaboration list, and Steinar Krokstad's name has been corrected. These corrections have been made to the online version as of Feb 3, 2022

Miras AD, le Roux CW. Metabolic surgery versus conventional therapy in type 2 diabetes. *Lancet* 2021; **397**: 256–57—In this Comment, the declaration of interest statement for Carel W le Roux has been corrected to read "CWR reports grants from the Irish Research Council, Science Foundation Ireland, Anabio, and the Health Research Board. He serves on advisory boards of Novo Nordisk, Herbalife, Gl Dynamics, Eli Lilly, Johnson & Johnson, Sanofi Aventis, AstraZeneca, Janssen, Bristol-Myers Squibb, Glia, and Boehringer Ingelheim. CLR is a member of the Irish Society for Nutrition and Metabolism outside the area of work commented on here. He is the chief medical officer and director of the Medical Device Division of Keyron since January 2011. Both of these are unremunerated positions. CWR was a previous investor in Keyron, which develops endoscopically implantable medical devices intended to mimic the surgical procedures of sleeve gastrectomy and gastric bypass. The product has only been tested in rodents and none of Keyron's products are currently licensed. They do not have any contracts with other companies to put their products into clinical practice. No patients have been included in any of Keyron's studies and they are not listed on the stock market. CLR was gifted stock holdings in September 2021 and divested all stock holdings in Keyron in September, 2021. He continues to provide scientific advice to Keyron for no remuneration." These corrections have been made to the online version as of Feb 3, 2022.