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Author Correction: Evaluating physician concordance in interpretation of tracheobronchomalacia diagnosis and phenotyping using dynamic expiratory chest computed tomography

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The original version of this Article contained errors.

As the result of the error during the figure processing in Figure 1, panel (B) was a duplication of panel (A). Consequently, Figure 1 legend was incorrect,

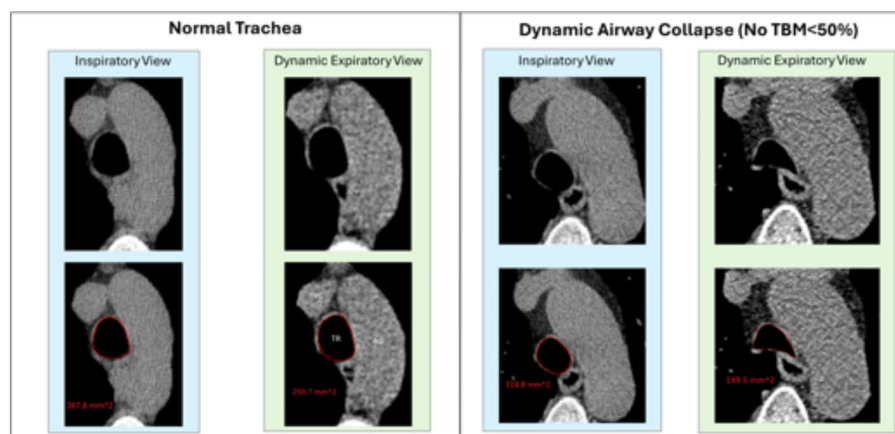
“Phenotypes of tracheobronchomalacia (TBM) based on paired inspiratory and expiratory images and percentage of luminal reduction. (A) Normal trachea and dynamic airway collapse. (B) Excessive dynamic airway collapse and crescent type airway collapse. (C) Circumferential airway collapse and saber-sheath airway collapse. No TBM is characterized by physiological dynamic airway collapse with less than 50% luminal reduction (A) Excessive Dynamic Airway Collapse (EDAC) is defined by a cross-sectional reduction in airway area of 50% or more during dynamic expiratory maneuvers, with morphologic preservation of the anterior “C” cartilage (B) Crescent Type features presumed softening of the anterior cartilaginous wall, leading to splaying and excessive narrowing of the airway lumen by 50% or more (B) Circumferential Type involves airway collapse of 50% or more affecting both the anterior and lateral cartilaginous walls, accompanied by wall thickening (C). Saber-Sheath Type is characterized by softening of the lateral walls forming an “A” shape, with expiratory airway narrowing of 50% or greater (C) Note that the Saber-Sheath Type image provided is an example of the pathology but is not a representative image of any patient included in the study.”

now reads:

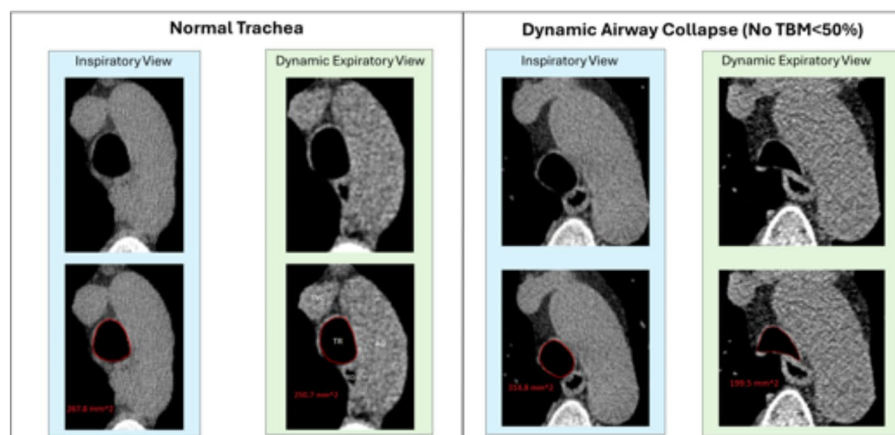
“Phenotypes of Tracheobronchomalacia (TBM) Based on Paired Inspiratory and Expiratory Images and Percentage of Luminal Reduction. No TBM is characterized by physiological dynamic airway collapse with less than 50% luminal reduction (A). Excessive Dynamic Airway Collapse (EDAC) is defined by a cross-sectional reduction in airway area of 50% or more during dynamic expiratory manoeuvres, with morphologic preservation of the anterior “C” cartilage (B). Crescent Type features presumed softening of the anterior cartilaginous wall, leading to splaying and excessive narrowing of the airway lumen by 50% or more (B). Circumferential Type involves airway collapse of 50% or more affecting both the anterior and lateral cartilaginous walls, accompanied by wall thickening (C). Saber-Sheath Type is characterized by softening of the lateral walls forming an “A” shape, with expiratory airway narrowing of 50% or greater (C). Note that the Saber-Sheath Type image provided is an example of the pathology but is not a representative image of any patient included in the study.”

The original Figure 1 and accompanying legend appear below.

Additionally, this Article contained an error in the paragraph in the Discussion section,



A



B



C

“Our findings contrast with the interobserver variability reported by Katz and Moore¹⁵, who identified significant variability among specialists assessing TBM using dynamic CT imaging.”

now reads:

“Our findings contrast with the interobserver variability reported by Mitropoulos et al¹⁵, who identified significant variability among specialists assessing TBM using dynamic CT imaging, magnetic resonance imaging or flexible fiberoptic bronchoscopy.”

Further, the article contained errors in References. As a result, in the Discussion section,

◀ **Fig. 1.** Phenotypes of tracheobronchomalacia (TBM) based on paired inspiratory and expiratory images and percentage of luminal reduction. (A) Normal trachea and dynamic airway collapse. (B) Excessive dynamic airway collapse and crescent type airway collapse. (C) Circumferential airway collapse and saber-sheath airway collapse. No TBM is characterized by physiological dynamic airway collapse with less than 50% luminal reduction (A) Excessive Dynamic Airway Collapse (EDAC) is defined by a cross-sectional reduction in airway area of 50% or more during dynamic expiratory maneuvers, with morphologic preservation of the anterior “C” cartilage (B) Crescent Type features presumed softening of the anterior cartilaginous wall, leading to splaying and excessive narrowing of the airway lumen by 50% or more (B) Circumferential Type involves airway collapse of 50% or more affecting both the anterior and lateral cartilaginous walls, accompanied by wall thickening (C). Saber-Sheath Type is characterized by softening of the lateral walls forming an “A” shape, with expiratory airway narrowing of 50% or greater (C) Note that the Saber-Sheath Type image provided is an example of the pathology but is not a representative image of any patient included in the study.

“In our cohort, 36% of patients were diagnosed with TBM or EDAC, a prevalence rate consistent with earlier reports^{13,16}.”

now reads:

“In our cohort, 36% of patients were diagnosed with TBM or EDAC, a prevalence rate consistent with earlier reports^{13–16}.”

“Conversely, our high level of concordance in differentiating between patients with and without TBM aligns with findings from another study¹⁴, which demonstrates strong diagnostic reliability across various centers and experts.”

now reads:

“Conversely, our high level of concordance in differentiating between patients with and without TBM aligns with findings from other reports^{14–15}, which demonstrates variable diagnostic reliability across various centers and experts.”

Finally, the Article contained errors in the Reference list, where References 13–22 were incorrect due to the corrupted file,

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22. Kim, D. H. & Lee, J. H. Saber-sheath trachea: a radiologic marker for COPD severity. *Eur. Respir. J.* **56** (6), 1901387 (2020).

now read:

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15. Mitropoulos, A. et al. Detection and diagnosis of large airway collapse: a systematic review. *ERJ Open Res.* **7**(3), 00055–2021. <https://doi.org/10.1183/23120541.00055-2021> (2021).

16. Bischoff, A. et al. Low-dose whole-chest dynamic CT for the assessment of large airway collapsibility in patients with suspected tracheobronchial instability. *Radiol. Cardiothorac Imaging* **6**(5), e240041. <https://doi.org/10.1148/ryct.240041> (2024).
17. Biswas, A., Jantz, M. A., Sriram, P. S. & Mehta, H. J. Tracheobronchomalacia. *Dis. Mon.* **63**(10), 287–302. <https://doi.org/10.1016/j.disamonth.2017.04.003> (2017).
18. Singh, R. et al. Pilot gene expression and histopathologic analysis of tracheal resections in tracheobronchomalacia. *Ann. Thorac. Surg.* **114**(5), 1925–1932. <https://doi.org/10.1016/j.athoracsur.2021.08.022> (2022).
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The original Article has been corrected.

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