In the article "Resuscitative Endovascular Balloon Occlusion of the Aorta and Resuscitative Thoracotomy in Select Patients with Hemorrhagic Shock: Early Results from the American Association for the Surgery of Trauma's Aortic Occlusion in Resuscitation for Trauma and Acute Care Surgery Registry," by Brenner and colleagues, which appeared in the May 2018 issue of the *Journal of the American College of Surgeons*, Volume 226, Number 5, pages 730–740, one of the collaborators for the American Association for the Surgery of Trauma (AAST) Aortic Occlusion in Resuscitation for Trauma and Acute Care Surgery (AORTA) Study Group was inadvertently excluded in the appendix listed on pages 738–739: Forrest O Moore, MD, FACS, Chandler Regional Medical Center, Chandler, AZ. The authors apologize for this error.

The article "Evaluating the Current Status of Rectal Cancer Care in the US: Where We Stand at the Start of the Commission on Cancer's National Accreditation Program for Rectal Cancer," by Brady JT, Xu Z, Scarberry KB, et al, on behalf of The Consortium for Optimizing the Treatment of Rectal Cancer (OSTRiCh), published in the May 2018 issue of the *Journal of the American College of Surgeons*, Volume 226, Number 5, pages 881–890, contained errors in the analysis involving process measures that affected results reported in the text and tables. Importantly, there were incorrect numbers for patients with circumferential margin assessed and with completed regression grading; and there was an error in analysis of how many patients completed all process measures. The original value for tumor regression grading (Table 3) was incorrect as it was reported as the number of patients who underwent tumor grading, not tumor regression grading. There also were some variations in denominators based on the variable. This confusion occurred due to the way some variables are coded in the National Cancer Database (NCDB). The current study was not just evaluating how well information was entered into the NCDB (evaluating the completeness of the database) but aimed instead to evaluate (as best assessed given limitations of large dataset) how well patients were being treated/meeting process measures.

These errors affected the outcomes results for the authors' analysis, and after re-analysis, 27.7% of patients, not 28.1%, met all process measures. This also led to some minor changes in the regression analysis results. While these errors change the percentages, they do not alter the overall conclusions nor the general message of the manuscript. The authors apologize for these errors.

Corrections to the text are:
Page 881, Abstract, Results:
However, completion of all included process measures occurred in only 27.7% of patients.

Page 885, Process measures:
Overall, completion of all of the current and proposed process measures was noted in only 27.7% of patients.

https://doi.org/10.1016/j.jamcollsurg.2018.07.006
ISSN 1072-7515/18

Page 884, Table 3:

Table 3. Process Measures

Measure*	Completed	
	n	%
Clinical staging (95%)	35,741	91.5
Serum CEA obtained before treatment (75%)	25,228	64.6
Treatment started within 60 d of diagnosis (80%)	33,267	85.1
Tumor regression grading (95%)	18,537	68.5
Circumferential radial margin assessed (95%)	33,110	84.7
Proximal and distal margin assessed (95%)	38,464	98.4
All process measures	9,522	27.7
All process measures achieved by clinical stage		
0	26	7.8
I	628	14.1
II	3,558	34.4
III	4,695	37.6
All above process measures completed by pathology stage		
0	1,281	41.5
I	540	18.9
II	2,441	28.0
III	2,476	27.5

Denominators used for table percentages: clinical staging, CEA, treatment within 60 days, proximal and distal margin assessed: 39,071; regression grade: 27,078; circumferential radial margin assessed: 39,071; all process measures 34,335. Clinical stage 0: 306; clinical stage I: 4,450; clinical stage II: 10,350; clinical stage III: 12,474. Pathologic stage 0: 3,086; pathologic stage I: 2,856; pathologic stage II: 8,719; pathologic stage III: 9,018.
*Compliance goals in parentheses.