

Nevertheless, some JAK inhibitors are reportedly well tolerated short-term.¹⁶ Also, the level and type of immunosuppression varies substantially with the range of targeted JAKs and with the dose and schedule used, with narrow and partial JAK inhibition potentially producing effects similar to some biologics frequently used in psoriasis therapy, whereas other biologics might produce more profound levels of immunosuppression. Also, the US Food and Drug Administration has accepted clinical studies with JAK inhibitors for alopecia areata by the so-called investigational new drug process, which implies a favourable risk-benefit ratio assessment.

We appreciate that JAK inhibitor treatment can change the life of affected alopecia areata patients, just as the introduction of biologics has done for patients with psoriasis. But, exactly as in the latter case, we remain challenged to carefully balance clinical advantages against possible disadvantages and risks of any new therapy; the use of JAK inhibitors for treating alopecia areata is not exempted from this rule.

Clearly, trials of the long-term efficacy and safety of JAK inhibitors with the most favourable toxicological profile that still effectively block the key signalling pathway in alopecia areata pathobiology (ie, interferon- γ signalling)^{2,14} are warranted specifically in alopecia areata patients and preferably with monotherapy (ie, exclusion of other immunosuppressants, such as glucocorticosteroids). Until these data are available so that the risk-benefit ratio can be assessed more robustly, it might be the most prudent and responsible alopecia areata management strategy to restrict systemic JAK inhibitor therapy stringently, and to accelerate the clinical exploration of topically applicable JAK inhibitors.

We declare no competing interests. We thank James G Krueger for helpful insights and crucial discussion.

*Amos Gilhar, Aviad Keren, Ralf Paus
doritg2000@gmail.com

Skin Research Laboratory, Faculty of Medicine, Technion-Israel Institute of Technology, Haifa, Israel (AG, AK); Department of Dermatology & Cutaneous Surgery, University of Miami Miller School of Medicine, Miami, FL, USA (RP); and Centre for Dermatology Research, University of Manchester and NIHR Manchester Biomedical Research Centre, Manchester, UK (RP)

- 1 Damsky W, King BA. JAK inhibitors in dermatology: the promise of a new drug class. *J Am Acad Dermatol* 2017; **76**: 736–44.
- 2 Gilhar A, Etzioni A, Paus R. Alopecia areata. *N Engl J Med* 2012; **366**: 1515–25.
- 3 Mackay-Wiggan J, Jabbari A, Nguyen N, et al. Oral ruxolitinib induces hair regrowth in patients with moderate-to-severe alopecia areata. *JCI Insight* 2016; **1**: e89790.
- 4 Strazzulla LC, Wang EHC, Avila L, et al. Alopecia areata: an appraisal of new treatment approaches and overview of current therapies. *J Am Acad Dermatol* 2018; **78**: 15–24.
- 5 Schwartz DM, Kanno Y, Villarino A, Ward M, Gadina M, O'Shea JJ. JAK inhibition as a therapeutic strategy for immune and inflammatory diseases. *Nat Rev Drug Discov* 2017; **16**: 843–62.
- 6 Moodley D, Yoshida H, Mostafavi S, et al. Network pharmacology of JAK inhibitors. *Proc Natl Acad Sci USA* 2016; **113**: 9852–57.
- 7 Winthrop KL. The emerging safety profile of JAK inhibitors in rheumatic disease. *Nat Rev Rheumatol* 2017; **13**: 234–43.
- 8 Chen Y, Gong FY, Li ZJ, et al. A study on the risk of fungal infection with tofacitinib (CP-690550), a novel oral agent for rheumatoid arthritis. *Sci Rep* 2017; **7**: 6779.
- 9 Lussana F, Cattaneo M, Rambaldi A, Squizzato A. Ruxolitinib-associated infections: A systematic review and meta-analysis. *Am J Hematol* 2018; **93**: 339–347.
- 10 Strand V, Ahadieh S, French J, et al. Systematic review and meta-analysis of serious infections with tofacitinib and biologic disease-modifying antirheumatic drug treatment in rheumatoid arthritis clinical trials. *Arthritis Res Ther* 2015; **17**: 362.
- 11 Ramakrishnan V, Akram Husain RS, Ahmed SS. Genetic predisposition of IL-10 promoter polymorphisms with risk of multiple sclerosis: a meta-analysis. *J Neuroimmunol* 2017; **306**: 11–18.
- 12 Iyer SS, Cheng G. Role of interleukin 10 transcriptional regulation in inflammation and autoimmune disease. *Crit Rev Immunol* 2012; **32**: 23–63.
- 13 Glocker EO, Kotlarz D, Boztug K, et al. Inflammatory bowel disease and mutations affecting the interleukin-10 receptor. *N Engl J Med* 2009; **361**: 2033–45.
- 14 Paus R, Bulfone-Paus S, Bertolini M. Hair follicle immune privilege revisited: the key to alopecia areata management. *J Invest Dermatol Symp Proc* 2018; **19**: S12–17.
- 15 Ito T, Ito N, Bettermann A, Tokura Y, Takigawa M, Paus R. Collapse and restoration of MHC class-I-dependent immune privilege: exploiting the human hair follicle as a model. *Am J Pathol* 2004; **164**: 623–34.
- 16 Hsu L, Armstrong AW. JAK inhibitors: treatment efficacy and safety profile in patients with psoriasis. *J Immunol Res* 2014; **2014**: 283617.

Rwanda and revisionist history

We were deeply saddened to read Laurie Garret's book review¹ (Sept 15, 2018, p 909) of *In Praise of Blood: The Crimes of the Rwandan Patriotic Front*² by Judi Rever. This book, and the accompanying Perspective,³ misrepresents or does not discuss certain facts about Rwanda's history. In particular, this revisionist account does not make any reference to documented plans of the Rwandan genocide against the Tutsis that were systematically implemented in phases starting in 1959. In 2018, over 18 000 bodies were found in 41 mass graves in just two Kigali districts.³ The book propagates inaccuracies about the catalysing event of the 100 days of genocide against the Tutsis, blames the victims, and does not accurately discuss the rebuilding and reconciliation that has since occurred in Rwanda.

Far too many accounts of the genocide in Rwanda have been written by revisionists who were neither present during the genocide, nor in the subsequent years—and it is their narrative that has dominated the world's sense of why Rwanda experienced such a tumultuous period. Some journalists and academics believe they understand the genocide and ethnic tension in Rwanda better than the survivors. This book and its dangerous claim that it is documenting history is no different.

Garret's Perspective³ makes no attempt to acknowledge Rwanda's contemporary progress to improve health outcomes.⁴ She quotes an American physician who visited Rwanda for a short time and presents his opinion as evidence of differing health outcomes between ethnicities. As much of the world knows, use of ethnic identifications in Rwanda has been banned since 1994 and is irrelevant to the country's health-care system. Such actions would be met with career-ending consequences and are illegal. We attest that any discussion regarding



Shout51/stock/Photo

differences for providing health or any other services on the basis of ethnicity is simply unthinkable in Rwanda.

We cannot understand why *The Lancet* would publish such a piece. Would they review David Irving's Holocaust denial books? Genocide denial is a reprehensible act and these assertions impede reconciliation not only between victims and perpetrators but also in the wider Rwandan community.

We declare no competing interests.

**Agnes Binagwaho, Ruton Hinda, Edward Mills*
abinagwaho@ughe.org

Office of the Vice-Chancellor, University of Global Health Equity, Kigali, Rwanda (AB); School of Public Health, University of Rwanda, Rwanda (RH, EM); and MTEK Sciences, Rwanda (EM)

- 1 Garrett L. Rwanda: not the official narrative. *Lancet* 2018; **392**: 909–12.
- 2 Rever J. In praise of blood: the crimes of the Rwandan patriotic front. Toronto: Penguin Random House Canada, 2018.
- 3 Mbonyinshuti J. Genocide: over 18 000 victims exhumed in Kigali mass graves. 2018. <https://www.newtimes.co.rw/news/genocide-over-18000-victims-exhumed-kigali-mass-graves> (accessed Jan 7, 2019).
- 4 Binagwaho A, Farmer PE, Nsanzimana S, et al. Rwanda 20 years on: investing in life. *Lancet* 2014; **384**: 371–75.

Palestinian ambulances and the Israeli military

Richard Horton (Nov 3, 2018, p 1612)¹ cites Israeli informants as alleging that Palestinian ambulances carry explosives. In 2002, Physicians for Human Rights–Israel (PHRI)² concluded that Israel had only ever provided evidence for one such case, when, in that year, a suicide belt had reportedly been found in an ambulance. But even this case was assessed by Amnesty International³ as suspicious: “The ambulance passed through four checkpoints on the way to Jerusalem without being searched (which is abnormal) and was then delayed for more than an hour before being searched to allow TV cameras to arrive (which suggests that the Israel Defence Forces [IDF] had, at the least, prior knowledge of something hidden there)”.

On the other hand, misuses of Palestinian ambulances by Israel have been well documented. In 2003, B’Tselem and PHRI⁴ wrote: “The IDF’s use of ambulances for military purposes is especially disturbing in light of repeated claims made by the IDF that Palestinians use ambulances to transport weapons and explosives... with the exception of one case, and despite repeated requests by Physicians for Human Rights and the International Red Cross, the IDF has not presented any evidence to support this contention, not even in response to petitions filed in the Supreme Court”. This has remained true over the years since.

Yet the allegation about Palestinian ambulances continues to be recycled and arguably serves above all as useful cover for the multiply documented shooting or rocketing of Palestinian ambulances on active duty—a violation of the fourth Geneva Convention—for many years, and the killing of the drivers, medical staff, and injured patients inside.

I declare no competing interests.

Derek Summerfield
derek.summerfield@googlemail.com

Institute of Psychiatry, Psychology & Neuroscience, King’s College, London SE5 8BB, UK

- 1 Horton R. Offline: The health of Palestinians is a global responsibility. *Lancet* 2018; **392**: 1612.
- 2 Physicians for Human Rights–Israel. A legacy of injustice - a critique of Israeli approaches to the right to health. November, 2002. <https://www.scribd.com/document/41542555/Physicians-for-Human-Rights-Israel-A-Legacy-of-Injustice-A-Critique-of-Israeli-Approaches-to-the-Right-to-Health-November-2002> (accessed Dec 20, 2018).
- 3 Amnesty International. Shielded from scrutiny. IDF violations in Jenin and Nablus. Nov 4, 2002. <https://www.amnesty.org/en/documents/MDE15/143/2002/en/> (accessed Dec 20, 2018).
- 4 B’Tselem - The Israeli Information Center for Human Rights in the Occupied Territories, Physicians for Human Rights–Israel. Harm to medical personnel. The delay, abuse, humiliation of medical personnel by Israeli security forces. December, 2003. <https://www.scribd.com/document/41541546/Physicians-for-Human-Rights-Israel-Harm-to-Medical-Personnel-December-2003> (accessed Dec 20, 2018).

Department of Error

Shuchman M. Logistical challenges in the DR Congo Ebola virus response. Lancet 2019; 393: 117–18—In this World Report, the word “not” was omitted from the following phrase: “Although these do not sequence the Ebola virus as accurately as an in-laboratory sequencer would, portable sequencers are considered a powerful tool for identifying new chains of transmission that link one infected person to the next”. This correction has been made to the online version as of Jan 15, 2019.

Tiwari V, Goyal A, Nagar M, Santoshi JA. Hyperphosphataemic tumoral calcinosis. Lancet 2019; 393: 168—In this Clinical Picture, the affiliation details should have read “Department of Orthopaedics, All India Institute of Medical Sciences, Bhopal, India (V Tiwari MS, M Nagar MS, JA Santoshi MS); and Department of Endocrinology, All India Institute of Medical Sciences, New Delhi, India (A Goyal DM). These corrections have been made online as of Jan 24, 2019.



Published Online
January 15, 2019

[http://dx.doi.org/10.1016/S0140-6736\(19\)30114-X](http://dx.doi.org/10.1016/S0140-6736(19)30114-X)