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REPLY



TO THE EDITORS: I thank Drs Zhan, Jackson, and Turrentine and the American Congress of Obstetricians and Gynecologists for their prompt and thorough response¹ to my Viewpoint in *AJOG* entitled “Management of premature rupture of membranes at term: the need to correct a recurring mistake in articles, chapters, and recommendations of professional organizations.”² With the letter of Drs Zhan, Jackson, and Turrentine, ACOG has shown a serious commitment to women’s health by recognizing an error in their Practice Bulletin, and has taken steps to amend the Practice Bulletin about the management of women with premature rupture of membranes (PROM) at term. This will inform the ACOG membership, allow the correct data to be shared with patients, and improve counseling of those patients presenting with PROM at term, which affects approximately 10% of pregnant women. I hope that ACOG and other professional

organizations can work with biomedical journals to rectify and prevent errors in the future.

Dr Brian Mercer’s account of how this error occurred is clear and transparent.³ I agree with Dr. Mercer that the errata to Table 1, published in a separate issue of the original journal (*New England Journal of Medicine*) several months later, may have made it difficult to identify the mistake. I also agree that biomedical journals and professional organizations should strive to correct errors and to publish corrected versions in the era of electronic publishing. Publishers could link the errata with the original article so that physicians and other health care professionals, as well as patients, would have access to the correct information.

Journals have a responsibility to promote an open dialogue for medicine and science to be self-correcting. I am grateful to the Editors-in-Chief of the *American Journal of Obstetrics & Gynecology* for allowing me the opportunity to publish the Viewpoint that made possible the correction of an error that could have misinformed patients and obstetric providers. ■

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Effective evidence-based medicine: considering factors not included in research studies



TO THE EDITORS: Rouzi et al¹ recently published a cross-sectional study showing a direct correlation between the severities of mutilation and subsequent sexual dysfunction. The horrific practice of female genital mutilation/cutting has been carried out for thousands of years in different societies.

I would be interested to know whether certain physiological or cultural aspects were taken into consideration during this research. According to the applied survey, a lower score increased the suspicion of sexual dysfunction.¹ A score of zero (0) was obtained when a participant replied “no sexual activity”/“did not

attempt intercourse,” and fewer points were awarded for painful or less pleasurable sex. Why was intercourse not attempted?

Of note, type III female genital mutilation/cutting was 1 of the 2 major subcategories of participants studied. These women also tended to be older and less educated and with more children.¹ There is no separate category for uninterested females suffering from loss of libido secondary to burdens of sustaining a household, fatigue, illness, postpartum injury, or feelings of low self-image.

Some Sudanese follow the tradition of forced, cruel, and polygamous marriage.² Was the husband significantly older

than the bride? Was he attending to a second spouse? Was he abusive? I propose that any of the previously cited factors are grounds for lack of interest and/or pleasure in sexual activity.

I comprehend that such an extensive research endeavor may have been outside the scope and time constraint of this cross-sectional study and do not argue that female circumcision undoubtedly plays a role in dyspareunia. Nevertheless, I would have liked more conclusive information encompassing factors that may have skewed the data, and a great practitioner should keep these limiting factors in mind when practicing evidence-based medicine. ■

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REPLY



We thank Ms Sakyi-Agyekum for her close review of our article.¹ The points she raises emphasize the difficulty in assessing sexual functioning in women with female genital

mutilation/cutting (FGM/C), and we encourage other researchers to investigate this issue, taking, for example, physiological and cultural covariates into consideration.

We used the Female Sexual Function Index in our study because it is considered the gold standard assessment of sexual functioning in women.² Within the context of sexual functioning among women with FGM/C, we agree that it would be interesting to examine why some couples do not attempt intercourse as well as the influence of age difference between the couple, polygamy, and abuse. These issues were, as Ms Sakyi-Agyekum suggests, outside the scope of our study, but we agree that research on these issues would add valuable information to the evidence base for policies regarding FGM/C. ■

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Beyond the traditional models of group prenatal care: the case for Moms2B



TO THE EDITORS: We read with interest the review of Mazzone and Carter¹ of the topic of group prenatal care (GPNC). As noted, GPNC is a complex and difficult model to achieve in health systems designed for individual prenatal care (IPC).

We have developed an alternative, scalable community-based group model (CGM) that addresses the barriers faced by health systems in utilizing GPNC. The model, called Moms2B, has been implemented to date in predominantly African-American neighborhoods in Columbus, OH, to address disparities in infant mortality, preterm births, and low birthweight babies.

We recently described our model and reported a 5-fold reduction in infant mortality at our first site.² At Moms2B, a

multidisciplinary team of health professionals empowers women living in poverty through weekly, 2 hour sessions focused on pregnancy and parenting education, stress reduction, and healthy nutrition. This CGM serves as an adjunct to traditional IPC and addresses the barriers to the implementation of traditional GPNC models as outlined in the [Table](#).

In summary, we suggest the CGM that we have developed allows health systems to continue to use their current IPC model while also addressing the social determinants of health in high-risk populations, thereby improving maternal and infant health. This alternative to GPC could be replicated in