

REPLY



I thank Dr van Baaren and colleagues for their letter concerning the meta-analysis and editorial of fetal fibronectin testing in women with symptoms of preterm labor.^{1,2} I believe the purpose of their letter is to point out that observational studies can also be used to assess the performance of diagnostic tests. To support this argument, the authors cite their own work, which was an observational study of how fetal fibronectin and cervical length could be used to risk-stratify women with symptoms of preterm labor.³ They suggest, based on careful analyses of their own data, that the combination of cervical length and fibronectin results could reduce the number of referrals and admissions to perinatal centers in 10% of all women.... Such a reduction would also result in fewer medications side effects, less maternal stress, and lower health care costs.

All of this of course sounds terrific, but I would point out the words “could” and “would” in the above sentence. Yes, this algorithm could, in theory, result in many things. What we need to know is not what *could* happen, but rather what *actually does* happen. How do physicians actually use these tests in real life? What do they do with the results? How does the test influence use of medications and admission? This is where the clinical trial data become important, and the results

of the meta-analysis by Berghella and Saccone¹ are clear and unambiguous.

I do agree with the authors that observational studies are very useful for determining the potential utility of a diagnostic test. But in the case of fetal fibronectin, we have to move away from theoretical musings of what *may* happen, and focus on what *does* happen. ■

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Letter to the editor

In response to the article entitled “Management of premature rupture of membranes at term: the need to correct a recurring mistake in articles, chapters, and recommendations of professional organizations,”¹ the American College of Obstetricians and Gynecologists (ACOG) shares the belief that published reviews, recommendations, and guidelines should be evidence based and published errata should be incorporated promptly.

ACOG acknowledges the inclusion of the original uncorrected information from Table 1 of the 1999 publication by Hannah et al² in the references Practice Bulletin entitled “Premature Rupture of Membranes”³ and recognizes that this may have resulted in patients being given incorrect statistics when they are counseled in general about term Premature Rupture of the Membranes (PROM) on admission. As a result, ACOG has taken steps to address this error by correcting the specified Practice Bulletin on PROM through an interim update that will be distributed to its membership.

However, it is important to note that it is unlikely that any inappropriate management advice resulted from the inclusion of this error. The uncorrected information has always been presented as background material and not as part of the Clinical Considerations and Recommendations section

regarding patient management. The clinical recommendation for prompt induction after presentation with term PROM is based on additional data, including a systematic review and meta-analysis, which has recently been updated and will be included in the interim update of the Practice Bulletin.^{4,5} ACOG continues to stand by its clinical recommendation.

ACOG has long had mechanisms in place to rectify these matters, and we have added steps to strengthen those checks to ensure that all ACOG publications provide accurate information for the obstetrician-gynecologist. We continue to strive for development and dissemination of accurate, current, and evidence-supported clinical guidance for the care of women. ■

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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