such studies and determined that there were inadequate or conflicting data to support or refute the use of aspirin for migraine prevention.²

Dr Evans and colleagues believe that what is commonly called “migraine trigger site deactivation surgery” is an effective treatment in properly selected patients. However, studies they cite have been criticized for major methodological limitations, as summarized by Diener and Bingel.³ Such potential considerations include an unrealistic use of the term cure for migraine, which is a complex genetic brain disorder; lack of clear inclusion criteria or reporting of important variables in the study population, such as comorbidities; a methodology in which the sample was enriched with placebo responders by selecting for onabotulinumtoxin A response; questionable validity of a sham procedure; “cure rates” not consistent with any other migraine preventive treatment; and use of a primary end point inconsistent with International Headache Society clinical trial guidelines. In the Choosing Wisely campaign, the American Headache Society states that this surgical procedure should be recommended only in the context of a clinical trial.⁴

Dr da Silva describes the problem of polypharmacy in many patients with migraine and suggests that nonpharmacological therapies, such as acupuncture, are underutilized. While my review noted the potential use of acupuncture for tension-type headache, I agree that there is increasing evidence for migraine treatment with acupuncture, although methodological heterogeneity limits collective interpretation of the clinical trials undertaken.⁵ My review also covered nonpharmacological treatments, including devices and behavioral therapies, but omitted the largest trial of mindfulness-based stress reduction in episodic migraine by Seminowicz et al,⁶ in which, unlike the other 2 studies on mindfulness included, a significant reduction in headache days was observed by 20 weeks.

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Conflict of Interest Disclosures: Dr Robbins reported serving on the board of directors for the American Headache Society and the editorial board for Headache and being a section editor for Current Pain and Headache Reports. He has received book royalties from Wiley.


CORRECTION

Percentage incorrect in 2 Places: In the Original Investigation titled “Association of Maternal SARS-CoV-2 Infection in Pregnancy With Neonatal Outcomes,”¹ published in the May 25, 2021, issue of JAMA, an incorrect percentage appeared in the abstract and in the text. In the Results section of the abstract, the first sentence should have been “Of 88 159 infants (49.0% girls), 2323 (2.6%) were delivered by mothers who tested positive for SARS-CoV-2.” In the Results section of the text, the second sentence should have been “Among 88 159 newborn infants included (49.0% girls), 2323 (2.6%) were delivered by 2286 SARS-CoV-2-positive mothers.” This article was corrected online.


Disclosures Added to Medical News Story: In the Medical News & Perspectives story titled “Semaglutide’s Success Could Usher in a ‘New Dawn’ for Obesity Treatment,” published in the July 13, 2021, issue,¹ the financial disclosures of the interviewees were inadvertently not included. The Article has been updated to indicate that several interviewees had financial relationships with the manufacturer of semaglutide, and some reported having relationships with other companies involved with weight loss products. This Article was corrected online.


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