Letters

that there are first-line pharmacotherapies shown to be effective in the management of CPP. There is also no evidence suggesting that surgical intervention should be first-line therapy for CPP. Even for endometriosis, for which laparoscopy is the gold standard for diagnosis, no consensus exists about whether laparoscopy should be done prior to medical treatment. Furthermore, for the most common CPP conditions such as irritable bowel syndrome, bladder pain syndrome, and pelvic myalgias, no recommended surgical interventions exist.

Fourth, we did address the quality of the guidelines and heterogeneity of the recommendations in the Limitations section of our article.1

Drs Garg and Shrigirwar state that our article should have included PCS as a cause of CPP. Pelvic congestion syndrome was not discussed in our Review because few guidelines mention this condition. Although diagnostic criteria for PCS are improving, evidence is limited regarding the best diagnostic approach and treatment for this condition. Two recent systematic reviews3,4 demonstrated that data on clinical outcomes related to pain are inconsistent; some studies have shown symptom improvement immediately and up to 6 months after percutaneous vascular treatments while other studies have not demonstrated these favorable results. A more recent systematic review5 concluded that vascular embolization treatments for PCS are effective, but the included studies had a high degree of methodological heterogeneity. As more data emerge, future guidelines on the management of CPP will likely incorporate recommendations for the management of PCS.

We agree with Dr Petros and colleagues that CPP can be caused by laxity in pelvic support structures. Research consistently shows that women with pelvic organ prolapse can have urinary symptoms, sexual dysfunction, and CPP. Although the guidelines we reviewed did not specifically mention it, practitioners performing pelvic evaluations should identify pelvic organ prolapse and refer patients to pelvic surgeons for advice. However, the best surgical approach and use of synthetic materials to reduce pelvic organ prolapse remains highly debated. De novo or worsening chronic pain after mesh implantation is a serious concern. Recent studies6 have shown that there are first-line pharmacotherapies shown to be effective in the management of CPP. There is also no evidence suggesting that surgical intervention should be first-line therapy for CPP. Even for endometriosis, for which laparoscopy is the gold standard for diagnosis, no consensus exists about whether laparoscopy should be done prior to medical treatment. Furthermore, for the most common CPP conditions such as irritable bowel syndrome, bladder pain syndrome, and pelvic myalgias, no recommended surgical interventions exist.

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In addition, there is no clear correlation between degree of prolapse and severity of CPP. Some women can have significant prolapse without pain. Moreover, no consensus exists on how to treat complications of pelvic support surgeries.

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Conflict of Interest Disclosures: Dr Lamvu reported serving as a consultant for AbbVie and as consulting scientific officer for Uroshape LLC and being on the board of directors for the International Pelvic Pain Society. Dr Ouyang reported being an employee of the federal government (Department of Veterans Affairs). Dr Rapkin reported serving as a member of the speaker’s bureau for AbbVie, serving as co-chair for the International Pelvic Pain Society patient education committee, and receiving personal fees from Bayer.


CORRECTION

Misspelled Surname: In the Original Investigation titled “Effect of Amoxicillin Dose and Treatment Duration on the Need for Antibiotic Re-treatment in Children With Community-Acquired Pneumonia: The CAP-IT Randomized Clinical Trial,” published in the November 2, 2021, issue of JAMA,1 the surname of the patient representative on the trial steering committee was misspelled. The correct spelling is Prichard. This article has been corrected online.


Guidelines for Letters

Letters discussing a recent JAMA article should be submitted within 4 weeks of the article’s publication in print. Letters received after 4 weeks will rarely be considered. Letters should not exceed 400 words of text and 5 references and may have no more than 3 authors. Letters reporting original research should not exceed 600 words of text and 6 references and may have no more than 7 authors. They may include up to 2 tables or figures but online supplementary material is not allowed. All letters should include a word count. Letters must not duplicate other material published or submitted for publication. Letters not meeting these specifications are generally not considered. Letters being considered for publication ordinarily will be sent to the authors of the JAMA article, who will be given the opportunity to reply. Letters will be published at the discretion of the editors and are subject to abridgement and editing. Further instructions can be found at http://jamanetwork.com/journals/jama/pages/instructions-for-authors. A signed statement for authorship criteria and responsibility, financial disclosure, copyright transfer, and acknowledgment are required before publication. Letters should be submitted via the JAMA online submission and review system at https://manuscripts.jama.com. For technical assistance, please contact jama-letters@jamanetwork.org.

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