ing data at all or pooling data using network meta-analysis, we chose the latter; indeed network meta-analysis has been shown to potentially give more reliable results because of the integration of additional information.\(^5\)\(^6\) Although studies included in our review were from different sources, they were all randomized controlled trials and hence contrasts between treatment groups within each study should be comparable. In addition, we focused only on CP/CPPS categories IIIA and IIIB to reduce heterogeneity due to disease severity and focused on outcomes measured using National Institutes of Health Chronic Prostatitis Symptom Index scales to reduce heterogeneity due to measurement error. Nevertheless, we explored potential discrepancies in treatment effects between direct and network meta-analysis results using the standardized normal method (z).\(^5\)\(^6\) Directions of treatment effect for the 2 methods were identical for all 12 comparisons; moreover, the magnitude of the effects between the 2 methods were similar except for \(\alpha\)-blocker vs placebo, where \(z\) was large and reached statistical significance (2.9380, \(P = .003\)). We believe that this is an example of increased precision of treatment effects due to the network method “borrowing” information from indirect comparisons.

Third, Jackson et al disagree that study data should be expanded using a Stata command so that it could be included in the meta-analysis, questioning how we could know the distribution of data. We only used this command for the treatment responsiveness outcome, which is a dichotomous outcome and does not need any assumption about distribution, normal or otherwise. We believe that using all available data, rather than omitting studies, is an advantage and will lead to more valid estimates.

Ammarin Thakkinstian, PhD
raatk@mahidol.ac.th
Section for Clinical Epidemiology and Biostatistics
Mahidol University
Bangkok, Thailand
John Attia, MD, PhD, FRCP, FRACP
Centre for Clinical Epidemiology and Biostatistics
University of Newcastle
Newcastle, Australia

Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.
physicians) with 28.8% (22.9 million) of total prescriptions, followed by internists (14.6%, 11.6 million), dentists (8.0%, 6.4 million), and orthopedic surgeons (7.7%, 6.1 million). For patients aged 10 to 19 years, dentists were the main prescribers (30.8%, 0.7 million), followed by primary care (13.1%, 0.3 million) and emergency medicine physicians (12.3%, 0.3 million) (FIGURE 1). All comparisons between specialties within an age group were significantly different from each other (P < .001), except general practitioners and emergency medicine physicians in the 0- to 9-year-old group (P = .34) and dentists and internists in the 30- to 39-year-old group (P = .06). For patients 40 years and older, primary care physicians were the main prescribers (30.4%, 17.9 million). On average, across all physician specialties included in this analysis, 56.4% (44.8 million) of opioid prescriptions were dispensed to patients who had already filled another opioid prescription within the past month (FIGURE 2).

Comment. Our analysis identified questions for further investigation. For example, do the 11.7% of prescriptions issued to those aged 10 to 29 years signal a potential problem for this population, which is the most likely to abuse drugs and develop addiction?3-5 Another unknown is whether the percentage of opioid prescriptions (56%) that were filled by patients who had recently received another opioid prescription is justified or suggests the need to improve information infrastructures that could enhance the safety of prescribed opioid analgesics and minimize diversion. Our conclusions are limited because causal links with opioid diversion and abuse cannot be drawn from prescribing practices alone and our analysis cannot account for illegal prescriptions. Nonetheless, the recent increases in opioid prescriptions2 and associated increases in abuse and overdoses4 highlight the need for additional research to understand positive and negative effects of current prescribing practices.

Nora D. Volkow, MD
nvolkow@nida.nih.gov
National Institute on Drug Abuse
National Institutes of Health
Bethesda, Maryland

Thomas A. McLellan, PhD
Center for Substance Abuse Solutions
University of Pennsylvania School of Medicine
Philadelphia

Jessica H. Cotto, MPH
Menar Karithanom, MPH
Susan R. B. Weiss, PhD
National Institute on Drug Abuse
National Institutes of Health

Author Contributions: Ms Cotto had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Volkow, McLellan, Weiss.

Acquisition of data: Cotto, Karithanom, Weiss.

Analysis and interpretation of data: Volkow, McLellan, Cotto, Karithanom, Weiss.

Figure 1. Percentage of Prescriptions Dispensed for Opioid Analgesics From Outpatient US Retail Pharmacies by Age and Physician Specialty, 2009

These unprojected data include new and refill prescriptions. Top 5 prescribers for each age group are shown. Age groups for individuals 40 years and older were combined because they shared the same top 5 prescribers. Note that percentages in each group do not sum to 100 because prescriptions from specialties other than the main prescribers are not shown. Opioids included codeine and combination noninjectable (USC 02232), morphine and opium noninjectable (USC 02222), morphine and opium injectable (USC 02221), codeine and combination injectable (USC 02231). ENT indicates ear, nose and throat; GP/FM/DO, general practitioner/family medicine/osteopathic physicians; IM, internal medicine; and OB/GYN, obstetrics/gynecology. Included as primary care physicians are general practitioners, family practitioners, and osteopathic physicians; descriptors of the roles are those used by SDI Health.

Figure 2. New vs Continuing or Switch/Add-on Opioid Prescriptions Dispensed by US Retail Pharmacies as a Function of Specialty, 2009

Shown are unprojected data. Prior prescriptions (dispensed within the past month) could be from the same or a different prescriber or specialty. GP/FM/DO indicates general practitioner/family medicine/osteopathic physicians; IM, internal medicine.
CORRECTIONS

Incorrect Sentence: In the Editorial titled “Antihypertensive Therapy for Prehypertension: Relationship With Cardiovascular Outcomes,” published in the March 2, 2011, issue of JAMA (2011;305[9]:940-941), the word “not” was missing, resulting in an incorrect sentence. On the first page, the end of the last sentence in column 2 should have read, “all-cause mortality compared with those not receiving antihypertensive therapy.” This article was corrected online.

Incorrect Values: In the Original Contribution entitled “Change in Disability After Hospitalization or Restricted Activity in Older Persons,” published in the November 3, 2010, issue of JAMA (2010;304[17]:1919-1928), incorrect values were reported in some instances. Errors in calculations led to inflated values for absolute risk, primarily for the transition from no disability to mild disability in the presence of physical frailty, and were discussed in the results section of the abstract, the “Results” and “Comment” sections of the text, Table 3, and the eTable. These errors did not affect the conclusions or implications of the report. The article and supplemental material have been corrected online.

The most stimulating challenge is one of mean degree between an excess of severity and a deficiency of it, since a deficient challenge may fail to stimulate the challenged party at all, while an excessive challenge may break his spirit.

—Arnold J. Toynbee (1889-1975)