to their use. If and when PAMORAs are used for OIC prophylaxis (especially in patients with cancer), developing constipation would need a thorough evaluation (history, physical examination, and assessment of accompanying symptoms such as nausea and abdominal pain, as well as other workup, such as laboratory and/or imaging studies) to evaluate biochemical, structural, or other causes of constipation, vs just assuming the constipation is related to OIC. Ongoing long-term PAMORA use in a patient with possible obstruction or a luminal lesion could be dangerous. Naloxegol and nalmedianine, 2 PAMORAs, are only approved for use in patients with noncancer-related pain and OIC. PAMORAs are also more costly compared with traditional laxatives, and payers often encourage step therapy (ie, a failure of traditional laxatives) before covering PAMORAs. As an example, the cash price of a 3-day supply of oral methylnaltrexone (another PAMORA) at the recommended dose of 450 mg once daily ranges from $206 to $221 on GoodRx.com.

Recent studies have demonstrated lower rates of bowel dysfunction and OIC with long-acting opioid/naloxone medication combinations (vs opioid alone), but these formulations are not routinely available and do not qualify as PAMORAs per se.4,6 Ongoing clinical trials are evaluating PAMORAs for preventing OIC (eg, ClinicalTrials.gov identifiers NCT02946580, NCT02977286) and we eagerly await their publication. In summary, PAMORAs are useful agents to treat laxative refractory OIC, but traditional laxatives, which are well tolerated, widely available (often over the counter), and inexpensive agents, remain first-line pharmacologic options for preventing and treating OIC.

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Error in the Results Section: In the article titled “Association of Testosterone Levels With Anemia in Older Men: A Controlled Clinical Trial,” published in the April 2017 issue of JAMA Internal Medicine, there was an error in the data presented in the Results section. Where it previously said “at month 12, 12 of 24 (58.3%) testosterone-treated men with unexplained anemia at baseline were no longer anemic, compared with 6 of 24 (22.2%) placebo-treated men,” the numerator was changed to 14 in the first case, and the denominator to 24 in the second case. This article was corrected online.


Error in Results Data: In the Research Letter titled “Association of Smoking and Cumulative Pack-Year Exposure With COVID-19 Outcomes in the Cleveland Clinic COVID-19 Registry,” published online January 25, 2021, there was an error in data reported in the Results section. For heavy smokers who were 1.89 times more likely to die following a coronavirus disease 2019 diagnosis, the correct 95% CI is 1.29 to 2.76. The article has been corrected online.


Error in Figure: The Challenges in Clinical Electrocardiography titled, “Progressive PR Prolongation in an Asymptomatic Man,” published online March 1, 2021, included an error in the Figure in which the labels identifying the PR intervals were not visible. The article has been corrected online.


Error in Author Affiliation: In the Original Investigation titled “Associations of Fish Consumption With Risk of Cardiovascular Disease and Mortality Among Individuals With or Without Vascular Disease From 58 Countries,” published online March 8, 2021, in JAMA Internal Medicine, the author affiliation for Sadi Gulce was incorrect. The correct affiliation is Cardiology Department, Ankara University Medical School, Ankara, Turkey. This article has been corrected.


Error in Figure Value: In the Original Investigation entitled “Effect of a Multifaceted Clinical Pharmacist Intervention on Medication Safety After Hospitalization in Persons Prescribed High-Risk Medications: A Randomized Clinical Trial,” the value listed in the “Randomized” oval of the Figure was “36/60,” but should be “45/9.” This article was corrected online.