

OBSTETRICS & GYNECOLOGY



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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*
- Email correspondence between the editorial office and the authors*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:

obgyn@greenjournal.org.

Date: Nov 01, 2018
To: "Cornelius D Jamison" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-1849

RE: Manuscript Number ONG-18-1849

Expedited Partner Therapy: Improving Women's Health and Combatting Sexually Transmitted Infections

Dear Dr. Jamison:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Nov 15, 2018, we will assume you wish to withdraw the manuscript from further consideration.

ASSOCIATE EDITORS' COMMENTS:

We would like to request that you send us your revisions to this manuscript as soon as possible, no later than two weeks from today (11/1; target date of 11/15). We would like to place this manuscript in our February issue, but to do that we would need to receive your revision by the target date in order to make our publisher-imposed deadlines. While we understand there are a lot of reviewer comments to address, we sincerely hope that you will consider this request. Feel free to contact the Editorial Office at any time if you have any questions: Obgyn@greenjournal.org; 202-314-2317

REVIEWER COMMENTS:

REVIEWER #1:

The authors present a commentary on the use of expedited partner therapy for the treatment of STIs. This is a very important and germane topic given the increased incidence of STI infection in the US as well as the development of multi drug resistant strains of organisms such as gonorrhea. Overall I found this to be a very well written commentary with a clear and cogent argument both on the pros and cons of EPT. My only minor comments are:

- 1) Lines 72; I would provide data on the increasing rates of STI particularly drug resistant gonorrhea in the US. This can be done as a table as I think it will further support your argument.
- 2) Do you have data available on the number of men/partners who go untreated and what the clinical sequelae are of this?
- 3) One component of this that should be commented on briefly is that of patient confidentiality...How does EPT protect patient privacy if the patient has had multiple sexual partners that need to be treated?

REVIEWER #2:

This commentary addresses the role that expedited partner therapy (EPT) could play in curbing the increasing serious consequences of inadequately treated sexually transmitted disease, principally chlamydia trachomatis and neisseria gonorrhoeae. With the increasing prevalence of these infections among young reproductive age women and the association between these infections and serious health complications it is imperative that we explore any and all options to reduce the rate of persistent infection and recurrent infection from partners who have not been treated.

The authors make a compelling case for why all providers involved in caring for young reproductive age women should be encouraged to participate in EPT address many of the existing barriers that may explain why EPT has not been substantially implemented. While several of these components are commendable the authors leave the reader with many unanswered questions including the very basis of the efficacy of EPT in 2018:

1. The authors assert that EPT is proven science, but don't provide adequate prospective evidence for this assertion. There is only one RCT referenced. The CDC monograph (referenced) describes a few other RCT's, but ultimately concludes that there are many remaining questions including the generalizability of the conclusions.
2. Much of the evidence that is referenced is also dated, greater than 10 years old despite the fact that many national organizations support EPT. What is the current clinical evidence that this approach is the best way to reduce STI's? Has the existing research factored in the significant impact of rising opioid use in compliance and efficacy?
3. The authors focus on many of the existing barriers that contribute to why EPT is not being implemented, but acknowledge that it is legal in 42 states. It would be valuable to identify the 8 states in which it is not legal. It would also be valuable for the authors to identify which of the 42 states EPT is being optimally implemented and what characterizes that success versus the states in which it is legal but not being used. Finally, it would be valuable for the reader to understand the shared characteristics of states, regions and or medial communities in which EPT is working the best.
4. Along these lines any information that the authors can provide that have led to community, regional or state's success will substantially improve women's health and contribute to reducing STI's.
5. The authors acknowledge that there are still significant research priorities, which could better define optimal practice among patients who will receive their EPT via prescription rather than dispensing of medication. I am curious what the authors propose as the most effective way to overcome the obstacles that persist? Few would dispute the value of reducing STI's and the value of expedited partner therapy (EPT) in accomplishing this goal seems intuitive, but the reluctance of providers is not without merit.

REVIEWER# 3:

1. The first half of the paper is a bit awkward and seems redundant in many places; the second half is better but still needs some stream-lining. Specific points are discussed more fully below.
2. The first statements of both the abstract and the Introduction note that incidence rates have reached record highs but no reference for this claim is given. Please reference.
3. The second sentence in the Abstract also needs a reference.
4. The second to last statement in the Abstract is incomplete; it starts "Prevention of STIS and STI-related complications can occur...but it well require the implementation of all tools...to do what?"
5. The last sentence of paragraph one discusses the number of cases for chlamydia and gonorrhea since 2016 but the words 'resulting in' are redundant. There was a 6.8% and 18.5% increase in the number of cases of chlamydia and gonorrhea, respectively, in 2016 but compared to what baseline year?
6. In the intro, third paragraph, second sentence, it should read "...enhance their understanding of the impact that undiagnosed, persistent, and/or repeat STIs..."
7. The last sentence of the Introduction awkwardly connects the idea that EPT fills a gap and the fact that there is incidence where states without EPT have increasing STI rates. It also implies that the STI rates are NOT increasing in states with EPT legislation; is this correct? If the presumption is that the rates are increasing (perhaps faster?) in states without EPT, is there evidence to support that EPT is the reason for this?
8. In the Practice of EPT section, in the first paragraph, in the first sentence, please insert "it" before "is permissible". And in the second sentence it is noted that a variety of organizations 'endorse' EPT but what the nature or purpose of that endorsement is not mentioned. Is it endorsed as 'good clinical practice' or a good policy idea or as a means of lowering STI morbidity/mortality? Please elaborate on the nature or intent behind the endorsements.
9. And finally, in that paragraph, the last sentence mentions EPT for treatment of Trichomonas "depending on state and local health...guidelines." As the focus of the paper is on chlamydia and gonorrhea, please either delineate the differences in EPT endorsements for Trichomonas compared to gonorrhea/chlamydia, why there are differences, what those differences imply for clinical course as well as care, and how significant those differences are.
10. In the Practice of EPT section, in the third paragraph, the last sentences notes that there is low uptake in clinician delivery. Please either note this will be discussed later or embark on the discussion following this statement of fact.
11. In the final paragraph of the Practice of EPT section, it is noted that it is important to re-test women at 3 months after

therapy; I would encourage also noting the need to test for cure in the first 2-3 weeks after therapy is given.

12. In the EPT Debate section, first paragraph, please remove the rhetorical questions, as well as the redundant sentence that follows. It would be better to address, in numerical order, the enumerated concerns that are presented in the first part of the paragraph.

13. In the EPT Debate section, second paragraph, reference 21 is from almost 3 years ago. Is there no newer data on reported allergic reactions to the hotline?

14. In the EPT Debate section, fifth paragraph, reference 29 is not peer reviewed and while reference 28 and 29 provide some insight into malpractice issues in 2 states, it is not a national review. Also, going to court is not the benchmark for litigation; it is more than conceivable that suits have been filed and either dropped or settled. I would be cautious in trying to impart the impression that there is no malpractice litigation risk associated with EPT.

15. In Future Directions and the Research Priorities, the second sentence should more clearly state the most important research priority: how to optimize the clinical implementation of EPT nationwide. A table listing these priorities would be beneficial as well as they tend to blur together in the paragraph.

16. In the Call to Action section, an appropriate sexual history of all women should be obtained. The third sentence starts with "The answers to these questions..." but there is only one question asked (the first line in the section) and it is redundant and could be eliminated. The last sentence of the first paragraph is a bit awkward; perhaps it is better to discuss lessening the perception that clinician's attitudes perpetuate the stigma associated with STI infections in lieu of 'decreasing STI-related stigma from clinicians'.

17. The first sentence in the Conclusion is a bit of a run-on and reads awkwardly. The last sentence of this section is redundant and overly dramatic.

18. Ref 12 discusses partner notification issues but is dated 2003; is there anything newer?

19. Ref 23 is not peer-reviewed and the package inserts may be a better reference.

20. Ref 25 was accessed in 2017; is it still there?

21. Ref 29 is a very weak reference for a point that may be overly emphasized in the manuscript. Also, in the Senate debate, there should be references to where they got their data that could be used as original data.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

2. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

3. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendices).

Please limit your Introduction to 250 words and your Discussion to 750 words.

4. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

* All financial support of the study must be acknowledged.

* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.

* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.

* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

5. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Current Commentary articles, 250 words. Please provide a word count.

6. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

7. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

8. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

9. The Journal's Production Editor had the following to say about this manuscript:

"Figure 1: Please provide a higher resolution version of this figure."

When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Figures should be no smaller than the journal column size of 3 1/4 inches. Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce. Refer to the journal printer's web site (<http://cjs.cadmus.com/da/index.asp>) for more direction on digital art preparation.

If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at <http://ong.editorialmanager.com>. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Nov 15, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982

2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

November 19, 2018

Nancy C. Chescheir, MD
Editor-in-Chief, Obstetrics & Gynecology
409 12th Street, SW
Washington, D.C. 20024

RE: Manuscript Number ONG-18-1849

Dear Chescheir,

Thank you for your email dated November 1st 2018 regarding our manuscript “**Expedited Partner Therapy: Improving Women’s Health and Combatting Sexually Transmitted Infections.**” We greatly appreciate the suggestions and have edited our manuscript accordingly. Our point-by-point responses to the comments provided by each reviewer are detailed below. Please accept our revised manuscript for continued consideration as a Current Commentary in *Obstetrics & Gynecology*.

We appreciate your consideration of our work for publication in *Obstetrics & Gynecology*.

Sincerely,



Cornelius D. Jamison, MD, MSPH, MS



REVIEWER #1:

The authors present a commentary on the use of expedited partner therapy for the treatment of STIs. This is a very important and germane topic given the increased incidence of STI infection in the US as well as the development of multi drug resistant strains of organisms such as gonorrhea. Overall I found this to be a very well written commentary with a clear and cogent argument both on the pros and cons of EPT. My only minor comments are:

1. Lines 72; I would provide data on the increasing rates of STI particularly drug resistant gonorrhea in the US. This can be done as a table as I think it will further support your argument.

RESPONSE:

We agree this is an important topic and have added greater detail regarding antibiotic resistant gonorrhea. We included this additional detail where we discuss gonorrhea resistance. The statement on Page 9, Lines 184-187 now reads:

“In 2017, susceptibility testing for ceftriaxone found 0.2% of isolates with an elevated minimum inhibitory concentration (MIC); for cefixime, there were 0.4% of isolates with an elevated MIC.¹”

2. Do you have data available on the number of men/partners who go untreated and what the clinical sequelae are of this?

Thank you for this inquiry. We have added this statement on Page 4, Lines 79-80:

“Early data suggest that 40-70% of male partners are untreated.²”

To include the clinical sequelae of men we have added this statement on Page 4, Line 80-82:

“The sequelae of untreated STIs in men includes urethritis, scarring of the reproductive tract, epididymitis, and possible infertility. Rarely, disseminated gonococcal infection may occur.¹”

3. One component of this that should be commented on briefly is that of patient confidentiality...How does EPT protect patient privacy if the patient has had multiple sexual partners that need to be treated?

RESPONSE:

We agree this is an important statement to add to the manuscript. The statement on Page 6, Lines 137-139 now reads:

“There is an added benefit of patient privacy, as the index patient is not required to provide partner names and is able to obtain the needed number of EPT prescriptions or medications for all partners.”

REVIEWER #2:

This commentary addresses the role that expedited partner therapy (EPT) could play in curbing the increasing serious consequences of inadequately treated sexually transmitted disease, principally chlamydia trachomatis and neisseria gonorrhoeae. With the increasing prevalence of these infections among young reproductive age women and the association between these infections and serious health complications it is imperative that we explore any and all options to reduce the rate of persistent infection and recurrent infection from partners who have not been treated.

The authors make a compelling case for why all providers involved in caring for young reproductive age women should be encouraged to participate in EPT address many of the existing barriers that may explain why EPT has not been substantially implemented. While several of these components are commendable the authors leave the reader with many unanswered questions including the very basis of the efficacy of EPT in 2018:

1. The authors assert that EPT is proven science, but don't provide adequate prospective evidence for this assertion. There is only one RCT referenced. The CDC monograph (referenced) describes a few other RCT's, but ultimately concludes that there are many remaining questions including the generalizability of the conclusions.

RESPONSE:

Thank you for the comments. There have been 26 RCTs conducted to evaluate EPT among heterosexual partners. However, there are not any “real-world” published studies to date.

2. Much of the evidence that is referenced is also dated, greater than 10 years old despite the fact that many national organizations support EPT. What is the current clinical evidence that this approach is the best way to reduce STI's? Has the existing research factored in the significant impact of rising opioid use in compliance and efficacy?

RESPONSE:

We understand and appreciate this concern. Many of the RCTs were performed several years ago, many of them used to develop the CDC's white paper on EPT. At this time, much of the research is in the implementation phase to test the external validity of EPT. We believe that EPT is one of several ways to combat rising STI rates and hope to conduct future studies to improve the current literature.

We understand the concern regarding sexual activity in relation to the opioid epidemic, but we are not aware of any literature on EPT and opioid use.

3. The authors focus on many of the existing barriers that contribute to why EPT is not being implemented, but acknowledge that it is legal in 42 states. It would be valuable to identify the 8 states in which it is not legal. It would also be valuable for the authors to identify which of the 42 states EPT is being optimally implemented and what characterizes that success versus the states in which it is legal but not being used. Finally,

it would be valuable for the reader to understand the shared characteristics of states, regions and or medial communities in which EPT is working the best.

RESPONSE:

Thank you for these comments. Since submission, another state allowed EPT, which we have included. In order to provide further details regarding the states that are not permissible, we have added the following statement to Page 5, Lines 108-110:

“While EPT is permissible in 43 states in the union and ‘potentially allowable’ in five states (SD, KS, OK, AL, NJ) and Puerto Rico, it is currently prohibited in South Carolina and Kentucky.^{2,5}”

We agree that understanding the characteristics of states and regions that have successfully implemented EPT would be valuable information. However, there aren’t any published data that detail state-level characteristics and EPT success.

4. Along these lines any information that the authors can provide that have led to community, regional or state's success will substantially improve women's health and contribute to reducing STI's.

RESPONSE:

We agree that this information would be valuable, and we provided some factors that may improve success under the “Call to Action” section.

5. The authors acknowledge that there are still significant research priorities, which could better define optimal practice among patients who will receive their EPT via prescription rather than dispensing of medication. I am curious what the authors propose as the most effective way to overcome the obstacles that persist? Few would dispute the value of reducing STI's and the value of expedited partner therapy (EPT) in accomplishing this goal seems intuitive, but the reluctance of providers is not without merit.

RESPONSE:

Thank you for these comments. Continued research that informs policies and practices at the national, state, and clinical level are needed to increase the implementation of EPT. In terms of EPT via prescription, there will need to be incorporation of EPT prescriptions into electronic medical record systems, along with collaborations among pharmacies that receive these prescriptions.

REVIEWER# 3:

1. The first half of the paper is a bit awkward and seems redundant in many places; the second half is better but still needs some stream-lining. Specific points are discussed more fully below.

RESPONSE:

Thank you for the comments.

2. The first statements of both the abstract and the Introduction note that incidence rates have reached record highs but no reference for this claim is given. Please reference.

RESPONSE:

The reference has been added to Page 4, Line 68. We did not include any references in the abstract.

3. The second sentence in the Abstract also needs a reference.

RESPONSE:

We did not include any references in the abstract.

4. The second to last statement in the Abstract is incomplete; it starts "Prevention of STIS and STI-related complications can occur...but it will require the implementation of all tools...to do what?"

RESPONSE:

We appreciate the comment and reworded the last two sentences in the Abstract for clarity. Page 3, Lines 55-64 now read:

“Despite EPT’s proven effectiveness, there are barriers to its implementation that must be understood in order to enhance STI treatment and prevention efforts. In this commentary, we discuss these barriers, and appeal to women’s health clinicians to implement or increase use of EPT for the management of women with STIs and their sexual partners.”

5. The last sentence of paragraph one discusses the number of cases for chlamydia and gonorrhea since 2016 but the words 'resulting in' are redundant. There was a 6.8% and 18.5% increase in the number of cases of chlamydia and gonorrhea, respectively, in 2016 but compared to what baseline year?

RESPONSE:

The statement on Page 4, Lines 68-71 now reads:

“According to the Centers for Disease Control and Prevention (CDC), there were over 1.7 million reported cases of chlamydia and over 555,000 cases of gonorrhea in 2017—resulting in increases of 6.8% and 18.5%, respectively, since 2016.¹”

6. In the intro, third paragraph, second sentence, it should read "...enhance their understanding of the impact that undiagnosed, persistent, and/or repeat STIs..."

RESPONSE:

We agree, and added the word “that” to the sentence. On Page 4, Line 87, it now reads:

“Those who provide OB/GYN care should improve and enhance their understanding of the impact that undiagnosed, persistent, and/or repeat STIs have on reproductive health.”

7. The last sentence of the Introduction awkwardly connects the idea that EPT fills a gap and the fact that there is incidence where states without EPT have increasing STI rates. It also implies that the STI rates are NOT increasing in states with EPT legislation; is this correct? If the presumption is that the rates are increasing (perhaps faster?) in states without EPT, is there evidence to support that EPT is the reason for this?

RESPONSE:

We are not implying that STIs in EPT permissible states have stopped increasing. The reference used for this statement (#3) showed that among the states designated permissible, prohibited, or potentially allowable, chlamydial infections saw an increase in each category. But the incidence rates for states with prohibitive EPT legislation grew significantly faster over time compared to states where EPT was permissible. The model used suggests that a lack of EPT legislation is associated with an increase in STI rates. The prior language was confusing, so we have added the following statement on Page 5, Lines 99-102 that now reads:

“For example, chlamydia incidence rates have grown significantly faster in EPT prohibitive states compared to EPT permissible states.”⁴⁹

8. In the Practice of EPT section, in the first paragraph, in the first sentence, please insert "it" before "is permissible". And in the second sentence it is noted that a variety of organizations "endorse" EPT but what the nature or purpose of that endorsement is not mentioned. Is it endorsed as "good clinical practice" or a good policy idea or as a means of lowering STI morbidity/mortality? Please elaborate on the nature or intent behind the endorsements.

RESPONSE:

This paragraph has been edited and the statement on Page 5, Lines 104-108 now reads:

“The CDC supports clinicians in the treatment of sexual partners of individuals diagnosed with chlamydia and/or gonorrhea, as do the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics, American Medical Association, and Society for Adolescent Health and Medicine.”

9. And finally, in that paragraph, the last sentence mentions EPT for treatment of Trichomonas "depending on state and local health...guidelines." As the focus of the paper is on chlamydia and gonorrhea, please either delineate the differences in EPT endorsements for Trichomonas compared to gonorrhea/chlamydia, why there are differences, what those differences imply for clinical course as well as care, and how significant those differences are.

RESPONSE:

We understand and appreciate these concerns. We have added the following statement on Page 6, Lines 116-120 now reads:

“However, the studies on EPT for trichomoniasis are conflicting. While one randomized clinical trial (RCT) showed partner therapy decreased repeat infections among infected women,⁷ two other RCTs showed either no effect or borderline effect.^{7,8}”

10. In the Practice of EPT section, in the third paragraph, the last sentences notes that there is low uptake in clinician delivery. Please either note this will be discussed later or embark on the discussion following this statement of fact.

RESPONSE:

Thank you for the comments. We provided some additional data to for the facts presented. While we do not go into an in-depth discussion, the references mentioned provide data regarding providers’ perceptions on EPT. We have added the following statement on Page 7, Lines 139-142 that reads:

“Despite the proven benefits of EPT, however, small studies have shown low uptake in clinician usage,^{17,18} including Rosenfeld, et al., who found that about 11% of health care providers used expedited partner therapy consistently.¹⁷”

11. In the final paragraph of the Practice of EPT section, it is noted that it is important to re-test women at 3 months after therapy; I would encourage also noting the need to test for cure in the first 2-3 weeks after therapy is given.

RESPONSE:

We appreciate the comment; however, the “test-of-cure” is not advised per the CDC (reference #19 provided for this statement):

Test-of-cure to detect therapeutic failure (i.e., repeat testing 3–4 weeks after completing therapy) is not advised for persons treated with the recommended or alternative regimens, unless therapeutic adherence is in question, symptoms persist, or reinfection is suspected. Moreover, the use of chlamydial NAATs at <3 weeks after completion of therapy is not recommended because the continued presence of nonviable organisms can lead to false-positive results.

12. In the EPT Debate section, first paragraph, please remove the rhetorical questions, as well as the redundant sentence that follows. It would be better to address, in numerical order, the enumerated concerns that are presented in the first part of the paragraph.

RESPONSE:

We have deleted the questions from this section.

13. In the EPT Debate section, second paragraph, reference 21 is from almost 3 years ago. Is there no newer data on reported allergic reactions to the hotline?

RESPONSE:

This reference from the California Department of Public Health (CDPH) is the most recent data found regarding reported adverse reactions to EPT medications. The hotline and now

email are still active, but we do not have any newer data. This reference is still maintained on CDPH's website.

14. In the EPT Debate section, fifth paragraph, reference 29 is not peer reviewed and while reference 28 and 29 provide some insight into malpractice issues in 2 states, it is not a national review. Also, going to court is not the benchmark for litigation; it is more than conceivable that suits have been filed and either dropped or settled. I would be cautious in trying to impart the impression that there is no malpractice litigation risk associated with EPT.

RESPONSE:

We understand and appreciate this concern. References #27 and #28 were obtained from an internal literature search conducted by the University of Michigan Law School and Michigan Medicine's research. It was a national review into the legality on EPT. We have updated the statement on Page 10, Lines 207-210 now reads:

“A national review of EPT malpractice litigation revealed that no active or pending lawsuits from a third party directed at clinicians have gone to court,^{30,31} although a lack of reported litigation does not mean liability claims have not occurred or been settled out of court.”

15. In Future Directions and the Research Priorities, the second sentence should more clearly state the most important research priority: how to optimize the clinical implementation of EPT nationwide. A table listing these priorities would be beneficial as well as they tend to blur together in the paragraph.

RESPONSE:

Thank you for these comments. We made changes to the statement to better address the most important research priority. Page 10, Lines 223-225 now reads:

“Most importantly, optimizing the clinical implementation of EPT will improve care for index patients and their sexual partners.”

16. In the Call to Action section, an appropriate sexual history of all women should be obtained. The third sentence starts with "The answers to these questions..." but there is only one question asked (the first line in the section) and it is redundant and could be eliminated. The last sentence of the first paragraph is a bit awkward; perhaps it is better to discuss lessening the perception that clinician's attitudes perpetuate the stigma associated with STI infections in lieu of 'decreasing STI-related stigma from clinicians'.

RESPONSE:

We agree that the statements were not clear. The first sentence references (#19) the “Five P’s” approach to obtaining a sexual history and these are the questions that are being referred to in the following sentence. The statement on Page 11, Lines 239-241 now read:

“An appropriate sexual history (e.g., the Five P’s: Partners, Practices, Prevention of pregnancy, Protection from STIs, and Past history of STIs) should be obtained by reproductive health clinicians.¹⁹”

Regarding STI-related stigma, we changed the statement on Pages 11-12, Lines 247-248 to now read:

“Improving the clinician-patient relationship will help to decrease STI-related stigma and the perceptions that inhibit quality care.”

17. The first sentence in the Conclusion is a bit of a run-on and reads awkwardly. The last sentence of this section is redundant and overly dramatic.

RESPONSE:

We agree and appreciate the reviewer’s comment. Regarding the first sentence in the Conclusion, the following statement on Page 12, Lines 264-267 now reads:

“Those who provide reproductive healthcare to women serve an important role in safeguarding their health and curbing the increasing incidence of STIs in the United States. This can be achieved by protecting them from STI-related morbidity with appropriate screening and treatment of STIs using all currently available options, including EPT.”

Regarding the conclusion, the authors are passionate about preventing the consequences of untreated STIs and improving the usage of EPT. We hope to convey this message appropriately through this Current Commentary.

18. Ref 12 discusses partner notification issues but is dated 2003; is there anything newer?

RESPONSE:

We attempted to provide the most up-to-date references for partner notification of STIs. While there are more recent publications on partner notification, they focus on HIV and MSM. Further research needs to be conducted on partner notification and STIs to improve the current literature.

19. Ref 23 is not peer-reviewed and the package inserts may be a better reference.

RESPONSE:

We understand and appreciate this concern. We reviewed several reliable sources for the information on adverse reactions for EPT medications. The package insert is very detailed and lengthy. We believed Medscape®, as a common medical reference, provided a neat and easy to access list of the adverse reactions.

20. Ref 25 was accessed in 2017; is it still there?

RESPONSE:

Yes, this reference is still active and maintained on the CDC's website. This reference and others have been retrieved during this revision and have been updated in the manuscript to reflect this.

21. Ref 29 is a very weak reference for a point that may be overly emphasized in the manuscript. Also, in the Senate debate, there should be references to where they got their data that could be used as original data.

RESPONSE:

Reference #31 was obtained from the University of Michigan Law School and Michigan Medicine's research into the legality on EPT. This reference displays the legislative debate surrounding EPT with several concerns voiced and the authorization of the Nebraskan bill. The debate does not provide additional references.

Daniel Mosier

From: Jamison, Cornelius [REDACTED]
Sent: Wednesday, November 21, 2018 1:59 PM
To: Daniel Mosier
Subject: Re: Manuscript Revisions ONG-18-1849R1
Attachments: 18-1849R1 ms (11-20-18v2)CJ_11-21-18.docx

Daniel Mosier,

Good afternoon, hope all is well. We have revised the manuscript (attached).

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
[Yes, we agree with the edits. Thank you.](#)
2. LINE 1: Do you agree with the edited title?
[Yes.](#)
3. LINE 51: Please be sure this is stated in the body of your paper. Statements and data that appear in the Abstract must also appear in the body text for consistency.
[We have edited this statement in the Introduction of the paper to be consistent with the Abstract. LINES 74-76 now read: "Reproductive-aged women \(ages 15-44\) accounted for 65% and 42% of the total reported *C. trachomatis* and *N. gonorrhoeae* cases, respectively, in 2017.¹"](#)
4. LINE 75: Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.
[These have been revised throughout the paper. Thank you.](#)

Please let me know if there is anything else you need us to complete. Thank you and Happy Thanksgiving!

Cornelius D. Jamison, MD, MSPH
VA Scholar
National Clinician Scholars Program
Institute for Health Policy and Innovation
University of Michigan

Clinical Lecturer
Department of Family Medicine
University of Michigan

From: Daniel Mosier <dmosier@greenjournal.org>
Sent: Tuesday, November 20, 2018 11:09:10 AM
To: Jamison, Cornelius
Subject: Manuscript Revisions ONG-18-1849R1

External Email - Use Caution

Dear Dr. Jamison,

Thank you for submitting your revised manuscript. It has been reviewed by the editor, and there are a few issues that must be addressed before we can consider your manuscript further:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 1: Do you agree with the edited title?
3. LINE 51: Please be sure this is stated in the body of your paper. Statements and data that appear in the Abstract must also appear in the body text for consistency.
4. LINE 75: Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Tuesday, November 27th**.

Sincerely,
-Daniel Mosier

Daniel Mosier

Editorial Assistant

Obstetrics & Gynecology

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Electronic Mail is not secure, may not be read every day, and should not be used for urgent or sensitive issues

From: [REDACTED]
To: [Stephanie Casway](#)
Subject: RE: O&G Figure Revision: 18-1849
Date: Wednesday, November 28, 2018 2:55:39 PM

Stephanie Casway,

Good afternoon, hope all is well. Thank you for the edits to the text in the figure.

In response to AQ1: Please keep the 'DOB: 01/01/2018' in the figure, as this is the generic DOB that should be added to all expedited partner therapy prescriptions in the state of Michigan.

We agree the remaining redactions. Thank you for all your help.

-Cornelius

From: Stephanie Casway <SCasway@greenjournal.org>
Sent: Tuesday, November 27, 2018 8:15 AM
To: Jamison, Cornelius [REDACTED]
Subject: O&G Figure Revision: 18-1849

External Email - Use Caution

Good Morning Dr. Jamison,

Your figure has been edited, and PDFs of the figure and legend are attached for your review. Please review the figure and legend CAREFULLY for any mistakes. In addition, please see our query below.

AQ1: Note that we did redact some of the text in the figure for privacy. If this is a concern, please let me know.

PLEASE NOTE: Any changes to the figures must be made now. Changes made at later stages are expensive and time-consuming and may result in the delay of your article's publication.

To avoid a delay, I would be grateful to receive a reply no later than Thursday, 11/29. Thank you for your help.

Best wishes,

Stephanie Casway, MA
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