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A.R.E. is employed by the American Board of Family Medicine. The remaining authors report no conflict of interest.

REFERENCES

1. Hollander MAG, Kelley D, Krans EE, et al. Medical specialty of buprenorphine prescribers for pregnant women with opioid use disorder. Am J Obstet Gynecol 2019;220:502–3.
2. Andrilla CH, Moore TE, Patterson DG, Larson EH. Geographic distribution of providers with a DEA waiver to prescribe buprenorphine for the treatment of opioid use disorder: a 5-year update. J Rural Health 2019;35:108–12.
3. Fordyce MA, Chen FM, Doescher MP, Hart LG. 2005 physician supply and distribution in rural areas of the United States. Final Report. Available at: http://depts.washington.edu/uwrhrc/uploads/RHRC%20FR116%20Fordyce.pdf. Accessed July 22, 2019.
4. Andrilla CH, Moore TE, Patterson DG. Overcoming barriers to prescribing buprenorphine for the treatment of opioid use disorder: recommendations from rural physicians. J Rural Health 2019;35:113–21.

 https://doi.org/10.1016/j.ajog.2019.07.005

REPLY

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We thank Eden et al for their letter regarding an oversimplification of the medical specialties categorized as primary care in our analysis. We agree that family medicine physicians, certified nurse midwives, and advanced practice providers are important providers of maternity care services, especially in rural settings, and play a critical role closing both the maternity and substance use treatment gap for pregnant and postpartum women.

The proportion of family medicine providers providing maternity care has declined steadily over the past decade, and we were unable to account for the provision of maternity care services beyond provider specialty in our analysis.[1,2] Because of the limitations inherent in our claims dataset, we choose to categorize family medicine providers as primary care providers.

Certified nurse midwives and other advanced practice providers (eg, nurse practitioners) are also important providers of both maternity care and substance use treatment services, including opioid pharmacotherapy. However, nurse practitioners and physician assistants have only been able to prescribe buprenorphine through the Comprehensive Addiction and Recovery Act since early 2017, and our analysis was limited to data from 2013−2016.[3] Thus, we were unable to include the important contribution from advance practice providers in our analysis.

Given that many pregnant women with opioid use disorder continue to lack access to evidence-based medication-assisted treatment, future research is needed to further understand the gaps in the substance use treatment provider workforce including the type, frequency, and quality of clinical care services beyond pharmacotherapy provided by prescribing providers. ■

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REFERENCES

1. Tong ST, Makaroff LA, Xierali IM, et al. Proportion of family physicians providing maternity care continues to decline. J Am Board Fam Med 2012;25:270–1.
2. Barreto T, Peterson LE, Petterson S, Bazemore AW. Family physicians practicing high-volume obstetric care have recently dropped by one-half. Am Fam Physician 2017;95:762.
3. Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver. Available at: https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/qualify-np-pa-waivers. Accessed June 5, 2019.

 https://doi.org/10.1016/j.ajog.2019.07.006

Should we absolutely reject the hypothesis that epithelium-based *Candida* biofilms contribute to the pathogenesis of human vulvovaginal candidiasis?

Check for updates

TO THE EDITORS: We read the article by Swidsinski et al[1] with great interest. The authors used fluorescent in situ hybridization of human vaginal tissue biopsies to demonstrate the absence of *Candida* biofilms in patients with vulvovaginal candidiasis (VVC). This is a very important finding because it might reset the treatment target for recurrent VVC (RVVC) from biotic biofilms to invasive fungi.

However; from the microbiologic aspect, it is reasonable to assume the involvement of *Candida* biofilms in VVC and their resistance to antifungals. Although most clinical isolates