Although we recognize that this study was intended to distinguish between intramuscular options for agitation, we would have appreciated more information on this hospital's efforts to reduce agitation without resorting to coercive measures.

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In reply:

Zeller et al[1] discuss their concern with the use of adequate sedation as "the primary goal of agitation treatment." We strongly believe that adequate sedation is necessary for patient and provider safety and to ensure a comprehensive patient evaluation. Adequate sedation, contrary to Zeller's comment, is *not* the same as oversedation. We at no point encouraged "heavy sedation to the point at which a patient is unarousable." As iterated multiple times, we observed a clinical protocol adopted by our emergency department (ED); the indication for sedation and the desired level of sedation were at the discretion of the treating physicians. We would also like to point out the definition of our primary outcome: an Altered Mental Status Score of 0 or lower. A score of 0 indicates someone who responds readily to his or her name in a normal tone, has normal speech, has a normal facial expression, and has no ptosis. This definition is certainly not that of an oversedated patient. Although many patients did achieve a deeper level of sedation, this was a therapeutic consequence of agitation treatments at these standard doses.

It is inaccurate to suggest that "the study authors favored midazolam." Our data demonstrated that midazolam was superior to haloperidol and ziprasidone but not olanzapine in regard to our primary outcome. Reporting conclusions based on an a priori primary outcome is a fundamental tenet of research design. We went on to present secondary outcome data for all medications at each point to allow the reader to consider what treatment would be ideal for his or her clinical practice; for some, that may be olanzapine or ziprasidone if they prefer antipsychotics, or perhaps even haloperidol if time to sedation is not an important factor.

Zeller et al focused primarily on the agitated psychiatric patient. However, in common with our study cohort, agitation observed in ED patients is usually a result of intoxication rather than acute psychiatric illness.[2-4] If the physician knows with certainty that the patient's agitation is due to psychiatric illness, perhaps an antipsychotic agent *is* the best choice. Unfortunately, more often, the emergency physician does not have the luxury of knowing the cause of agitation at the onset of the encounter. We believe that viewing agitation in the ED as an undifferentiated process is critical. As such, we sought to identify the safest and most effective treatment for the patient whose diagnosis is not known, representing a more realistic ED practice.

We have the utmost respect for our patient population, and communicating with them to attempt to de-escalate is fundamental to our clinical practice. However, the purpose of this study was to describe the effects of various medications once the provider had determined that parenteral sedation was indicated. This encompasses a patient population notably different from those who respond to nonpharmacologic methods or who are willing to receive oral medications. It seems Zeller et al are envisioning a group of agitated patients vastly different from those included in our work.

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Why a Pelvic Exam is Needed to Diagnose Cervicitis and Pelvic Inflammatory Disease

To the Editor:

We respectfully disagree with the conclusions by Farrukh et al[1] that the pelvic examination may not be of added benefit in the evaluation of young female patients with suspected cervicitis or pelvic inflammatory disease. First, both cervicitis and pelvic inflammatory disease are clinical diagnoses that cannot be made without a pelvic examination. In accordance with the 2015 Centers for Disease Control and Prevention (CDC) sexually transmitted infection treatment guidelines, cervicitis is characterized by one or both of these major diagnostic signs: the presence of visible purulent or mucopurulent endocervical exudate or easily induced sustained endocervical bleeding. Pelvic inflammatory disease is a clinical diagnosis based on a history of pelvic or lower abdominal pain plus cervical, uterine, or adnexal tenderness on examination. The specificity of the diagnosis of pelvic inflammatory disease is enhanced by the clinical findings of abnormal cervical mucopurulent discharge or cervical friability or the presence of many WBCs in saline solution microscopy of vaginal fluid, further underscoring the importance of the examination. The CDC states that the absence of WBCs on a saline solution wet mount suggests that pelvic inflammatory disease is unlikely and other diagnoses to explain the clinical presentation should be considered.[2]

For a young female patient presenting with complaints suggestive of cervicitis or pelvic inflammatory disease, the only way to diagnose these clinical entities is by performing a pelvic examination to determine whether the clinical criteria are present. The correct diagnosis will guide treatment because pelvic inflammatory disease is treated with antibiotics for 2 weeks rather than with single-dose therapy. The diagnosis of a sexually transmitted infection is not needed to meet the clinical criteria for pelvic inflammatory disease or cervicitis, and organisms other than *Neisseria gonorrhoeae, Chlamydia trachomatis,* and *Trichomonas vaginalis* have been associated with both diagnoses. Simply testing for these sexually transmitted infections in women who present with lower abdominal or pelvic pain, as this article suggests, may fail to diagnose pelvic inflammatory disease and places young female patients at increased risk of incurring complications. Furthermore, performing a pelvic examination for women with genitourinary complaints is necessary to diagnose causes other than cervicitis or pelvic inflammatory disease, including nonsexually transmitted vaginitis, genital herpes simplex, and foreign body.

Twice the authors state that the use of the pelvic examination for asymptomatic women has been questioned by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the CDC. Although this may hold true for asymptomatic patients, all patients in this study were symptomatic, rendering these statements irrelevant. The American College of Obstetricians and Gynecologists clearly recommends that a pelvic examination be performed for women with symptoms including vaginal discharge, pelvic pain, and urinary issues.[3] The American Academy of Pediatrics specifically states that a pelvic examination should be performed for young female patients with lower abdominal pain and persistent vaginal discharge, exactly the population represented in this study.[4] Thus, failing to perform a pelvic examination for symptomatic women, as this article suggests, would be a clear departure from the recommendations of these professional associations.

In summary, cervicitis and pelvic inflammatory disease are clinical diagnoses requiring a pelvic examination. Neglecting to conduct one for a symptomatic young