Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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This study would be more convincing if the authors provided a complete sensitivity analysis, including only the patients tested for SARS-CoV-2 in both the groups to the readership.

With the present results, the association between SARS-CoV-2 and preeclampsia could be overestimated owing to the asymptomatic pregnant population in the control group.

David Desseauve, MD, MPH, PhD
Obstetric Research Lab
Department Woman-Mother-Child
Lausanne University Hospital and University of Lausanne
Lausanne, Switzerland
Department of Obstetrics and Gynecology
Centre Hospitalier Universitaire Vaudois
1011 Lausanne, Switzerland
david.desseauve@chuv.ch

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The link between COVID-19 and preeclampsia

We thank the authors for their interest in our work.1,2 Boujenaha3 suggests that the association between COVID-19 and preeclampsia1 may be because of selection bias, as the nondiagnosed group included women without a negative test (Desseauve et al4 make the same point); we acknowledge that this group may have included a small number of unidentified, asymptomatic, and infected women. However, this is not a strong source of bias, because including infected women in the reference group would dilute, rather than strengthen, the observed association. Secondly, although it is possible that preeclamptic women admitted to the hospital were more likely to be diagnosed with COVID-19, the study design2 avoided such systematic bias by selecting 2 women immediately after a diagnosed woman at the same level of care, as the reference group. Thirdly, the study ended in February 2021 when vaccine use in pregnancy was still uncommon; the case numbers here would be largely unaffected. Finally, adjustment by study site as a covariate and using mixed-effects models with random slopes by site were conducted in the study, and the results were very similar (Table 2 in the original report).

We have now undertaken further analyses that are restricted to undiagnosed women who had a negative polymerase chain reaction or antibody test result, reducing the total sample size to 1359 women. The association between COVID-19 diagnosis and preeclampsia (compared with Table 2 in the original report) had a similar but slightly reduced risk ratio (RR) of 1.71 (95% confidence interval [CI], 1.14–2.56) in the unadjusted and 1.52 (95% CI, 1.01–2.31) in the full model (adjusted for maternal age, previous parity, tobacco use during pregnancy, overweight status, and the history of diabetes, cardiac disease, hypertension, kidney disease, or adverse pregnancy outcomes). The associations with hypertensive disease in pregnancy and gestational hypertension (GH) (previously reported in Table 4) were similar, with a slightly increased RR for GH. The RRs for hypertensive disease in pregnancy and GH were 1.61 (95% CI, 1.21–2.13) and 1.80 (1.21–2.68), respectively, in the unadjusted model; and 1.47 (95% CI, 1.10–1.95) and 1.66 (95% CI, 1.11–2.47), respectively, in the adjusted model.

We initiated a pragmatic, observational study within routine clinical care just a few days after the World Health Organization declared COVID-19 a global pandemic5 and long before universal testing became available. By carefully selecting women diagnosed with COVID-19 and a reference group, we obtained vitally important data, quickly. Strict quality control measures were implemented to ensure that the enrolment of women who were not diagnosed was unbiased; the data have been explored for possible selection bias using several strategies. The results remain largely unchanged, suggesting that the association between COVID-19 and preeclampsia is not because of confounding by common risk factors.

Aris T. Papageorghiou, MD
Fetal Medicine Unit
Department of Obstetrics and Gynaecology
Nuffield Department of Women’s & Reproductive Health
University of Oxford
Women’s Centre
John Radcliffe Hospital
Headington
Oxford OX3 9DU, United Kingdom
Oxford Maternal and Perinatal Health Institute
Green Templeton College

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TO THE EDITORS: Bougie et al1 have recently published an article regarding a population-based cohort study of patients who underwent surgical management for endometriosis in Ontario. The surgical interventions were classified as diagnostic laparoscopy, minor conservative surgery, major conservative surgery, and hysterectomy. One of the conclusions of the study was that 1 in 5 patients who underwent major conservative surgery required additional surgeries for endometriosis. Despite the relevance of the information provided in the study, some important issues need to be discussed.

First, the authors did not mention the percentage of patients who had deep endometriosis (DE). DE is the most severe type of endometriosis, affecting the bowel in up to 25% of cases. It is also frequently associated with dyspareunia, infertility, dysmenorrhea, noncyclic pelvic pain, and a reduced quality of life.2,3 The true prevalence of DE is unknown, because definitive diagnosis requires surgical visualization and the estimates vary widely among population samples and diagnostic approaches.4 Thus, the authors’ descriptions of the prevalence of DE in their samples would be important. When more definitive epidemiologic and clinical data are available, we would be better equipped to counsel patients regarding the management of endometriosis, depending on the population with this pathology. Why not include the management of this condition in major surgery? Would surgical recurrence rates be different in this group of patients? Recurrence is variable and depends on several factors such as severity, endometrioma, and intestinal involvement.5 Thus, the authors should have provided this important information to advice patients during preoperative counseling on the fertility outcomes, recurrence of symptoms, and the need for reoperation. Finally, laparoscopy is the gold standard procedure among surgical approaches in patients with endometriosis.6 The laparoscopic approach presents many advantages over open surgery, including reduced trauma, stress, postoperative adhesions, hernia, hospital stay, and a shorter recovery time. It would be important for the broad readership of the journal if the authors compared the final results between laparoscopy and laparotomy.

Long-term follow-up after endometriosis surgery: what about deep endometriosis?

University of Oxford
Oxford, United Kingdom
St George’s University Hospitals National Health Services Foundation Trust
London, United Kingdom
aris.papageorghiou@wrh.ox.ac.uk

Robert B. Gunier, PhD
Centre for Environmental Research and Community health
School of Public Health
University of California
Berkeley, CA

José Villar, MD
Nuffield Department of Women’s & Reproductive Health
University of Oxford
Oxford, United Kingdom

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