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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. ■

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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. ■

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



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 advise 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. ■

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