proportion under the fixed and random effects model. The method used by Mr Martinez-Portilla in an attempt to replicate our results was based on adding an arbitrary continuity correction factor (0.5) to the number of observed COVID-19 cases in each study that has zero cases of COVID-19. However, this fixed correction method has been shown by Sweeting et al[4] to have the undesirable effect of biasing study estimates toward no difference and artificially inflating the weight of each such zero study when the sample size is large. Here are 2 examples: using the arcsine square root transformation used in our study, the Ferazzi study (n=42; k=3) and the London study (n=48; k=0) have similar relative weights—4.41% and 5.03%, respectively (Figure 3).[1] In contrast, the 0.5 continuity correction factor method proposed results in 1.3% and 10.5%, respectively, which is counterintuitive and creates obvious bias. In another example using the arcsine square root transformation, the Yan study (n=86; k=0) has a weight of 8.93%, whereas the Knight study (n=244; k=12), which is the largest study in the meta-analysis, has a weight of 25.2% (Figure 3).[1] Moreover, the 0.5 continuity correction factor method results in a relative weight of 33.1% for the smaller Yan (zero) study and only 11.0% relative weight for the larger Knight study. Thus, using the 0.5 correction as proposed by Mr Martinez-Portilla is simply wrong and clearly inflates the relative weights of the zero studies, resulting in an underestimation of the pooled COVID-19 neonatal NP positivity proportion. In a recent Centers for Disease Control and Prevention report (November 2, 2020) representing the largest longitudinal data to date on pregnant women diagnosed as having COVID-19 from the Surveillance for Emerging Threats to Mothers and Babies Network (https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e2.htm), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection was found in 16 of 610 cases (2.6%) among neonates known to have been tested for SARS-CoV-2, which is very similar to the pooled estimates reported in our study (3.2%). ■

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The importance of shared decision making and patient preferences in uterine fibroid treatment outcomes research

Check for updates

TO THE EDITORS: We appreciated Tran et al's[1] call for the development of a core set of outcomes to be used for uterine fibroid treatment trials. Although we commend the authors' emphasis on the importance of incorporating outcomes that are important to patients into the development of the fibroid outcome measures, we would like to highlight that individual-level patient preferences should also be supported when deciding on treatment courses.

The authors note that although the available treatment options for uterine fibroids have widely expanded to encompass a variety of treatments, the ability to compare the effectiveness of these treatments is hindered by the heterogeneity of uterine fibroid outcome measures.[1] The lack of comparability requires that the benefits and harms of each treatment be considered individually, increasing the importance of considering an individual's values and preferences when deciding treatment courses.[2] This can be accomplished through the use of shared decision making, which, in addition to informing patients of treatment options and discussing the potential harms and benefits of

those options, includes a discussion of the patient's individual values and preferences and supports the choice of an option that best aligns with those preferences.[3] This is especially important, given the varying presentations of fibroids and the degrees of symptom severity and impact on quality of life that they cause. We are concerned that although the authors discussed the development of new fibroid treatment interventions and patients' desires to consider alternatives to a hysterectomy when given the option, there was no discussion in "The Patient Perspective" section about the importance of using shared decision making to incorporate patient preferences.

Developing and utilizing a core set of outcome measures that includes the incorporation of patient preferences into uterine fibroid treatment choices will generate comparative evidence of the effectiveness of treatments and their effects on patient preferences. In return, patients will be able to access greater comparative data to better determine which treatment aligns most directly with their preferences. Thus, shared decision making, including the use of high-quality decision aids, to support patients in choosing preference-based treatment options and using preference-based criteria to measure outcomes in clinical trials are inextricably linked and vitally important. Developing an evidence base in the implementation of decision aids, in addition to developing core outcome measures, is also imperative for improving fibroid treatment outcomes. ■

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Authors' response to letter to the editor: the role of core outcomes in shared decision-making for uterine fibroid treatment

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TO THE EDITORS: In response to our call to action[1] that made the case for developing a core outcome set (COS) for uterine fibroids, Ms Engel and Dr Foster highlight the importance of incorporating individual-level patient preferences in a shared decision-making process when deciding on fibroid treatment. We wholeheartedly agree and would like to emphasize that the ultimate goal of COS development is to improve the evidence available for decision-making, including at the point of care.

When determined collaboratively by a multistakeholder group, a core set should ideally contain outcomes meaningful to the quality of life and functioning of patients. Therefore, consistent use and reporting of a COS by researchers can feed into the development of high-quality decision aids. It is important to note that implementing a COS does not preclude individual values; rather, it lays the groundwork for effective evidence-based decision-making upon which individual preferences can be built. In other words, although a COS helps to address substantial gaps in knowledge about clinical effectiveness, conversations between the patient and provider are essential to develop a treatment plan that aligns with individual priorities. This is particularly relevant in the case of uterine fibroids, because clinical presentation and treatment preference can vary greatly among patients.

We appreciate Engel and Foster's letter because it illustrates the importance of engaging patients in decisions about their own care and in improving the evidence available to inform those decisions. ■

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