In addition, in Figure 1, the data for the time between diagnosis and the CMR image (78 days vs 67 days) and troponin level (17.8 pg/mL vs 16.7 pg/mL) were incorrectly reported, leading to an inconsistency with Figure 3, which did not change. Also, the legend for Figure 1 did not indicate that the representative images are from 2 different patients in the cohort.

We discovered a few other errors. The initial calculations were based on an early version of the data set that included only 54 instead of 57 patients in the risk factor–matched cohort. We have recalculated all percentages against the correct final group of 57 risk factor–matched controls and updated Figure 2 accordingly. Also, some counts in the risk factor–matched control groups were erroneously based on clinical assignments rather than standard deviation–based cutoffs. We have recounted all data using the research cutoff values. Consequently, the counts in the risk factor–matched group are now different than originally presented.

During the correction and recalculation process, we were able to provide some missing data from the original CMR scans as well as correct some data entry errors. Consequently, some minor changes are needed in the area under the receiver operating characteristic curve (AUC) values in Table 2. However, only the comparison for left ventricular mass index between those with COVID-19 and healthy controls changed from a significant to a nonsignificant association.

In addition, there may have been a lack of clarity on how the counts for T1 and T2 were obtained and which cutoff values were used. We clarify in the Methods section that the cutoff values for abnormal native T1 and T2 values were based on previously derived sequence-specific standard deviations above the respective means in a healthy population and not based on the current healthy control group, as this was a selected sample to match for age and sex. To avoid confusion with cutoff values determined from the current data set, we removed these AUC-based cutoff values from Table 2.

We are pleased to confirm that reanalysis of the data has not led to a change in the main conclusions of the study. As we originally reported, compared with healthy controls and risk factor–matched controls, patients recently recovered from COVID-19 had lower left ventricular ejection fraction, higher left ventricle volume, and elevated values of T1 and T2. However, the corrected findings no longer show higher left ventricular mass in these patients. We confirm that there are no other errors. The errors and corrections affect the Abstract, Methods and Results sections, Tables, and Figures, and the article has been corrected online.7 We most sincerely apologize to the readers and editors of JAMA Cardiology for any confusion, and we appreciate the opportunity to correct the original publication.

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Letters

CORRECTION

Error in Organization Name for Reported Recommendations: In the Invited Commentary titled “Transcatheter Mitral Valve-in-Valve—A Plausible Option but Questions Remain,” published online July 29, 2020, the wrong organization was listed regarding class IIa recommendations. The American College of Cardiology/American Heart Association, rather than the New York Heart Association, should have been cited. The article has been corrected online.

Errors in Figure: In the Research Letter titled, “High-Sensitivity Cardiac Troponin Concentrations at Presentation in Patients With ST-Segment Elevation Myocardial Infarction,” published online August 12, 2020, there were errors in the Figure. In all 4 panels, the y-axes labels should be Probability instead of Hours, and the y-axes scales should be removed. The panel labels should be <2 h of Symptoms, peak troponin; ≥2 h of Symptoms, peak troponin; <2 h of Symptoms, presentation troponin; and ≥2 h of Symptoms, presentation troponin for panels A, B, C, and D, respectively. This article was corrected online.

Errors in Statistical Numbers and Data: In the Original Investigation, “Outcomes of Cardiovascular Magnetic Resonance Imaging in Patients Recently Recovered From Coronavirus Disease 2019,” published online July 27, 2020, there were errors in statistical tests and data, including the use of inaccurate metrics (eg, mean vs median) for the values in Table 1, inconsistencies between the reported data in the title and legend of Figure 1, and the data points provided for the patients with coronavirus disease 2019 (COVID-19) in Figure 2. The authors were able to provide some missing data from the original cardiovascular magnetic resonance images and corrected some data entry errors, resulting in some minor changes in the area under the receiver operating characteristic curve values in Table 2 and a change in the comparison of left ventricular mass index between those with COVID-19 and healthy controls from a significant to nonsignificant association. In addition, the authors have clarified in the Methods section that the cutoff values for abnormal native T1 and T2 values were based on previous studies, not on the current healthy control group. The errors and corrections affect the Abstract, Methods and Results sections, Tables, and Figures 1 and 2. The authors explain these corrections in a Letter to the Editor, and the article has been corrected online.

Conflict of Interest Disclosures: None reported.

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Editor’s Note
Explanation for the Corrections for the Study of Cardiovascular Magnetic Resonance Imaging in Patients Recently Recovered From Coronavirus Disease 2019

In response to appropriate questions regarding the presentation of data by Puntmann et al,1 we proceeded with a repeated statistical review and requested reanalysis and revision by the original investigators. We now publish a letter of correction,2 a correction notice,3 and the corrected article.4 A rigorous review has confirmed that the findings as originally reported remain valid.

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