only finding in relation to diastolic RV physiology and should not be seen in isolation. We strongly believe there is a need to address possible relations between age at repair and other contributing factors to subsequent diastolic physiology in larger studies. Unfortunately, so far, the interest for studies of early repair and diastolic RV function have been lacking from several large centers.

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REPLY

We appreciate the interest expressed by someone as experienced in the field of heart diseases and pregnancy as Dr. Oakley (J Am Coll Cardiol 1999;33:287) concerning our analysis of pulmonary vascular disease (PVD) in pregnant women (1).

We recognized well in advance and clearly stated the limitations of our analysis of PVD in pregnancy (1). There is plenty of room for disagreement, because local experiences, successes and failures with pregnant women who have PVD may differ widely. It is left to the readers to extrapolate the findings of our study in accordance with their own institutional practice. The statistical analysis showed that cesarean section was a significant risk factor in secondary pulmonary vascular hypertension, but not in the group of patients with Eisenmenger's syndrome. When cases of Eisenmenger's syndrome and primary and secondary pulmonary vascular hypertension were pooled together, operative delivery emerged as a strong risk in the univariate analysis, but as a weaker one in the multivariate analysis (1). We cited the editorial of Dr. Oakley, who wrote ". . . fetal growth will eventually fail and the fetus has to be delivered. The safest route is by cesarean section under general anaesthesia with generous hydration, avoidance of systemic vasodilation agents, and prompt replacement of blood loss" (2). With regard to cyanosis in women with low pulmonary pressure, again a position in favor of cesarean section is taken by Dr. Oakley (2). Thus, the citation, as stated in the editorial, did not misrepresent the author's views. Our conclusion was that cesarean section should be considered a risk (co)factor in parturients with PVD, and the editorial was cited to express the difference with Oakley's opinion on the "safest" route for delivery (1,2).

The link(s) between a single aspect of management and outcome, except for the late diagnosis and late hospital admission (1), are missing and nothing seems to be "safe" in pregnant women with PVD. Of course, it is possible that patients delivered operatively may have represented more severe cases (less so for cyanosis but more so for severity of PVD), or that an individual patient would be much better managed by some other techniques or strategies than those actually used. The retrospective overview showed that timing and mode of delivery could not differentiate between maternal survival and death in Eisenmenger's syndrome (1). We agree that conclusions drawn from an overview of the published data can be misleading. False conclusions may be drawn from case reports, prospective randomized studies or editorials. If we made the same mistake as made by Gleicher et al. (3) in their classic paper on Eisenmenger's syndrome and pregnancy in 1979, so be it, we take it as a compliment. Dr. Oakley ends by questioning our personal experiences in these matters. Clinical experiences are never visible in the quotations.

In the meantime, as has been the case over the past 50 years (1,3), pregnant women with Eisenmenger's syndrome continue to survive or die independently of vaginal or operative delivery, general or regional anesthesia and, unfortunately, despite the availability of new pulmonary vasodilators (4–9). At the maternal mortality rate of 30% to 50%, the "safest" route of management of pregnant women with Eisenmenger's syndrome still remains to be defined.

[Dr. Weiss's reply to Dr. Oakley was received February 26, 1999. We regret the delay in publishing this reply.]

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