intake cases, these gestational ages were thought to be reasonable to account for the increased early and mid-pregnancy loss rates for patients with gestational hypertension. In the initial pregnancy group 4 of the 15 patients did not reach 37 weeks. For those cases the data from their last study before delivery were included with the week-37 data. On the other hand, some patients were delivered at 40 to 41 weeks of gestation because the blood pressure was reasonably controlled. The data on the repeated-pregnancy cases were handled in a similar manner. When the data are divided into data on 2 smaller groups according to whether the repeated-pregnancy birth weights increased or decreased (see Table III of article), it is clear, as Dr Laros pointed out, that the gain in birth weight is related to gestational age.

As for the question on the value of rapid ejection time in relation to blood pressure, it can be said that the rapid ejection time is easily obtained with this noninvasive monitoring system and can be recorded continuously for many hours at a time. The test is conducted by licensed vocational nurses, and the data are reliable and reproducible. The main advantage of using the dMAP (determinants of the magnitude of MAP) system over a simple cuff manometer, in my opinion, is that it provides information on the predominant physiologic cause of the blood pressure elevation in a given case. Is it volume? Is it vasoconstriction, or a combination of both? Although clinical application of dMAP data is still empiric, a larger structured multicenter study is being planned.

As for the pulse wave arrival time, it is a systolic time interval that correlates with the status of myocardial function or dysfunction. In patients with heart failure or myocardial dysfunction, the pulse wave arrival time prolongs to beyond 200 ms, indicating a sluggish response by the myocardium; that is, the pulse wave arrival time measures the time between the R wave on the electrocardiogram and the onset of the peripheral pulse recorded at the fingertip. In the presence of hypertension or vasoconstriction, this interval shortens.

Regarding the question on fluid infusion, we do restrict the amount of fluid given to our hypertensive patients to about 50 to 80 mL/h. In hypovolemia the rapid ejection time shortens markedly and the pulse wave assumes the form of a rapid up-and-down shape with the notch reaching the bottom, which is well recognized as typical of this condition. In fact, analysis of the pulse waveform in conjunction with the rapid ejection time gives the most information regarding the condition of the arteries in relation to the circulating blood volume.

On the question regarding the patient given furosemide (see Fig 4 of article), she did not receive any other antihypertensive medication except nifedipine, which was given sublingually when she was initially hospitalized with severe hypertension. She was also given phe- nobarbital, a mild sedative. This patient was also found to have marked “white coat” hypertension. The blood pressure measurements were significantly lower at home or in our laboratory than in the clinic. For this reason a home monitoring system was developed that allows the patient to self-test once or twice a day. She then sends the data to our laboratory by facsimile message.

In the 2000-odd patients monitored to date, >10,000 records have been made. Observer differences among the various staff members have been negligible. To minimize the effect of spurious data, the microprocessor averages the data set for approximately 1 minute to calculate the dMAP data obtained during the initial sitting and standing positions. Finally, we have not tested or compared this system with the Doppler-based hemodynamic system.

---

**Correction**

In the article by Schneider et al, entitled “Cervicography screening for cervical cancer among 8460 women in a high-risk population” (Am J Obstet Gynecol 1999;180:290-8), in Table 1, on page 291, under the heading “Not referred for colposcopy,” the definition for “Atypical 1 (A1)” should have been: “A trivial lesion outside the transformation zone is visible, but colposcopy is not recommended because of the benign appearance or site of the lesion.” Also under the heading “Not referred for colposcopy,” the definition for “Atypical 2 (A2)” should have been: “A trivial lesion inside the transformation zone is visible, but colposcopy is not recommended because of the benign appearance or site of the lesion.” These categories of cervigram classification are consistent with the referral criteria used by National Testing Laboratories Worldwide between 1989 and December 1994. All of the data in the paper were collected in 1993 and 1994, corresponding to this time period. The definitions for Atypical 1 and 2 were reversed beginning January 1, 1995.