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Reply

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Reply:

(No conflicts of interest in this reply.)

Potential conflicts of interest in the original manuscript as outlined in the original manuscript)

Letter:

We appreciate the authors' letter which nicely articulates an important but often underappreciated fact; at very high levels, $p\text{CO}_2$ has a significant impact upon calculated base excess. Thus, in the presence of markedly elevated $p\text{CO}_2$ values, the traditional distinction between short term, clinically benign fetal respiratory acidemia and longer term, potentially important fetal metabolic acidemia cannot be made using base excess and pH alone. The elevations of $p\text{CO}_2$ commonly seen in adult medicine are generally such that this effect is clinically insignificant. However, when using blood gas analysis in an attempt to determine the presence, severity and duration of putative in-utero oxygen deprivation, this effect often becomes important. Our use of standard base excess calculations reflects current clinical capabilities in most laboratories; our results simply confirm in clinical terms the authors' mathematical observations. (1,2)

Various methods have been proposed to correct for this $p\text{CO}_2$ effect. In addition to the authors' previously published use of eucapnic pH, other investigators have distinguished the commonly performed blood base excess from extracellular fluid base excess and proposed the latter as a more accurate approach. All use mathematical models based on modifications of the Henderson-Hasselbalch and Van Slyke equations. (2-6) In our opinion, all of them are valid. Thus we do not disagree with the premise of these authors and will certainly consider their generous proposal for collaboration.

However, such collaboration would seem to us to be a very low priority for the following reasons. Even if one could perfectly correct calculation of base deficit

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