the previous model (areas under the curve [AUCs] were not statistically different).

These findings are intriguing and likely warrant further investigation, either with registry data or multicenter collaboratives. The reliability of the VGP designation in the NCDB data needs to be better understood. Importantly, the absence of VGP did not predict a completely indolent melanoma, as the risk of SLN metastases in this cohort was nearly 4%. We again appreciate the comments of Roncati and Piscioli and hope this commentary inspires additional study in the peer-reviewed literature on the utility of VGP in predicting SLN metastases in thin melanoma.

REFERENCE

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Reluctance to Operate on Pregnant Women

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The reluctance to operate on pregnant women is not new and is based on limited and flawed data.[1] We fear that the conclusions advanced in the recent publication by Fong and colleagues[2] may serve as unjustified support for such delay in surgery, exposing pregnant women to complications.

Our group recently reviewed the available literature on maternal and neonatal outcomes of nonobstetric surgery during pregnancy.[1] Indeed, the most feared complication of surgery in the third trimester of pregnancy is preterm delivery. However, data to support a cause and effect relationship of surgery and preterm delivery are nonexistent. Many studies, including the study by Fong and colleagues,[2] are confounded by the effects of the disease process itself. Pregnant women with an infectious or inflammatory intra-abdominal process would be expected to experience a higher rate of preterm delivery than pregnant women without such a process. Moreover, it is difficult to distinguish the physiologic and inflammatory effects of the disease process itself from the effects of surgery.

In the study by Fong and associates,[2] a comparison of the indication for cholecystectomy (ie symptomatic cholelithiasis, acute cholecystitis, gallstone pancreatitis, etc) between the groups should have been provided. It is possible that women with delayed surgery had a less acute or noninfectious process; an infectious and proinflammatory process (not the surgery) may have led to preterm delivery in the antepartum cholecystectomy group.

A recently published study evaluating pregnant women with acute biliary pancreatitis showed a lower rate of ERCP and cholecystectomy in pregnant women, as compared with nonpregnant women, and a higher risk of 30-day readmission for pregnant women.[3] This study exemplifies the potential dangers of delayed care resulting from the reluctance to appropriately treat pregnant women.

Finally, we are puzzled by the finding that eclampsia, a disease with a pathogenic basis on placental hypoperfusion and endothelial dysfunction, would be less common in women who have a gallbladder. This spurious observation highlights the inherent problems encountered when attempting to extract clinical information from administrative datasets, and casts doubt on the reliability of other conclusions in this study.

We applaud the authors on the large sample size of women undergoing a single type of abdominal surgery, but the study design limits the applicability of the results and cannot definitively answer the question of immediate vs delayed operation for women with such disease processes during pregnancy. In the absence of randomized data, and the knowledge that such a study is extremely unlikely, the decision to operate in pregnancy should continue to be individualized, with input from an experienced surgeon and an obstetrician or maternal-fetal medicine subspecialist.

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