nancies, this variable has not yet been addressed in patients with TTTS.[4]

Umar et al should be recognized for their thoughtful contributions to understanding this challenging problem of contemporary obstetrics. They must bear in mind that some clinical features of TTTS may interfere with determining valid rates of procedural complications in the various therapies they study. We shall continue to treat severe TTTS cases with laser but recommend that cervical assessment, and cerclage placement when indicated, be incorporated into the clinical care of patients with TTTS regardless of therapy, and that this issue be addressed in future TTTS studies.

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Reply

To the Editors: We thank De Lia and Carr for their interest in and appreciation of our work. We also acknowledge the contributions of these authors to the clinical treatment of twin-twin transfusion syndrome (TTTS).

The spontaneous abortion rates of 11% after laser therapy and 4% after single reduction amniocentesis quoted in our paper were based on reported clinical results. Specifically, our literature review[1] produced reports of 57 spontaneous abortions among 521 laser procedures for TTTS (as published in 5 papers) and 50 procedure-related deliveries among 1,157 amniocenteses for TTTS (as published in 16 papers). It is clear that these complications are related to clinical variables, likely a combined effect of the sequelae of TTTS (ie, polyhydramnios) and the clinical intervention. Although patient selection may be a factor, the greater spontaneous abortion rate after laser therapy compared with amniocentesis may relate to the markedly larger size of the fetoscope.[1] Cerclage procedures are unlikely to affect losses occurring as a result of puncturing the amnion membrane. However, improved methods may develop from studies of membrane healing after puncture.[2] Cerclage may primarily affect losses associated with polyhydramnios-mediated labor. In these cases, improved outcome may occur as a result of earlier diagnosis, treatment of TTTS, and, therefore, reduction of polyhydramnios, rather than cerclage alone. Nevertheless, the inclusion of cervical length evaluation both before and after amniotic fluid reduction and/or laser therapy is to be commended and may provide critical prognostic information. However, we advise caution in the implementation of cerclage procedures in the absence of a controlled study.

One purpose of our mathematic model was to simulate treatments and predict outcomes using select possible variables. Because the impact of cervical change and/or cerclage in patients with TTTS treatment is unknown and has generally not been reported, we were unable to incorporate this variable into our model. We look forward to additional factors and further results from De Lia and Carr to enhance our future models. Together, clinical trials, mathematic models, and basic research will aid us in understanding the pathophysiologic mechanisms and proposing treatments for patients with TTTS.

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The G-spot: Some missing pieces of the puzzle

To the Editors: The publication of Terence Hines' article, "The G-spot: A modern gynecologic myth,"[1] has created considerable controversy and, unfortunately, much misinformation about the existence of the "G-spot," the existence of female ejaculation, and the female prostate.

Hines asserts that the confusion over the G-spot and female ejaculation occurs because "the two are often considered together." Actually, the two should be considered together, along with the structure on which the G-spot is located—and this is the missing piece of the puzzle.

Regarding the anatomic structure, Huffman[2] did exquisitely rendered wax casts of the female urethra and the surrounding tissue, identifying up to 31 prostate-like glands, including the two near the urethral meatus identified by Skene in 1880, and described them as "homologous with the [male] prostate." O'Connell, et al[3] confirmed that the urethra is "surrounded by erectile tissue" except for the part embedded in the vaginal wall. This erectile body, running the length of the female urethra, can be easily accessed through the vaginal wall. Many women report that during sexual response they can locate a spot or area along the roof of the vagina that is

hypersensitive to touch, pressure, or vibration. This is the G-spot.

Regarding the fluid, evaluations so far have focused on proving that it is not urine, with most finding higher levels of prostatic acid phosphatase and glucose in female ejaculate and lower levels of these substances in urine. Zaviacic[4] and others have found prostate specific antigen—a substance that does not appear in either male or female urine—in female ejaculate.

Regarding morphology and embryology, it has long been established that the lower one fifth of the vagina and the entire female urethra, as well as the male prostate and prostatic urethra, and innervation of both, develop from the mesonephric tubule, and that both originate in the urogenital sinus.[5] The upper four fifths of the vagina, as well as the uterus, tubes, and ovaries, arise from the mullerian ducts. Because the original fetal template is female, the female must possess an embryonic prostatic structure for the male to have one.

Ultimately, researchers who have endeavored to illuminate the anatomy and function of the female prostate may thank Hines and the Journal for bringing this issue before the medical community. The article would have had more value, however, if it had been based on a complete review of the literature as well as on discussions with those participating in ongoing research.

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The G-spot: A modern gynecologic myth

To the Editors: As the two researchers who named the sensitive area felt through the anterior vaginal wall halfway between the back of the pubic bone and the cervix, along the course of the urethra, the "Gräfenberg spot," we felt we should respond to Terence M. Hines' poorly researched article "The G-spot: A modern gynecologic myth."[1]

Unfortunately the article is based on only 24 of the more than 250 peer-reviewed research publications concerning the Gräfenberg spot and female ejaculation. It also ignores the research concerned with the adaptive significance of this sensitive area.

Our purpose in conducting the original research published in peer-reviewed journals in the early 1980s[2,3] was to validate and find a scientific explanation for the reported experiences of many women, not to create new goals. These were women who did not fit into the monolithic clitoral-centric model of sexual response, that is, they reported vaginal sensitivity and orgasm from vaginal stimulation and in some cases an expulsion of fluid that was not urine from the urethra. By saying that the Gräfenberg spot is a myth, Hines has now contributed to denying women's sexual response and pleasurable experiences.

In our research, we first established that the Gräfenberg spot was a "sexologic" reality, that is, a concept that many women found useful to describe their personal experiences. The second research question concerned the underlying anatomic reality for this experience. Skene's glands, the paraurethral glands, which have often been called the "female prostate" throughout history, emerged as the anatomic basis for the experiences of these women (see Zaviačič,[4] 1999, more than 250 references).

Hines may want to review Whipple and Komisaruk[5] (1991) (52 references), and other studies published since that time. It is our hope that Hines and your readers will not do a disservice to the multitude of women who do enjoy stimulation of the area called the Gräfenberg spot or who expel a fluid from the urethra that is different from urine. We hope that physicians will listen to the reports of their patients, review the literature, and base their judgments on scientific data, not on a biased interpretation of less than 10% of the published literature.

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The G-spot

To the Editors: The Clinical Opinion paper "The G-spot: A modern gynecologic myth" by Terence M. Hines[1] suggested that the following brief comments on the female prostate and ejaculation would be relevant and of interest to the readers.