

## Reply

*To the Editors:* We read with interest the comments of Thylan. We agree that the possibility of an endometrioma should be included among the differential diagnoses of ovarian cysts in both premenopausal and postmenopausal women treated with tamoxifen, and indeed we found a case of a chocolate cyst among one of our patients. Furthermore, in a preliminary study we have recently reported that gonadotropin-releasing hormone agonist might be an appropriate treatment for tamoxifen-treated women with ovarian cysts.<sup>1</sup> It was demonstrated that gonadotropin-releasing hormone agonist caused regression of the ovarian cysts and enabled continuation with the adjuvant tamoxifen treatment. Because gonadotropin-releasing hormone agonist is one of the established treatments for endometriosis, this might be another piece of clinical evidence to suggest that some of these tamoxifen-induced cysts might be associated with endometriosis.

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## REFERENCE

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## Ultrasonographic observation of a female fetus' sexual behavior in utero

*To the Editors:* Fetal movement offers the opportunity for observing fetal behavior in utero. Parents, curious to know their child's sex, frequently request visualization of the fetal genitalia.

During second-trimester ultrasonographic examinations it is usual to see fetuses explore their body and their environment. They handle their own feet, head, genitalia, umbilical cord, and so on.

We recently observed a female fetus at 32 weeks' gestation touching the vulva with the fingers of the right hand. The caressing movements were centered primarily on the region of the clitoris. Movements stopped after 30 to 40 seconds and started again after a few minutes. Furthermore, these slight touches were repeated and were associated with short, rapid movements of pelvis and legs. After another break, in addition to this behavior, the fetus contracted the muscles of the trunk and limbs, and then clonicotonic movements of the whole body followed. Finally, she relaxed and rested.

We observed this behavior for about 20 minutes. The mother was an active and interested witness, conversing with observers about her child's experience.

Evidence of male fetuses' excitement reflex in utero, such as erection or "masturbation" movements,<sup>1</sup> has been previously reported.

The current observation seems to show not only that the excitement reflex can be evoked in female fetuses at the third trimester of gestation but also that the orgasmic reflex can be elicited during intrauterine life.

This would agree with the physiologic features of female sexuality: The female sexual response is separate from reproductive functions and doesn't need a full sexual maturity to be explicit.<sup>2, 3</sup>

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## Preterm delivery and bacterial vaginosis—Logistic regression analysis

*To the Editors:* I read with interest the article by Meis et al. (Meis PJ, Goldenberg RL, Mercer B, Moawad A, Das A, McNellis D, et al. The preterm prediction study: significance of vaginal infections. *Am J Obstet Gynecol* 1995; 173:1231-5). I have a question regarding the control of potential confounding variables. In the initial analysis the authors identified several factors that were associated with bacterial vaginosis in the study cohort: young age, black race, unmarried, low monthly income, and low education level. All these except marital status have been shown to be significant risk factors for prematurity. However, in the logistic regression analysis only race, parity, smoking, and bacterial vaginosis diagnosed at 28 weeks were included. I would ask the authors as to the procedure for selecting the variables included in the model (i.e., forward or backward stepwise regression) and why potentially important confounding variables such as age and socioeconomic status were not included.

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