compliance with the telephone diary (six women), or personal reasons (six women)."

This sentence refers to the 6 patients who had adverse events noted above, plus an additional 12 women who discontinued treatment because of non-treatment-related reasons. The total of 18 of 75 patients corresponds to 24%, but as clearly implied by the numbers in parentheses the majority of these cases were not due to "treatment-related effects of testosterone replacement."

In view of the emphasis given in the abstract and conclusions of Modelska and Cummings' article to the "adverse effects of testosterone replacement therapy," it appears that their misreading of our publication may have lead to an overly negative assessment of the safety profile of transdermal testosterone. In fact, the currently published literature on transdermal testosterone replacement therapy in women (including studies in human immunodeficiency virus-infected women[3,4]) shows that it has been very well tolerated by the great majority of patients who have used it, both locally and systemically.

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Reply

To the Editors: We appreciate that Shifren and Mazar have clarified the report of adverse events in the original article[1] and corrected the typographic error in units of the transdermal testosterone delivery rates in our review (Table I). The correct units were used in the body of our manuscript.

Although the short-term tolerability of testosterone appears to be reasonable,[1,2] the safety of long-term use still remains untested. Larger and longer trials are needed to assess the effects of chronic testosterone replacement on women's risk of heart disease, breast cancer, and other important clinical outcomes.

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The laborist: Do not repeat the mistakes of other medical systems

To the Editors: Weinstein[1] introduced a concept of a laborist, similar to a hospitalist, as a new form of practice for the obstetrician. The main reason for the laborist existence is to improve physician lifestyles and well-being. Similar to a hospitalist, the laborist will manage the labor while giving the private obstetrician the option to perform the delivery. Similar to working shifts in the emergency department, the laborist will have predictable hours and lifestyles and will avert all the aspects of an office practice. The concept of laborist or laborists had been in existence in many European and Middle Eastern countries. In Eastern Europe, for example, in Russia, Poland, and Germany, prenatal care is provided by office obstetricians and deliveries by a team of full-time hospitalists-laborists.[2] As someone who practiced obstetrics within the "laborist" system, I clearly recall its numerous faults: disruption of the continuity of care, patient fears to see a "stranger" during the culmination of pregnancy, lack of familiarity of the laborist with the patient's personality, beliefs, fears, etc. Many patients who may arrive in advanced stages of labor or in pain would like to see a familiar face rather than the physician "on shift."

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Reply

To the Editors: I appreciate Dr Petrikovsky taking time to read and comment on my article about the laborist. His leading statement is "not to make the mistakes of other medical systems." He tries to compare my proposal to

the practice of obstetrics in Eastern European and Middle Eastern countries. This is an unusual comparison of medical systems that I would equate to comparing apples to watermelons. I have been pleasantly surprised that, of all the articles I have written, including those on the HELLP (hemolysis, elevated liver enzymes, and low platelets) syndrome, I have received more positive feedback on the laborist concept than anything else I have published during the last 10 years. I would suggest that Dr Petrikovsky consider for adoption the 12 good rules (especially 5, 6, and 7) ascribed to Charles I who was King of England in the first half of the 17th century: (1) urge no healths, (2) profane no divine ordinances, (3) touch no state matters, (4) reveal no secrets, (5) pick no quarrels, (6) make no comparisons, (7) maintain no ill opinions, (8) keep no bad company, (9) encourage no vice, (10) make no long meals, (11) repeat no grievances, and (12) lay no wagers. I firmly believe that we would all be better health care providers with adoption of these rules in our daily lives.

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Gynecology knots

To the Editors: The article by Schubert et al[1] has impressed me very much; it is an excellent work about knots so essential in gynecology. The general principles were well explained. I would like to know how a knot slightly different from those covered in the article would do if it was to be evaluated.

To approximate the skin edges with nonabsorbent monofilament suture, I throw two nonidentical sliding loops. Then I place my index finger between the two loops to apply the desired tension and quickly release the second loop. Then a third loop is done. After these three loops are done, I change so that the suture that was throwing the loops becomes the straight one, and three more nonidentical loops are done to finish it. For the deep vascular pedicles, I agree with the authors when they say "the surgeon's knots are not ideal for the vascular pedicles." Using the retarded absorbable suture, I do the porky knot,[2,3] which is a double loop knot to start with. The analogies to this are two consecutive loops on a continuous running lock stitch or two consecutive nonidentical sliding loops around the pedicle. This knot has a very strong tightening capability and holds with this suture; now without hurry I throw one or two square loops and then a surgeon's knot to finish it. It does very well on my patients. I wonder how these knots would do in the experts' evaluation.

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Reply

To the Editors: We appreciate very much Escamilla's interest in our article and his suggestions as to two additional knots that have performed well for him. Although we have no personal experience with these knots, the first appears to be a modification of the so-called parallel sliding knot. The knot is reported to be as reliable as the nonidentical sliding knot.[1] We plan to do additional laboratory testing on parallel knots in the future.

As pointed out by Escamilla, the surgeon's knot seems to be a poor choice for deep vascular pedicles because it can be difficult to tighten sufficiently without breaking. If the "porky knot" is able to overcome this problem while maintaining the security of the surgeon's knot, clearly it will be a useful addition to the surgeon's armamentarium.

We believe that, whenever it is possible, flat knots such as the square and surgeon's knot be used because these are clearly the most stable of all knots when applied to various suture materials. However, at times these knots may be neither possible nor desirable, such as in the deep spaces of the pelvis or the vagina. Under these circumstances, other knots may be more useful. However, the surgeon must be aware that the stability of some knots may be influenced by the choice of suture material.

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