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Reply

To the Editors: We appreciate the interest in our study shown by O'Connor and Magos. We are grateful for the comments expressed by such a prominent investigator in this field. Certainly, the issue of small sample size is valid and care must be taken in drawing conclusions from our experience alone. However, our results differ from those of O'Connor and Magos in only two areas. First, we chose not to perform repeat ablations after an initial failure, unlike O'Connor and Magos¹ and O'Connor et al.² Second, our reoperation rate continued at the same rate beyond 3 years, whereas that of O'Connor and Magos¹ did not. We would like to address these issues further.

Our 34% hysterectomy rate represents the total reoperation rate over 5 years. Because of our concerns with the ablation procedure itself and the possibility of unrecognized gynecologic disease, we did not perform repeat ablations. Repeat ablations have a significantly lower success rate and a higher complication rate than the initial procedure does.^{1,2} Our reoperation rate is not higher than that reported in other studies. Sculpher et al.³ reported a 23% reoperation rate (hysterectomy, repeat ablation, or both) during the first 2 years of follow-up after transcervical endometrial resection in the Bristol trial. O'Connor and Magos¹ reported a 20% reoperation rate at 3 years in their long-term study. Most recently, O'Connor et al.² have reported a 22% reoperation rate within 3 years after endometrial resection in their own randomized trial of endometrial resection versus hysterectomy. Our reoperation rate at 3 years was 19.5%. Thus it seems unlikely that either operator experience or operative technique is a major factor accounting for the difference in long-term outcome between our patients and those of O'Connor and Magos.¹ Of course, differences in our respective patient populations could account for the reoperation rate continuing to increase beyond 3 years in our series, whereas it did not in the long-term series of O'Connor and Magos.¹ Unfortunately, neither our patients nor theirs had preoperative measurement of menstrual blood loss, so it is difficult to assess whether these are really identical populations under study. Indeed, there is evidence that they are not. Although 11 of the 14 women undergoing hysterectomy

in our series were found to have gynecologic pathologic features, only 21 of 42 in the series of O'Connor and Magos¹ demonstrated similar pelvic disease. As reported in both our article and their own randomized series, the presence of underlying pelvic pathologic features may negatively impact the outcome of endometrial ablation. Finally, criteria for success are subjective and postoperative satisfaction may be more related to preoperative expectations (patient or physician) than to objective results.

Again, we appreciate the comments of O'Connor and Magos. Our small series is meant to stimulate further study in the area of menorrhagia and the role of endometrial ablation in its treatment. Objective methods to ensure proper patient selection and to evaluate long-term outcome are clearly needed.

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Other ways of saying cesarean section

To the Editors: Cesarean section has a long and interesting history. There are several explanations as to the origin of the operation.¹ I am interested in how the name of the operation is spelled in languages other than English. Following are 16 examples: Czech, *cisarsky rez*; Dutch, *keizersnede*; Finnish, *keisarileikkaus*; French, *cesarienne*; German, *Kaiserschnitt*; Greek, *kesarihi tomi*; Hebrew, *metuah keseri*; Hungarian, *csaszar metszes*; Icelandic, *keisaraskurdur*; Italian, *taglio cesareo*; Norwegian, *keisersnitt*; Polish, *ciecie cesarskie*; Portuguese, *sessao cesaria*; Russian, *kessarevo sechenie*; Serbian, *carski rez*; and Spanish, *cesarea*. Danish and Swedish are very similar to Norwegian. I thought the readers would be interested in this.

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