patient of 20 with three miscarriages. However, after having drawn this distinction, the authors then consider recurrent miscarriage as a homogeneous condition, and quote a live birth rate of 55–75% without further classifying the patients into subgroups. Secondly, the author’s claim that the abortus should be karyotyped. In our series, 40% of abortuses who could be karyotyped had an anomaly. Any trial of treatment will only treat maternal factors. If the outcome of the next pregnancy is complicated by a 40% chromosomal anomaly rate, no treatment will be shown to be effective unless corrected for the chromosomal defects.

References
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Dear Sir,
I wish to thank Carp and Toder (1995) for their comment and the opportunity to keep the discussion about recurrent abortion alive.

Thyrotoxicosis and Wilson’s disease are mentioned in our publication as rare and extremely rare respectively. With regard to diabetes we mentioned only that there is an increased risk of spontaneous abortion in cases of poor glycaemic control in insulin-dependent diabetic women. However, we do not know of any study on 1500 patients with recurrent abortion which systematically tested for hyperhomocystinaemia.

The debate about the efficacy of immunopotentiation therapy will continue. The studies from Carp et al. (1993) and Daya and Gunby (1994) were available but we were not aware of the results of the ‘Recurrent miscarriage immunotherapy trialists group’ and the benefits claimed from double-blind randomized and non-randomized trials. In the review and meta-analysis by Fraser et al. (1993) on data obtained from four randomized controlled trials and 19 case-series there was a simple final conclusion: unless its efficacy can be established through other randomized controlled trials, this treatment should be abandoned.

The facts about polycystic ovary syndrome (PCOS) and luteinizing hormone (LH) hypersecretion have been reviewed, as far as we feel, with considerable reserve. In a more recent study, 56% of 500 consecutive women presenting with a history of recurrent miscarriages (Clifford et al., 1994) had an ultrasound diagnosis of PCOS. Based on early-morning urinary LH analysis, 58% of these women demonstrated hypersecretion of LH. We agree about the fact that the Johnson and Pearce papers (Johnson and Pearce, 1990; Pearce, 1991) do not provide strong evidence about the efficacy of pituitary suppression but we also used other references.

The septate uterus is a difficult area in recurrent abortion. Theoretically, it has been suggested that early abortion in a septate uterus may be due to insufficient vascularization of the septum. Late abortion may be due to cervical incompetence. A combination of early and late abortions are often encountered in patients with a septate uterus. We do not know of studies indicating which cases should be operated on and which ones should be treated conservatively. By ‘properly selected cases’ we intended to make clear that an operation should not be obligatory.

In summary, we agree with the two major pitfalls. A third one could be: as abortion is time-related, treatment started during the next pregnancy is more effective when started late and 100% effective when started at the end of the abortion period.

References
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