A big first step
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The singleton, term gestation, live birth rate per cycle initiated (BESST) endpoint proposed at the beginning of 2004 is a first big step which should be added to by the consideration of multiple pregnancy rates in relation to singleton rates, by recording of fetal reductions and of pregnancies resulting from cryopreserved material. After three or more steps we may have an accurate reporting system which helps patients to distinguish the pros and cons for singleton term delivery.

Key words: multiple pregnancies/pregnancy reporting/singleton deliveries

Bravo to the Monash group and to David Healey, its Director, for taking a bold first step to suggest a reporting system for ART (Min et al., 2004), which gives consideration to contemporary medical and social realities. I suspect there is a preponderance of opinion which is not unanimous but which states that no country has a reporting system which is in step with today’s state of affairs.

As much as the Monash effort is to be admired, it probably should be considered only a first step, as it does not give consideration to a number of factors which modify the concept of single term gestation live baby per ART cycle begun. Furthermore, these modifying factors are integral to the information which the patient should want to know. They include the following points:

The multiple pregnancy rate must be revealed, as this greatly influences the single term delivery rate. Most national data do not distinguish term from premature deliveries so that a restatement of the Monash data is necessary to make this particular point.

If the singleton premature deliveries at Monash are added to the term deliveries, the singleton delivery rate becomes 12%, instead of 11% (328/2600 = 12%). This rate (12%) may be compared with the SART 2001 data which show a 19.1% singleton delivery (preterm and term) per initiated cycle (Assisted Reproductive Technology Success Rates, 2001).

However, the Monash multiple pregnancy rate was 5% of initiated cycles (120/2600 = 5%) which compares to the SART multiple pregnancy rate of 8% of initiated cycles (664/74,957 = 8%). Thus, the 55% superior SART single pregnancy rate was accomplished at the expense of a 60% increase in the multiple pregnancy rate.

All concerned need to evaluate the significance of the multiple pregnancy rate in relation to the singleton pregnancy rate.

All delivery rates—term and premature—are influenced by multifetal reductions and selective fetal reductions. Except for France, no other reporting system records these data. Contemporary practice is such that this information should be made available to all concerned as there is evidence that even patients who use fetal reduction are subsequently handicapped by burdensome afterthoughts.

Such fetal reduction data must be included in a contemporary reporting system. No reporting system provides information on the total reproductive potential of a single oocyte harvest. This means that the pregnancies resulting from cryopreserved material are not added to the pregnancy rates from fresh transfers from the harvest of a single stimulation.

All national reporting programs report pregnancies from fresh transfers, separate from pregnancies from the transfer of frozen material. Thus, it is impossible to ascertain the total pregnancy potential for a particular individual from a single oocyte harvest. But this is exactly what the patient wants to know.

Thus, Monash has suggested a big first step, but it seems necessary that we take step two, and then step three, and perhaps other steps before we have a system of reporting ART which gives consideration to contemporary realities.

To be sure, accurate reporting may not completely solve the multiple pregnancy problem, but if a reporting system could be devised that made clear to the patient what the pros and cons are for a singleton term delivery, there is a high probability that the patients could separate the wheat from the chaff.

References