firm the absence of viral contamination in selected sperm used for blood testing, we cannot be sure that the single injected sperm was free of HIV. A risky business?

Sir,

We would like to thank Dr Garrido and Dr Meseguer for their interest in the study published by our group in Human Reproduction (Mencagli a et al., 2005). Their main criticism concerns the lack of any tests to confirm the absence of viral contamination in selected sperm used in assisted reproduction by ICSI.

The group of serodiscordant couples reported in our paper was referred for reproductive treatment between January 2001 and December 2003, as reported in the Materials and Methods. At this time, we did not apply any protocols for HIV semen testing before ICSI in order to assess the infectious status of a single sperm.

As reported in previous papers, quoted in our article, a percentage of sperm cells may be infected by the HIV virus (Dussaix et al., 1993; Baccetti et al., 1994) and unlike peripheral blood testing, we cannot be sure that the single injected sperm is free of infection by extrapolation from the absence of HIV in half of a selected semen sample. The risk of transmission is therefore only ‘theoretically’ zero, even after many tests.

In the same period, another group (Pena et al., 2003) expressed some doubts about HIV tests in sperm before assisted reproduction. Semprini et al. (2000) reported over two thousand intra-uterine insemination and more than one hundred ICSI/IVF-ET cycles with washed sperm without seroconversion or viral contamination of babies. We therefore considered that sperm washing and ICSI ensured a substantial decrease in the risk of infection. Patients were of course informed about the efficacy of sperm washing and ICSI in reducing the risk of contamination, and they accepted ICSI without any attempt to detect viral presence in selected sperm samples.

Our published data increased the number of HIV serodiscordant couples treated by sperm washing and ICSI without viral contamination, irrespective of testing for HIV in selected sperm samples.

Nowadays, we agree with Dr Garrido and Dr Meseguer that excellence in assisted reproduction includes testing sperm samples before ICSI.

Since the year 2004, washed sperm samples of all serodiscordant couples treated in our reproductive centre have undergone viral tests, in collaboration with the Molecular Biology Department, Virology Section, Siena University.

References


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Reply to: ‘Use of washed sperm for assisted reproduction in HIV-positive males without checking viral absence. A risky business?’

Sir,

We would like to thank Dr Garrido and Dr Meseguer for their interest in the study published by our group in Human Reproduction (Mencaglia et al., 2005). Their main criticism concerns the lack of any tests to confirm the absence of viral contamination in selected sperm used in assisted reproduction by ICSI.

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References


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Comment on ‘Season of birth influences the timing of menopause’

Sir,

We read with great interest the article by Cagnacci et al. (2005a), which related that season and month of birth influenced the timing of menopause. Cagnacci simultaneously published an article, which also examined the seasonal onset of menopause, in another journal (Cagnacci et al., 2005b). In the latter article, which retrospectively researched 2436 postmenopausal women, the onset of menopause was more frequent (P < 0.0001) in winter (32.5%) than in spring (20.8%), autumn (20.3%) and summer (26.2%); a minor peak was also observed (P < 0.0001 versus spring and autumn).

Cagnacci et al.’s study would have been more useful if opinions about the seasonal onset of menopause had been included with that former study to reduce the bias.

References

A year has to pass before the woman reaches that critical preferential season for the onset of menopause, may prolong menopause. For example, birth in a season distant from the basis of season of birth is influenced by the seasonal onset of the analysis showing a different timing of menopause on the point made by Shukunami and colleagues. It may be that the timing of menopause is influenced by the season in which environmental conditions favour the definitive postnatal events including a woman’s ovarian exhaustion. The two papers relate to two different and separable issues—the former to season and reproduction, the latter to environment and fetal development. However, we understand that the role that prenatal environmental factors exert on the effect of the season of birth on the timing of menopause (Cagnacci et al., 2005b) was written earlier, although published later, and the analysis was performed on 2432 post-menopausal women. The data in this paper indicate that the onset of menopause is not evenly distributed throughout the year, but occurs preferentially in some seasons (in winter and to a lesser degree in summer) compared with others. The data emphasize the important role that environmental factors linked to season play in the regulation of reproductive life including its termination. The paper on the seasonal onset of menopause (Cagnacci et al., 2005a) was written later, although published earlier. Between the two analyses, we were able to retrieve additional information from the paper records of our patients, which were entered into the electronic databases. Accordingly, the analysis was performed in 2822 women. The results indicate that the timing of menopause is influenced by the season in which a woman is born. The data are interesting because they point to the role that prenatal environmental factors exert on postnatal events including a woman’s ovarian exhaustion. Accordingly, the two papers relate to two different and separate issues—the former to season and reproduction, the latter to environment and fetal development. However, we understand the point made by Shukunami and colleagues. It may be that the analysis showing a different timing of menopause on the basis of season of birth is influenced by the seasonal onset of menopause. For example, birth in a season distant from the preferential season for the onset of menopause, may prolong the reproductive period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical season in which environmental conditions favour the definitive cessation of her menstrual cycles. In order to exclude this possible confounder we re-analysed the data on the season of birth and timing of menopause, taking into consideration also the actual season in which menopause occurred. The additional data included in the database did not modify our previous conclusion (Cagnacci et al., 2005b) that the onset of menopause is more frequent (P < 0.0001) in winter (920/2822, 32.7%) than in spring (583/2822, 20.6%), summer (743/2822, 26.3%; P < 0.001 versus spring and autumn) and autumn (576/2822, 20.4%). In multiple regression analysis this time we tested the influence on the timing of menopause exerted not only by menarche, body mass index, smoking, education, type of job and season of birth, as previously reported (Cagnacci et al., 2005a), but also by season of menopause onset. Timing of menopause remained influenced by season of birth with results comparable to that previously reported (Cagnacci et al., 2005a), and was not influenced by the seasonal onset of menopause. Indeed, considering winter as the season of reference, the influence of the other seasons on the timing of menopause was not significant and expressed by regression coefficients (with 95% interval of confidence) which were 0.270 (–0.187, 0.726) for spring, 0.384 (–0.04, 0.809) for summer and 0.082 (–0.374, 0.539) for autumn. We think that this re-analysis responds to the appropriate criticism of Shukunami and colleagues, and further confirms the genuine effect that the season of birth exerts on the timing of menopause.

References


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Is 250 μg rHCG always better and safer than 500 μg rHCG?

Sir,

We read with interest the recent article written by Al-Inany et al. (2005). Amongst the four trials included in this meta-analysis, only one compared the effect of two different doses of recombinant (r)HCG (Chang et al., 2001). Ovarian hyperstimulation syndrome (OHSS) was more commonly reported in patients treated with 500 μg rHCG (9.0%) as compared to the group receiving 250 μg rHCG (3.2%), although this was not statistically significant. A recommendation was made by Al-Inany et al. (2005) that ‘increasing the dose of rHCG

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