year prior to starting IVF treatment, and the criteria differ from one region to another. In the UK, early diagnosis of hydrosalpinx does not make a lot of difference because it is usually made by the patient’s local gynaecologist prior to referring them for IVF treatment. According to a postal survey by Hammadieh et al. (2004), 90% of these gynaecologists discussed the negative effects of hydrosalpinx on IVF outcome.

At the initial consultation, all patients were properly counselled about hydrosalpinx, and surgical correction was offered. Some declined the surgical procedure because they did not want to have any intervention or because of the long waiting list for elective surgeries at that time in the UK. It is worth noting that a good proportion of patients were first diagnosed with hydrosalpinx during IVF treatment in spite of previous investigations which did not show signs of hydrosalpinx.

A couple of patients had accumulation of fluid in the uterine cavity at oocyte collection time but the fluid disappeared when they came back for embryo transfer. One patient was in the aspiration group and the other was in the control. Neither of them got pregnant.

The main reason patients declined entering the study was concern about infection impact on treatment outcome (60%) and the rest were not interested in the study. Hydrosalpinx was measured during the study and we managed to get the volume as well.

One patient out of the three women who had fluid reaccumulation got pregnant but unfortunately had early pregnancy loss.

We had pregnancy from bilateral hydrosalpinx; however, there was not much difference in the outcome between the unilateral and bilateral hydrosalpinx. It was noted that while large hydrosalpinx had less chances of getting pregnant, it was not significant.

We agree with you that hydrosalpinx aspiration during oocyte collection is a safe procedure as there was no infection morbidity associated with vaginal hydrosalpinx aspiration in all our cases.

References


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Women with consistently or variably elevated early follicular phase FSH

Sir,

We read the recent paper by de Koning et al. (2008) with great interest and we think that this adds considerably to the body of knowledge on this interesting topic and is really useful to those working with and managing these clinical problems. The authors categorize some women with elevated basal FSH levels as being high initially and high in the study cycle (‘High, High’; H,H group) or high initially and normal in the study cycle (‘High, Low’; H,L group). This is a useful distinction to be aware of as many clinics still follow the view that the highest measured FSH level is the most predictive of response, say, to gonadotrophins. Recognizing the small sample size of the study, can the authors say whether women move between the categories? Do they consider that women stay as H,H or H,L or can they move between? We also wondered whether they had a view on whether inhibin B is the most useful hormone in the cycle prior to treatment for ovulation induction or for IVF in GnRH antagonist cycles.

It is interesting to know that the authors have observed anti-Müllerian hormone (AMH) to be lower in both groups de Koning et al. (2008), and this may support the theory that the production or secretion of AMH by granulosa cells is not under a stringent extraovarian hormonal control van Rooij et al. (2002).

Considering the antral follicle count (AFC) as a good prognostic indicator of ovarian response in assisted conception Bancsi et al. (2002), we feel that correlating the AFC to the two FSH groups H,H and H,L may add valuable information in predicting ovarian response prior to IVF.

Of more importance to reproductive physicians will be the clinical pregnancy rates of both groups H,H and H,L after superovulation and IVF.

References


Reply: Managing IVF in women with consistently or variably elevated early follicular phase FSH

Sir,

We thank Drs El Hakim and Cahil for their interest and reaction to our paper (de Koning et al. 2008).

It is true that the highest measured FSH level is the one that makes clinicians aware of the possible low ovarian reserve. It is known that a normal or moderately elevated FSH can still be found in women with low ovarian reserve due to variable FSH levels and possibly variable cohort size. In our paper, we categorize the women with elevated FSH levels as ‘High, High’ (H,H group) when they showed an elevated FSH level both in a screening cycle and in the study and as ‘High, Low’ (H,L group) when they showed high FSH levels in a screening cycle but normal (<10 IU/l) in the study cycle.

The answer to the question whether the women moved between the groups is as follows: of the 11 women in the original H,H group, five had a normal FSH level in the third cycle and of the 11 women in the original H,L group, six had an elevated FSH level in the third cycle. This indeed shows the strong inter individual variation of FSH in these women. And interestingly, this is associated with concomitantly large variation in inhibin B levels in the preceding luteal phase, and in our view, this could be a useful value to evaluate in the cycle immediately before the stimulation for IVF.

The anti-Müllerian hormone (AMH) levels were indeed not different in the patient groups with either normal or elevated Day 3 FSH values and this is in line with observations that AMH does not vary much between the cycles (Fanchin et al., 2005) and is not under a stringent extra ovarian control (La Marca et al., 2006).

Our study was not designed to correlate FSH levels or AMH levels or AFC to clinical pregnancy rates but to describe the endocrinology in the spontaneous cycle of women with elevated FSH levels in the early follicular phase. In a prospective study, these parameters can be studied in this respect.

Why do couples drop-out from IVF treatment?

Sir,

We read with interest Verberg et al.’s (2008) recent article ‘Why do couples drop-out from IVF treatment? A Prospective Cohort Study’ in which the authors suggest that so-called mild treatment protocols might improve IVF outcomes by decreasing the number of patients who discontinue treatment before a pregnancy is achieved. Although we congratulate the authors on attacking this challenging subject and bringing the issue of patient drop-out to the forefront, we have several concerns with the methodology and ultimately of the conclusions in this article.

Despite the claim that there was an equal distribution of reasons underlying patient drop-out, 14% (5/35) of patients in the mild treatment arm and 36% (11/36) of conventionally treated patients had ‘unknown’ reasons for discontinuing treatment. The large number of patients with essentially ‘no data’ undermines the ability to draw conclusions with certainty about the psychological effect of the treatment protocol. In addition, since an almost equal fraction of respondents in each group indicated that ‘physical or psychological burden of treatment’ was the primary reason for discontinuing treatment, it can hardly be concluded that mild-stimulation techniques are the primary factor influencing a patient’s persistence. As previously measured by the authors, depression/anxiety scores were not significantly different between groups after treatment, (Heijnen et al., 2007) though a difference might have been expected if the psychological impact of treatment protocol influenced patient resolve.

We have gone on record in the past in asserting that the time has come to define ‘patient-friendly’ treatment as that which results in a healthy newborn achieved in a safe, cost-effective and timely manner (Flisser et al., 2007). It is clearly erroneous to conclude that patients fare better psychologically when sub-optimal treatment protocols are chosen. In fact, we would claim that the opposite is true. Because of the high likelihood of drop-out, patients must be treated in the most efficient and cost-effective manner possible, and emphasis must therefore be placed on early success.

References

