removal of endometriomas may not be beneficial to COH (Somigliana et al., 2006a, b); however, the discussion is still open in term of pregnancy rate.

References


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Reply: Report of three infertile patients with unilateral ovarian endometriotic cysts diagnosed by ultrasound

Sir,

We appreciate Tocci et al.’s consideration of our study (Benaglia et al., 2009) and adding new insight to this topic. The endometrioma-related damage to ovarian reserve is still debated.

We agree that it is difficult to measure ovarian function directly and that the ovarian response to gonadotrophin stimulation is currently considered the most appropriate surrogate measurement for ovarian function. Therefore, we consider the investigation of IVF outcome on patients with ovarian endometriomas at the time of oocyte retrieval to be very interesting.

In 2006, Somigliana et al. recruited 36 patients with monolateral endometrioma that were undergoing IVF. The presence of ovarian endometriomas was associated with a reduced responsiveness to gonadotrophin stimulation. In this study, the number of codominant follicles developing in affected gonads was reduced when compared with the contralateral intact ovaries of the same patients. However, the number of analyzed cases was quite small because only patients at first cycle of hyperstimulation were considered for the study, as should be done, and the difference between the affected ovary and the healthy ovary was not statistically significant (Somigliana et al., 2006).

Tocci et al. reported three patients but they lack the description of the ovarian responsiveness of the whole population that underwent IVF and were affected by ovarian endometriomas. Moreover, the reduced ovarian responsiveness seems to be further supported by the observation that this effect is dependent on the size and number of the cysts, and they reported four cysts with a mean diameter <3 cm. Moreover, we do not necessarily deny that women with endometriomas at the time of IVF may have a high-quality responsiveness but it is necessary to confirm this conclusion in a larger group.

Finally, in our article ‘Endometriotic ovarian cysts negatively affect the rate of spontaneous ovulation’ (Benaglia et al., 2009), our conclusion was that the presence of endometriomas *per se* may negatively influence ovarian function but the magnitude of the negative effect on ovarian reserve is unknown. A minimal difference in quantity of ovarian damage may reflect a remarkable difference in ovulation rate.

References


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Reply: A new method for testing a hypothesis on a cause of polycystic ovary syndrome

Sir,

I was delighted to see Dr James’ brilliantly simple suggestion for testing the hypothesis that exposure to high levels of androgens *in utero* is a cause of polycystic ovary syndrome, a hypothesis which was reiterated in my recent article (Homburg, 2009). We have taken up the idea with relish and thanks and have started a sibling-sex survey and counting.

Reference

Reply: Fertility preservation in adolescent males: experience over 22 years at Rouen University Hospital

Sir,
Menon et al. (2009) report a population of 156 adolescents who cryopreserved sperm at Rouen University Hospital over 22 years. Only 18 patients (11.5%) were unable to provide a sample, and not 40% as indicated by Carmignani et al. Most of our patients who failed to provide a sample had cancer and not specifically testicular cancer. Onco-TESE was performed in only five patients because the remaining patients were seen from 1984 to 1999, prior to the introduction of Onco-TESE in our centre. I agree with the absolute necessity to introduce testicular sperm extraction in the management of fertility preservation when patients failed to provide a semen sample, or when azoospermia is discovered. However, this proposition should not be limited to testicular cancer but to the situations of cancer treatment at very high risk of testicular irreversible damage.

References

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