Reproductive epidemiology

Incidence of retinoblastoma in Dutch children conceived by IVF: an expanded study

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BACKGROUND: In 2003, we reported an increased risk of retinoblastoma in children conceived by IVF between 1995 and 2002. However, population-based studies among children conceived by IVF did not find an elevated risk of retinoblastoma.

METHODS: From nationwide estimates of numbers of live births conceived by IVF (n = 40,330), we estimated the expected numbers of patients with retinoblastoma conceived by IVF in the period 1995–2007. The observed number of retinoblastoma diagnoses in children conceived by IVF was obtained by questionnaires sent to the parents of children with retinoblastoma diagnosed between 1995 and 2005. For non-responders and patients diagnosed after 2005, information was available through the medical files, in which information on fertility treatment has been routinely recorded since 2000. The relative risk (RR) of retinoblastoma among children conceived by IVF was calculated for the total study period (1995–2007) and for the expanded study period (2002–2007).

RESULTS: Of all eligible patients with retinoblastoma (n = 162) diagnosed in the period 1995–2007, seven were conceived by IVF. In the total study period (1995–2007) the risk was significantly elevated [RR = 2.54, 95% confidence interval (CI) = 1.02–5.23]. In the expanded study period (2002–2007), no significantly elevated risk (RR = 1.29, 95% CI = 0.16–4.66) was found.

CONCLUSIONS: We found a significantly increased risk of retinoblastoma in children conceived by IVF in the total study period 1995–2007. However, this increased risk was mostly based on the much stronger risk increase observed previously, for 1995–2002. Caution and awareness on the one hand and avoiding unnecessary worries on the other hand are important at this stage of our knowledge.

Key words: retinoblastoma / IVF / the Netherlands / ICSI

Introduction

Retinoblastoma is a rare malignant tumour that arises in the retina. The disease is hereditary in 40% of the cases (mostly two eyes affected) and non-hereditary (always one eye affected) in 60% of the cases. In the Netherlands the incidence of retinoblastoma has been stable from 1945 onwards (1:17,000 live births) (Moll et al., 1997). In 2003, we reported on an increased risk of retinoblastoma after IVF, based on five newly diagnosed patients with retinoblastoma born after IVF, observed between 2000 and 2002 (Moll et al., 2003a, b). In that study, we estimated the relative risk (RR) assuming that the proportion of all children in the Netherlands conceived by IVF lay between 1.0 and 1.5%; the RR for retinoblastoma was significantly increased, and varied between 7.2 (95% Confidence Interval (CI): 2.4–17.0) and 4.9 (95% CI: 1.6–11.3), respectively. We concluded that this indication of an increased risk of retinoblastoma after IVF required further research to confirm or refute the association. Therefore, we collected information about fertility treatments from parents of all patients with retinoblastoma diagnosed in the Netherlands between 1995 and 2007.

Materials and Methods

Study design

From nationwide estimates of numbers of live births conceived by IVF from 1996 to 2007, we estimated the expected numbers of patients with retinoblastoma conceived by IVF in the period 1995–2007.
The actual (observed) number of children conceived by IVF among Dutch patients with retinoblastoma was obtained by questionnaires sent to the parents and from data in medical files.

Our cohort of patients with retinoblastoma has been described previously (Marees et al., 2008). In total, we have data available for 1068 Dutch cases diagnosed from 1862. The registry is estimated to have had nationwide coverage since 1945 (DerKinderen et al., 1990). For each cohort member data were collected concerning demography, family history of retinoblastoma, tumour laterality, treatment for retinoblastoma, second and subsequent cancers and date and (underlying) cause of death.

Questionnaires sent to the parents of patients with retinoblastoma diagnosed between 1995 and 2005 also included questions about number of pregnancies, infertility treatments, gestational age, pregnancy outcome and birthweight. When the child with retinoblastoma was conceived by IVF, further information on number of IVF cycles, cause of infertility and other fertility treatments was collected and cross-checked at the fertility centres concerned. Since the early 2000s, parents of all newly diagnosed patients with retinoblastoma were asked whether the child was conceived by IVF or other fertility treatments, which was recorded into the medical file. For patients diagnosed after 2005 and the non-responders of the questionnaire, information on whether the child was conceived by IVF was obtained from these medical files. Information about the conception status recorded in the medical files and given in the questionnaires did not differ.

For this study, we selected all patients with retinoblastoma who were diagnosed between 1 January 1995 and 31 December 2007 (n = 165). We excluded one patient because she apparently had retinoma (a tumour with spontaneous growth arrest), and two patients were lost to follow-up. Finally, 162 (98%) patients with retinoblastoma were eligible for this study.

This study was approved by the Medical Ethics Committees of all participating hospitals, and was conducted in accordance with the principles of the Helsinki declaration.

DNA-mutation screening

Since the early 1990s, DNA-mutation screening of the retinoblastoma (RB1)-gene has been performed in lymphocytes of all newly diagnosed patients with retinoblastoma. All patients with bilateral tumour and patients with a family history of retinoblastoma were classified as hereditary. All patients with unilateral tumour without a RB1-mutation and a negative family history were classified as non-hereditary. If a RB1-mutation was detected in a child, parents were offered mutation testing.

DNA analysis included direct sequencing of exon 1, exon 15 and the RB1-promoter and denaturing gradient gel electrophoresis analysis of the other exons and flanking intronic sequences. To detect large deletions and duplications, multiplex ligation-dependent probe amplification analysis was performed.

Statistical analyses

In the Netherlands nationwide data on ongoing pregnancies (an intrauterine pregnancy >10 weeks after embryo replacement confirmed by ultrasound) after IVF and ICSI are available since 1996 from the Dutch Society of Obstetrics and Gynaecology (NVOG) and the National Infertility Registry (LIR). All 13 certified IVF centres in the Netherlands provided their annual results from 1996 to 2007 to the NVOG (1996–2002) and the LIR (2003–2007). Numbers of live births after IVF are not available, however. Therefore, we assumed that each ongoing pregnancy resulted in a live born child, and that the number of ongoing pregnancies in 1995 was the same as in 1996. In total, we estimated that 40,330 live births after IVF (including ICSI) had occurred in the period 1995–2007.

Subsequently, the expected number of retinoblastoma cases in children conceived by IVF in the period 1995–2007 were calculated using the number of births and the 1-year age-, sex- and calendar year-specific mortality rates from Statistics Netherlands, and the age- and sex-specific retinoblastoma incidence rates from the Netherlands Cancer Registry.

The RR for the total study period (1995–2007) and the expanded study period (2002–2007) was calculated as the ratio of the observed and the expected number of retinoblastoma diagnoses among children born after IVF in the time period concerned, and a 95% CI was calculated based on the Poisson distribution (Pearson et al., 1976). The observed number of retinoblastoma diagnoses was based on the results of our questionnaire survey. The absolute excess risk (AER) was calculated by subtracting the expected number of cases from the number observed, dividing by person-years at risk and multiplying by 10,000.

All analyses were processed with the Statistical Package for the Social Sciences statistical software (SPSS, Chicago, IL, USA).

Results

The Dutch retinoblastoma register contains a total of 165 patients with retinoblastoma diagnosed between 1 January 1995 and 31 December 2007, of which 162 (98%) were eligible for this study. In total, 115 questionnaires were sent to the parents of patients with retinoblastoma diagnosed in the period 1995–2005. Three patients had emigrated and consequently did not receive a questionnaire. From 2005 to 2007, 44 new patients with retinoblastoma were diagnosed. Of all questionnaires sent, 80% was filled in and returned. For all patients who did not respond to the questionnaire, had emigrated or were diagnosed after 2005, information on birth after IVF was obtained from medical files. Eighty-one (50%) had hereditary retinoblastoma and 81 patients (50%) had non-hereditary retinoblastoma. Seven patients (4%) were conceived by IVF; three non-familial bilateral cases, and four non-familial unilateral cases without a detectable RB1-mutation.

A summary of the characteristics of these seven patients with retinoblastoma is given in Table I. The patients were born between 1997 and 2005, and the diagnosis of retinoblastoma was made between 2000 and 2007. The family history of retinoblastoma was negative for all patients. Ophthalmological examination of the parents was unremarkable. The parents of the two patients that were found to carry a RB1-mutation tested negative for the mutation. Three patients were one of twins; the siblings of these three twins had no ocular abnormalities. Furthermore, two of the four singletons were born after an initial twin pregnancy in which one fetus died. In one case the fetus died because of a spontaneous miscarriage at 8 weeks of pregnancy; in the other case the fetus died because of an umbilical cord blood supply restriction after 30 weeks of pregnancy. The cause of infertility was unexplained in three of the seven cases; male infertility was the cause in three cases, and maternal infertility in one case. The IVF technique (supplemented by ICSI in two cases) was performed in five different Dutch IVF Centres.

The affected eyes of the four patients with unilateral retinoblastoma were enucleated. For all three bilaterally affected patients one eye was enucleated, the other eye was treated with a radioactive ruthenium plaque in one patient and with external beam radiation therapy in the two other patients. Two patients needed six cycles of preventive chemotherapy because tumour extension into the optic nerve past the lamina cribrosa was found by pathology examination. All patients are
currently alive, free of disease, and had a median follow-up of 6.1 years (range = 0.5–7.1).

For the expanded study period 2002–2007, the expected number of retinoblastoma cases conceived by IVF was estimated at 1.55 cases. With two observed retinoblastoma cases conceived by IVF, the RR was 1.29 (95% CI = 0.16–4.66). For the total study period (1995–2007) we estimated an expected number of 2.76 retinoblastoma cases among children conceived by IVF. With seven observed cases, the RR was 2.54 (95% CI = 1.02–5.23). The AER of retinoblastoma among children conceived by IVF in the total study period was 1.05 per 10 000 person-years.

Figure 1 gives the percentages of expected and observed retinoblastoma cases in the general Dutch population, and the percentage of observed patients with retinoblastoma conceived by IVF per year.

**Discussion**

In the total study period (1995–2007), the risk of retinoblastoma among children conceived by IVF was significantly elevated. In the expanded period (2002–2007), however, the risk of retinoblastoma was not significantly increased. The increased risk in the total study period was mostly based on the much stronger risk increase observed in our previous report for the period 1995–2002.

The first report on retinoblastoma occurring in a child conceived by IVF was published in 2001 (Anteby et al., 2001). In 2003, we added another five cases from the Netherlands (Cruysberg et al., 2002; Moll et al., 2003b), and since then only Lee et al. (2004) reported one additional case from the USA. However, two IVF register-based studies did not find an indication of an increased risk of retinoblastoma after IVF (Bradbury and Jick, 2004; Lidegaard et al., 2005). Bradbury and Jick (2004) used the UK-based General Practice Research Database to identify all live births, cases of retinoblastoma and IVF procedures occurring between January 1989 and December 2001. They found no cases of retinoblastoma among the 176 children conceived by IVF. As BenEzra (2005) stated in his letter to the editor; the power of this study was very low since the incidence of retinoblastoma worldwide is around one case per 15 000–20 000 live births. In the
other study, that compared the frequency of diseases linked to genetic imprinting in children conceived by IVF \((n = 6052)\) with the incidence in naturally conceived children \((n = 442 \, 349)\), no children with cancer (including retinoblastoma) were found in the IVF group, whereas five retinoblastoma cases were found in the non-IVF group (Lidegaard et al., 2005; this study covers a 7-year period (1995–2001) with 4.5 years follow-up in the Danish National Register of Patients and the Central Register of Psychiatric Diseases (including all diagnoses from somatic and psychiatric hospitals/clinics). Lidegaard et al. (2005) found fewer specific imprinting diagnoses in both IVF and non-IVF children than expected, however, this cohort was also too small to find at least one case of retinoblastoma. Therefore, we recommend larger extended follow-up studies of children conceived by IVF to provide adequate power to examine the association between IVF and retinoblastoma risk.

On the basis of the literature, only in the Netherlands an elevated risk of retinoblastoma was found among children conceived by IVF during the period 1995–2001. In the present study, no significantly elevated risk was found for the period 2002–2007. Previous research on women undergoing IVF in the Netherlands from 1980 to 1995 revealed no cases of retinoblastoma in the offspring (Klip et al., 2001).

An association between retinoblastoma and IVF is difficult to explain. An explanation might be that, as suggested before, the association between retinoblastoma and IVF is an example of clustering or a chance finding (BenEzra, 2003), which is supported by the fact that the association was not found before 1996 and not confirmed in the period 2002–2007. However, there are many other possible explanations for the observed elevated risk. Since 2002 reports have suggested an association between assisted reproduction technology (ART) and imprinting disorders, specifically Beckwith–Wiedemann syndrome (DeBaun et al., 2003; Maher et al., 2003), and Angelman syndrome (Cox et al., 2002). Animal studies have demonstrated alterations in gene imprinting of embryos cultured in vitro (Khosla et al., 2001). The association of retinoblastoma, IVF and imprinting is suggested because 10–12% of the mutations in the retinoblastoma tumour are caused by hypermethylation of the \(RB1\) promoter (Zeschник et al., 2004). In the Netherlands seven patients with retinoblastoma conceived by IVF were observed in the period 1995–2007. In two patients a causative \(de\,\,novo\,\,RB1\) germline mutation was found. Whether the second hit was caused by promoter hypermethylation of the other allele, is currently not known. In the third bilaterally affected patient and the four isolated unilaterally affected retinoblastoma patients, no germline \(RB1\) mutation could be detected by current screening techniques.

Another explanation for the elevated risk of retinoblastoma could be that the same genetic factors are involved in infertility and the occurrence of retinoblastoma. This has also been suggested for Beckwith–Wiedemann syndrome, Angelman syndrome and Prader–Willi syndrome (Doornbos et al., 2007), and an increased risk for all three syndromes among children conceived by ART was initially observed. However, the authors also demonstrated that, after correction of data for impaired fertility, the incidence was not increased: it was concluded that ART does not seem to have a direct effect on the increase of imprinting diseases, but that the increased risk can be explained by maternal or paternal causes of subfertility (Doornbos et al., 2007). Several other studies have implicated that subfertility itself, as opposed to ART, is the factor which may increase risk of imprinting defects (Ludwig et al., 2005; Kobayashi et al., 2009) or congenital malformations (Zhu et al., 2006).

Yet another explanation might be sought in the IVF procedure itself (Sato et al., 2007; Fortier et al., 2008; Rivera et al., 2008) or in changes of the IVF protocol. It is known that in 1999 the Dutch IVF centres stopped using HCG and started using recombinant FSH (recFSH) (Kremer et al., 2008). However, a causal link between use of recFSH and retinoblastoma is unlikely as recFSH was also used after 2002, when the incidence of retinoblastoma is low. Any suggestion of adverse effects resulting from changes in hormone use is purely speculative at this stage.

Our study focused on the risk of retinoblastoma among children conceived by IVF and provides information on a cohort of retinoblastoma patients. Nevertheless, a number of study limitations should be considered when interpreting the results. Unfortunately the IVF registration from NVtOg and UIR has some restrictions (Kremer et al., 2008). In short, the IVF registry is based on retrospective data obtained from the centres; no validation studies have been done. Relevant data, such as numbers of embryos per transfer, complications, number of live births, congenital abnormalities and health of the child, are not registered. Therefore, we assumed that each ongoing pregnancy resulted in one live born child. Despite these limitations, it is the best available information on IVF in the Netherlands at this moment. Some assumptions were made to estimate the risk of retinoblastoma and the overall percentage of live births among children conceived by IVF, therefore, it is possible that we have slightly under- or overestimated the risk.

Unfortunately, the present study has not resolved the issue of a possible association between IVF and the occurrence of retinoblastoma. Whether treatment using ovarian stimulating regimens increases the risk of childhood cancer remains an important question, especially with the increasing numbers of women undergoing treatment for infertility. Future, larger studies in children conceived by IVF have to consider the number of IVF treatments and other fertility drugs administered prior to IVF. It should be taken into account that serious disorders in children conceived by IVF may be diagnosed earlier through close medical surveillance.

In conclusion, we found a significantly increased risk of retinoblastoma in children conceived by IVF in the period 1995–2007. However, the increased risk in the total study period was mostly based on the much stronger risk increase observed in our previous report for the period 1995–2002. In the expanded period of 2002–2007, no significant risk elevation was observed \((RR = 1.29)\), but numbers were small \((n = 2)\). These findings confirm that further research in larger patient numbers is required to explore a possible causal mechanism. Caution and awareness on the one hand and avoiding unnecessary worries on the other hand are important at this stage of our knowledge.

**Authors Role**

T.M. contributed to the design, acquisition, analysis and interpretation of the data, and drafting and editing the article. C.J.D. contributed to the acquisition and interpretation of the data, and drafting and editing the article. S.M.I., W.A.K. and P.J.R. contributed to the interpretation of the data, and drafting and editing the article. F.E.L. and A.C.M.
contributed to the conception, design, acquisition, analysis and interpretation of the data, and drafting and editing the article.

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References

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