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doi:10.1093/humrep/des236
Advanced Access publication on June 27, 2012

Reply: In vitro fertilization and ovarian malignancies: potential implications for the individual patient and for the community

Sir,

We thank Vercellini and co-authors for their appreciation of our work. Among the invasive ovarian cancers observed in our study, 35% (not 28%) were mucinous, clear cell or endometrioid (Type I malignancies) and 60% were serous cancers (van Leeuwen et al. 2011). We went back to our cancer registry data and pathology reports to see whether grade was available. Of 25 invasive serous cancers (in the IVF and control groups), only 5 were low grade, 6 were intermediate grade, 9 were high grade and for 5 cancers grade was unknown. When restricted to the IVF group, only 3 out of 20 serous cancers were low grade, 4 were intermediate grade and 8 were high grade. So, on the basis of our currently available morphology information, only 15% of serous tumours in the IVF group concerned Type I tumours, which would suggest that the Type II serous tumours were probably not arising from borderline tumours, but rather from the fallopian tube. We would like to emphasize that the histology of the ovarian malignancies in our study was not reviewed.

To review the morphology and to examine other characteristics of ovarian malignancies developing after fertility treatment, we are currently planning to collect paraffin-embedded tissue blocks for all ovarian tumours.

We fully agree with Vercellini and co-authors that our cohort is still rather young to evaluate a potential increase in the risk of invasive ovarian cancer; as mentioned in our paper, more prolonged follow-up is needed to draw conclusions about this important health issue. We also agree that it would be extremely interesting to examine ovarian cancer risk separately in nulliparous and parous women, and in long-term oral contraceptive (OC) users versus non-users. In this respect it is of interest to remember that Whittemore et al. (1992) showed in their pooled analysis of 12 case–control studies a stronger association between fertility drug use and ovarian cancer in nulliparous women. In our published analysis we did not have sufficient power to examine modifying effects of parity and OC use on the risk of ovarian malignancy following IVF treatment. We are currently expanding follow-up of our existing cohort and also enlarging the cohort with women who received IVF treatment in the period 1995–2000. We will certainly address the issues mentioned by Vercellini and co-authors once we have completed data collection and accrued more cases.

References


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doi:10.1093/humrep/des238
Advanced Access publication on June 27, 2012

A uterovaginal septum and imperforate hymen with a double pyocolpos

Sir,

We are very pleased to read the article ‘A uterovaginal septum and imperforate hymen with a double pyocolpos’ by Fedele et al. (2012)