The same time, the specifics of ART as a field should be recognised in the criteria adopted.

INVITED SESSION

Session 64: Endometriosis-associated pain

Wednesday 10 July 2013 12:00 - 13:00

O-249  Endometrium, nerves and endometriosis
I.S. Fraser
University of Sydney, Dept. of Ob/Gyn - Faculty of Medicine, Sydney NSW, Australia

Background: Surprisingly little is known about the generation of pain signals within the pelvic organs in women with endometriosis, in spite of the fact that pain is the cardinal symptom of endometriosis in most sufferers.

Materials and Methods: nerve fibres within the endometrium, pelvic organs and lesions were studied primarily using specific immune-histochemical techniques.

Results: The pattern of nerve fibre distribution in the pelvis is different between women with endometriosis and those without. Fine C nerve fibres (sensory, sympathetic and parasympathetic) are much more densely present in the uterus, affected peritoneum, ovary and deep invasive lesions in endometriosis sufferers and those without. Indeed, the endometrium is not normally innervated in women without endometriosis, whereas there is considerable density of neurites throughout the endometrium in women with endometriosis, even up to the luminal epithelial surface. Small numbers of A-delta nerve fibres are present throughout the reproductive tract and in much greater density than normal. It seems highly likely that these sensory-type nerve fibres play active roles in the generation of pain within pelvic organs and lesions. Nerve growth factor, other neurotrophins and their receptors are strongly present in those tissues exhibiting increased nerve fibre density. There also seems to be some relationship between certain of the dysregulated immune cells of the endometrium and the pelvic lesions and the presence of nerve fibres.

Conclusions: Much remains to be learned about these associations between different types of nerve fibres, immune cells and the generation and conscious experience of endometriosis pain.

O-250  Central nervous system (CNS) mechanisms of pain in endometriosis
K.J. Berkley
Florida State University, Program in Neuroscience, Tallahassee, U.S.A.

Endometriosis is an estrogen-dependent disorder defined by extratubal growths of uterine endometrial tissue. Symptoms range from severe dysmenorrhea to chronic pelvic pains that co-occur with other pain disorders. How the abnormal growths relate to pain is poorly understood, and the pain is difficult to alleviate with using hormones that often produce intolerable side effects. Although surgical removal of the growths can alleviate pain in ~50% of selected patients, pain returns in at least half of them. Studies with a rat model provide clues for mechanisms and treatments. Growths in the model and women recruit sensory and sympathetic nerve branches that sprout from nerves that supply nearby areas, creating a direct two-way, "sensory-sympathetic coupled" interaction between the growths and the central nervous system (CNS). The sensory fibers become sensitized, and both types of nerve fibers are influenced by the ovarian cycle. This peripherally-dynamic condition produces local and remote CNS sensitization and affects CNS estrogen receptors. Thus, the dynamic and estradiol-responsive nervous system becomes directly involved in endometriosis, allowing generation by the CNS of pains that in turn can become independent of the abnormal growths and chronic. Consistent with these findings are brain imaging studies in women demonstrating that the presence of severe dysmenorrhea, such as that which occurs in women with endometriosis, is associated with profound effects on CNS structure, metabolism, and connectivity. Together, the findings support a change in focus from endometriosis pathology to the pain, acknowledging that the origin of the pain is the CNS. This change encourages a multi-therapeutic approach to treatment as well as recognition that translational research inclusive of basic scientists, clinicians, and patients can bring about productive advances.

INVITED SESSION

Session 65: Paramedical invited session – Nursing (Debate): Patients have the right for an anonymous donor

Wednesday 10 July 2013 12:00 - 13:00

O-251  Pro
L. Schmidt
University of Copenhagen, Department of Public Health Section of Social Medicine, Copenhagen K, Denmark

Debate summary: Patients have the rights for anonymous donor

For all individuals it is of importance to have a narrative identity including knowledge of how the family was established. When heterosexual couples, lesbians and single women use donated gametes in order to establish their family, they overall prefer the treatment form that suits them best, in terms of anonymous or non-anonymous gamete donation. Using the treatment method that suits the parents’ best will increase the probability that the parents tell the child how the child came into this family and thereby contribute importantly to establish the child’s narrative identity. In Sweden, where only non-anonymous gamete donation has been available since 1985, only 11% of donor-conceived children (age 1-15) have been informed about how they were conceived. However, nearly 60% of the parents have told others about the donor treatment (Gottlieb et al., 2000). These results indicate that mandatory non-anonymous donation support, in contrast to the intention, that the far majority of children are not informed about how the family was established and many have the risk of becoming aware of their origin by accidental disclosure by other people. Studies shows that disclosure to the child before age 18 is beneficial (Jadva et al., 2009), and accidental disclosure could be seriously harmful. Longitudinal cohort studies have repeatedly shown that gamete donor families, also those that have used anonymous gametes, function well (Owen and Golombok, 2009; Kovacs et al., 2013). There are no significant differences between donor gamete families in psychosocial functioning or in the children’s well-being and psychosocial development, when compared to families established by either other kind of fertility treatment, adoption or children conceived without the use of assisted reproduction. Indeed the fathers of children conceived by anonymous donor insemination have higher average involvement in the child compared to fathers in other type of families. Historically, families often consist of a mixture of children genetically related to both parents, to only one of the parents or to none of them. It is surprisingly to see that during the few last decades several Western cultures increasingly emphasize the importance of genetic relationships for mental well-being, identity and social relations (Penning, 2012). Research in families based on anonymous gamete donation shows that this is not the case.

O-252  Con
C. Gottlieb
Sophiahemmet, IVF-Unit, Stockholm, Sweden

Do patients have the right for an anonymous donor? The question should be put: Do the patients not have the right to an identifiable donor? Or rather: Do the children conceived through gamet donation not have the right to an identifiable donor? Why? Everyone has the right to his/her genetic origin. Not to tell a child that it has been created through gamet donation leads to a problematic secrecy within the family. Parents against the child. With the risk that the child (or in adulthood)