Bausell, 2009). There is a very high a priori unlikeliness that trials will produce credible (positive) outcomes. We as scientists will all agree easily on this matter (Barker, 1999) of our conventional biomedical science adds insult to injury and explains why the real evidence base of positive scientific data from high quality research and the lack of interest of colleagues, working in the field. The institutions representing and regulating this community are the scientific journals and scientific organizations like ESHRE and ASRM. In these institutions one rarely encounters serious propping of alternative treatments, as could be expected given the scarcity of positive scientific data from high quality research and the lack of interest among serious researchers to investigate methods of which the theoretical base is of mythological or pseudoscientific origin (Renckens, 2002). The fact that alternative healers are using a terminology that is untranslatable into the jargon of our conventional biomedical science adds insult to injury and explains why there is a very high a priori unlikeliness that trials will produce credible (positive) outcomes. We as scientists will all agree easily on this matter (Barker Bausell, 2009).

Our patients seem to be of another opinion, but the question is not whether alternative medicine has anything to offer to our patients in the sense of evidence based treatments, which is obviously not the case and will never be. The real question is whether the numerous couples using one form or another of alternative medicine do get any advantage of it, may experience disadvantages or can be considered as going through a rather harmless pastime. There will certainly be differences between countries, but roughly one third of the patients seeking relief

INTEGRATED MEDICINE, PATIENTS FEELING IN CONTROL?

INVITED SESSION
SESSION 63: PARAMEDICAL DEBATE SESSION “ALTERNATIVE MEDICINE. PATIENTS FEELING IN CONTROL?”

Wednesday 30 June 2010 12:00 - 13:00
for their childlessness are employing one or more alternative treatments and they will not usually inform their doctor or nurse about that. This underlines that there is a great need amongst these patients to do anything extra on top of the regular treatment they are receiving, the results of which have always to be awaited and seem to be partly depending on chance and luck. That many of our patients see this kind of help and by doing so experience a sense of control of their situation is undeniably true. But does this entail that we should leave them alone in those curious adventures, which are taking their time, their money and sometimes their ability to see their chances as realistically as they are? An attitude in which we leave them indulging in Chinese acupuncture, nutritional supplements, paranormal therapies and prayer could be defended with the argument that a feeling of control and ‘doing something themselves’ leads to a reduction in stress and a better outcome of treatment, even although we know that the nature of the alternative treatment is completely irrelevant. This argument comes close to what the American philosopher and skepticist Daniel Dennett once called ‘believers in belief’: atheists who say that it is good for our society that citizens believe in supernatural beings in which they them selves do not believe at all. This is to my opinion an immoral position, which involves keeping your own opinion on the matter as a secret for your patient and it essentially is a demonstration of contempt for your patient. It is also incompatible with the patient as a well-informed consumer and an ally of his/her doctor making rational choices. Even if false hope and stress-reduction, generated by the rituals and context of the alternative treatment, would improve pregnancy-rates, it would still be immoral and a risky business as well, because sooner or later articles – even in the lay literature - will appear which undermine this belief (in nonsense). The patient may then wonder why she was not informed by her trusted doctor.

Fortunately the influence of stress on the results of our reproductive medical treatments appears to be very limited if existing at all (Lintsen, 2009). This means that we are not withholding our patients a possibly advantageous influence on their chances, making a difficult consultation of our conscience unnecessary. Besides the absence of advantages there may be disadvantages. There are reports of poorer outcome of IVF-treatments in couples using alternative therapies, but this has to be confirmed and I am tempted to not believe it: my guess would be that the influence is neither positive nor negative. But there are other disadvantages. Apart from the financial costs, undergoing alternative treatment also means that the patient is brainwashed into believing absurd theories on the function and anatomy of the human body, will not rarely become dependant on the alternative therapist, will experience feelings of guilt when the usually strict regime has not been followed exactly (and the treatment failed) or may - in rare cases- undermine the sticking to the orders given by their regular doctor. We should therefore discourage our patients from embarking on alternative medicine as it means empowerment, underestimation and contempt of people who seek our help and who should be able to trust us in every word that we say to them.

References:
2 Lintsen BAME, Verhaak CM et al. Anxiety and depression have no influence on the cancellation and pregnancy rate of a first IVF or ICSI treatment. Human Reproduction 2009; 24: 1092-1098.

Abstract of the 26th Annual Meeting of ESHRE, Rome, Italy, 27 June – 30 June, 2010

Introduction: Previous studies indicate that up to 80% of the embryos that reaches the uterine cavity fail to implant. This may be attributed to multiple factors including embryo implantation potential, endometrial receptivity and the embryo transfer technique itself. Among the factors which may affect the success of embryo transfer, the catheter type; catheter loading; easiness of transfer; flushing of the endometrium; presence of blood and/or mucus in the catheter; ultrasound-guidance; and the best site for embryo deposition have been discussed. The ultrasound guidance during the embryo transfer allows visual monitoring of the process, while navigating embryo placement within the uterine cavity with high precision. In fact, when performed with ultrasonography, transfers are subjectively easier, but whether the IVF outcome is improved is still under debate. On the other hand, the length of the uterine cavity measured by transvaginal ultrasonography during the controlled ovarian stimulation (COS), as the ovarian follicular growth is usually followed by transvaginal ultrasonography, could also determine the depth of the embryo insertion into the uterine cavity, increasing the efficiency of embryo transfer without requirement of ultrasonography monitoring. Our goal for this study was to test the hypothesis that ICSI outcomes related to embryo transfers based on previous uterine length measurement would be compared to that related to standard ultrasonography-guided embryo transfer method.

Material and Methods: A total of 200 patients undergoing intracytoplasmic sperm injection (ICSI) cycles for the first time were randomly assigned to the following embryo transfer procedure: based on previous uterine length measurement (ULM group, N = 100) or performed though standard ultrasonographic-guidance (Control group, N = 100). For patients in Control group, abdominal ultrason was performed during embryo transfer to visualize the full length of the endometrium, the cervix and the uterine fundus. Under the transcervical guidance, the tip of the catheter was positioned aiming to place the expelled embryo in the middle of the cavity length. For ULM group, embryos’ replacement was based on the previous uterus length measurement during COS. For all patients, a soft embryo transfer catheter (Wallace, Smiths Medical International, Hythe, UK) was used. Transfer was considered difficult when the assistance of a more rigid catheter was required to successfully accomplish the embryo transfer. Cycle’s general characteristics and treatment outcomes were compared between these groups.

Results: The causes of infertility were equally distributed between groups; no differences were found on female age (35.1 ± 4.7 vs 35.0 ± 4.1, P = 0.879); number of retrieved oocytes (11.8 ± 8.9 vs 10.9 ± 8.3, P = 0.292), number of MII retrieved oocytes (8.4 ± 6.6 vs 9.1 ± 7.3, P = 0.274), number of transferred embryos (2.6 ± 0.9 vs 2.5 ± 0.8, P = 0.425) and endometrium thickness (12.0 ± 2.3 vs 12.4 ± 1.9, P = 0.131), for Control and UML groups, respectively. Embryo transfers were classified as easy or difficult and the groups were equal regarding the presence of blood on the catheter (4.7% vs 4.3%, P = 1.000) and easiness of transfer (95.3% vs 96.0%, P = 1.000) for Control and UML groups, respectively. Both implantation (11.9% vs 20.7%, P < 0.001) and pregnancy rates (25.3% vs 44.0%, P < 0.001) were significantly higher in the ULM group.

Conclusion: Embryo transfer is the last step in the IVF process, and despite major advances achieved on ovarian stimulation protocols, in vitro embryo development and embryo selection, few modifications have been developed on embryo transfer technique. In conclusion, our findings suggest that embryo replacement in the middle of the cavity, based on previous uterus length measurement during COS, results in satisfactory pregnancy and implantation rates without ultrasonography monitoring requirement.

O-254 Can fresh embryo transfers be replaced by cryopreserved-thawed embryo transfers in assisted reproductive cycles? A randomized controlled trial
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Introduction: Despite many advances in ART, pregnancy rates remain low. Implantation is the “rate-limiting step” in the success of in vitro fertilization (IVF) cycles. Controlled ovarian hyperstimulation (COH) has been shown to advance endometrial maturation and affect adversely implantation in assisted reproduction technology (ART) cycles. It has been reported that there is a better embryo-endometrium synchrony in frozen-thawed embryo transfer (FET) cycles than fresh embryo transfer (ET) cycles. We designed this study to evaluate the effect

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