

Letter From Ragni

The correspondence from Dr. Ragni of Milan is a good example of this self-correcting process at work. Dr. Ragni points out some potential factual errors in the "IFFS [International Federation of Fertility Societies] Surveillance 07" publication. This is a remarkable document developed by the IFFS that summarizes practices in assisted reproductive technologies (ARTs) from 57 different countries. These annual surveys of ART practices around the world started in 1998 and were the brainchild of Howard Jones, Jr., and Jean Cohen. They are published periodically as a supplement to *Fertility and Sterility*, and they provide a matrix of information for the continued discussion of ART practices around the world. The authors of "IFFS Surveillance 07" (Howard Jones Jr., Jean Cohen, Ian Cooke, and Roger Kempers) are notable for their many lifetime contributions to the reproductive sciences.

International Federation of Fertility Societies

It is interesting to note that the IFFS dates back to 1950. It was first called the International Fertility Society and was composed of a select group of individual physicians. In 1968, the society shifted gears, and the units of membership became countries. Today, the IFFS is unique in that it is a federation of 54 countries. This transition was spearheaded by Dr. S. Jan Behrman. This upgrade made the IFFS a society that was truly global in scope and was structured to provide a unique overview of infertility practice around the world. It could not have come at a better time, with ART technology waiting in the wings.

In certain areas of the world, the IFFS has strived to revive cultures of education, research, and publishing that have been in a downward spiral as a result of political upheaval and poverty. Since the arrival of the Internet, the IFFS has made substantial improvements in communicating the health sciences to the underdeveloped world. Their boards and committees consist of people who are carefully selected to represent different parts of the world and different specialties, as well as to include patients. The IFFS, through its membership, is uniquely positioned to form strategic alliances across countries and professional societies. Its work has helped to improve telecommunications and Internet access in developing countries. The IFFS held its 19th congress early this year in Durban, South Africa. The congress provides a global forum for the discussion of reproductive health care.

Recommendations for the Future

Online searches of published reports should be accompanied by relevant letters, corrections, and other pertinent comments. Using this type of Web-based mechanism, the corrections suggested by Dr. Ragni would immediately pop up and be available with the original "IFFS Surveillance 07" report. In the future, a universal system needs to be developed to promptly link articles with other relevant materials. More journals are working to integrate this feature

seamlessly into the Web-based version of the journal. Linking articles to letters online will help to close the circle and make continued peer review a reality.

Paul G. McDonough, M.D.
Associate Editor Letters
Medical College of Georgia
Augusta, Georgia

July 14, 2007

doi:10.1016/j.fertnstert.2007.07.1364

Quality of residual follicles may depend on the etiology of "declining" ovarian function?

To the Editor:

We read with interest the article by Weghofer et al. (1) concerning aneuploidy rates in embryos from women with prematurely declining ovarian function, and we congratulate the authors for their contribution to the relevant literature.

First, we want to comment on the terminology used in their article. We believe that the terms used are very important because there is chaos about this topic, and the terminology, such as "poor," "low," or "bad" responder or "nonresponder", "diminished ovarian reserve", and now, "prematurely declining ovarian function", that exists in the studies is confusing for the audience.

In the study by Weghofer et al. (1), the group with so-called prematurely declining ovarian function was constituted arbitrarily, not according to the generally accepted poor-responder criteria. In that study, the peak E₂ values and number of oocytes retrieved in the patients with so-called prematurely declining ovarian function, the latter of which could be considered to be quite a good number for a group with declined ovarian function, were not significantly different from those in the control group. Although there is a lack of uniformity in definitions, numerous criteria have been used to characterize poor response. The number of oocytes retrieved, which varies among different investigators and ranges from less than three to less than five (2, 3), is the most important criteria for defining poor ovarian response, and in addition, a peak E₂ level of <300 to <500 pg/mL has been suggested to be crucial for defining poor response (4, 5). As stated in the literature, there is a clear need to standardize the definitions of low ovarian response. Thus, we thought that the study group would better have been formed according to the generally agreed-upon poor-response criteria, in order not to cause any argument. Therefore, we note that interpretation of the results of the article should take into account the stimulation characteristics of the study group, which were virtually similar to those of the control group.

Second, we want to draw attention to the miscarriage rate in the patients with so-called prematurely declining ovarian

function. It was found to be 50%, which is very high for a group that has had preimplantation genetic diagnosis performed. Because that rate would probably be even higher without preimplantation genetic diagnosis, it may be better to recommend oocyte donation with their own oocytes instead of IVF treatment to patients who have so-called prematurely declining ovarian function. Otherwise, those women should be counseled thoroughly about the high miscarriage rate with IVF treatment that others like them experience.

Banu Kumbak, M.D.
Engin Oral, M.D.
*Department of Obstetrics and Gynecology
Cerrahpasa School of Medicine
Istanbul University
Istanbul, Turkey*

July 25, 2007

REFERENCES

1. Weghofer A, Barad D, Li J, Gleicher N. Aneuploidy rates in embryos from women with prematurely declining ovarian function: a pilot study. *Fertil Steril* 2007;88:90–4.
2. Rombauts L, Suikkari A, MacLachlan V, Trounson A, Healy D. Recruitment of follicles by recombinant FSH commencing in the luteal phase of the ovarian cycle. *Fertil Steril* 1998;69:665–9.
3. Surrey ES, Bower JA, Hill DM, Ramsey J, Surrey MW. Clinical and endocrine effects of a microdose GnRH agonist flare regimen administered to poor responders who are undergoing IVF. *Fertil Steril* 1998;69:419–24.
4. Brzyski R, Muasher S, Droesch K, Simonetti S, Jones G, Rosenwaks Z. Follicular atresia associated with concurrent initiation of GnRH agonist and FSH for oocytes recruitment. *Fertil Steril* 1988;50:917–21.
5. Raga F, Bonilla-Musoles F, Casan EM, Bonilla F. Recombinant FSH stimulation in poor responders with normal basal concentrations of FSH and oestradiol: improved reproductive outcome. *Hum Reprod* 1999;14:1431–4.

doi:10.1016/j.fertnstert.2007.08.066

Reply of the Authors:

We appreciate the interest of Kumbak and Oral in our work and agree that the definition of “diminished ovarian reserve” greatly varies in the literature. In preparation for our study, we built on considerable precedent in the literature (1, 2), although one can always argue about selection criteria as long as uniformly accepted criteria do not exist. Indeed, to attempt better standardization of ovarian function, we recently urged the use of age-specific baseline FSH levels, in place of standard levels encompassing all ages (3).

We are also pleased that Kumbak and Oral noted the surprisingly high miscarriage rate in women with diminished ovarian reserve, although considering the small number of cases, we urge caution in interpretation of those data. The findings were interesting enough for us to ask ourselves what may have caused such a pattern. Articles on immunological studies, ethnic or genetic contributions, and FRM1 mutation prevalence in young women with diminished ovar-

ian reserve either are already in press or are in the process of being submitted for publication.

We disagree, however, with the suggested assumption that PGD reduces miscarriage rates in such a patient population. We disagree even more with Kumbak and Oral’s recommendation for oocyte donation. As we not too long ago reported in this journal, if women, especially younger ones, who have diminished ovarian reserve are diagnosed properly and in a timely fashion and then are treated on the basis of ovarian rather than chronologic age, they will experience practically normal IVF pregnancy rates (4). Even an increased miscarriage rate will then still allow for a respectable take-home-baby rate. In our opinion, oocyte donation should only be a last resort.

Andrea Weghofer, M.D., Ph.D.^{a,b,c,d}
David Barad, M.D., M.Sc.^{c,d}
Norbert Gleicher, M.D.^{a,c,d}

^a Department of Obstetrics, Gynecology, and Reproductive Sciences, Yale University School of Medicine, New Haven, Connecticut; ^b Department of Obstetrics and Gynecology, Medical University, Vienna, Austria; ^c Center for Human Reproduction, New York, New York; and ^d Foundation for Reproductive Medicine, Chicago, Illinois

August 22, 2007

REFERENCES

1. Fasouliotis SJ, Simon A, Laufer N. Evaluation and treatment of low responders in assisted reproductive technology: a challenge to meet. *J Assist Reprod Genet* 2000;17:357–73.
2. Nikolaou D, Templeton A. Early ovarian ageing: a hypothesis. Detection and clinical relevance. *Hum Reprod* 2003;18:1137–9.
3. Barad DH, Weghofer A, Gleicher N. Age-specific levels for basal follicle-stimulating hormone assessment of ovarian function. *Obstet Gynecol* 2007;109:1404–10.
4. Gleicher N, Barad D. “Ovarian age-based” stimulation of young women with diminished ovarian reserve results in excellent pregnancy rates with in vitro fertilization. *Fertil Steril* 2006;86:1621–5.

doi:10.1016/j.fertnstert.2007.08.067

Re: Balloon catheter vs. cervical vacuum cup for hysterosalpingography: a prospective, randomized, single-blinded study

To the Editor:

In the June 2007 issue of *Fertility and Sterility*, Dr. Ricci and colleagues conclude that performing hysterosalpingography with a nontraumatic device can be painless or mildly painful. Use of a balloon catheter device is better tolerated compared with use of a cervical vacuum cup device.

However, the authors indicate that hysterosalpingography balloon catheter insertion was moderate to severely painful in 21.2% of patients and contrast injection was moderately to severely painful in 20.3% of patients. The high incidence