DEBATE—continued

European Classification of Infertility Taskforce (ECIT) response to Habbema et al., ‘Towards less confusing terminology in reproductive medicine: a proposal’

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The European Classification of Infertility Taskforce (ECIT) has been formed by ESHRE to develop a set of infertility-related codes (descriptions, interventions and outcomes) appropriate for computerization (http://www.ecit.info). In this article, ECIT reflects on previous suggestions in this Debate series, agreeing with the weaknesses of the current terminology used in reproductive medicine. Although ECIT is enthusiastic about the extension of terminology, caution is raised in abandoning familiar terms that may lead to greater rather than less confusion. Instead, ECIT suggests a way forward using structured computerized statements to retain current terms but extend their meaning.

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Habbema et al. (2004) have rightly drawn attention to the weaknesses of the current terminology used in reproductive medicine. The term ‘infertility’ is shown to mean different things to different people, encompassing a wide range of probabilities to achieve pregnancy from relatively normal to impossible. Similarly the terms ‘fertility’, ‘fecundity’ and ‘fecundability’ are used inconsistently. The confusion arising from the nomenclature may lead to false expectations, unnecessary treatments and disagreement between Health Care Providers on whether involuntary failure to conceive is a health care problem deserving insured or nationally funded coverage. In view of the importance of this issue, Habbema’s group tackles the difficult issue of changing nomenclature, suggesting that all the preceding terms are abandoned. Instead they suggest the ‘infertility’ of a couple should be summarized in a descriptive statement, a diagnostic statement and a prognostic statement.

Completely abandoning such terms as ‘infertility’ and ‘fertility’ may increase the confusion, giving rise to practical issues such as the need to rename many professional groups and journals. For instance, this article will continue to use the term ‘infertility’, as otherwise discussion would prove difficult. Nevertheless we support an approach that provides more information when assessing the problem of infertility, and we feel Habbema et al.’s approach should be considered fully.

Assessment of infertility considers a physiological explanation (e.g. age, breastfeeding), detectable pathology (e.g. tubal damage, ovulatory dysfunction, sperm dysfunction), lifestyle factors (e.g. smoking, weight problem, stress) and sexual dysfunction. This information could be incorporated into Habbema et al.’s descriptive statement and diagnostic statement. Management of infertility considers whether any factors may be improved by the couple or by their doctor. Often several options may be appropriate with differing efficacy, costs, risks and other relevant factors leading to a discussion with patients to determine a plan that is appropriate for individual circumstances. For instance, we intervene at an
earlier stage in older women than younger women, as time is running out. Thus Habbema et al.’s prognostic statement may be more difficult to apply in practice, so it should be examined in detail.

Infertility describes a symptom such as abdominal pain or bleeding which is associated with a temporal element that can be short (i.e. acute) or long (i.e. chronic). In this context it is considered to represent a ‘relative’ condition rather than ‘sterility’ which is an ‘absolute’ condition (e.g. azoospermia, ovarian failure, absent uterus). Thus, the first step in the categorization of infertility is to determine whether the patient has an absolute or a relative condition. This can be achieved from the history but usually requires some testing. So both models (the traditional and the proposed new model) are in agreement on this issue. If infertility is established to be a ‘relative’ condition, it is clear that there are many factors that have to be considered. These are all prognostic factors, whether we categorize them as descriptive (i.e. duration of infertility is a prognostic variable), diagnostic (i.e. the diagnosis may influence prognosis) or prognostic categories.

The value of the prognostic statement is further limited by the ‘shifting sands phenomenon’ and changing diagnostic categories of patients. The descriptive statement will change with time because inherent in this statement is a temporal element (shifting sands issue). So, a subject who participates in clinical investigation will always have to be relabelled for duration of infertility. In our current approach, we use the threshold of ‘greater than x months of infertility’, a label that remains with the patient. In essence, however, both the traditional and the proposed new approach are saying the same thing, i.e. couples presenting with infertility need to be assigned a number that reflects this duration—recognizing that it changes with time since the first encounter with the physician. The ‘changing diagnosis’ issue presents a bigger problem to deal with, because the initial evaluation is geared towards establishing a ‘cause’ or causes of the infertility. This initial attempt will vary based on the comprehensiveness of the evaluation. There is no consensus on the optimal diagnostic evaluation for couples presenting with infertility. Having established a diagnosis, how should couples with more than one factor (e.g. male factor and oligoovulation) be categorized? Will this definition then change in response to treatment? For example, should women with polycystic ovarian syndrome, who do not conceive after 6 months of therapy with ovulation induction, be placed in the same category as those who do not ovulate with 6 months of treatment? Similarly, if a woman does not respond well to ovarian stimulation for IVF in previous cycles, she is identified as a poor responder even though she may have had unexplained infertility. Will her diagnostic statement be changed to reflect this change in status as a result of treatment? In the traditional approach, she is still identified as being infertile but is now placed in a poor prognosis category.

The prognostic statement still uses the term ‘fertility’, presenting gradations that appear purely arbitrary. There is no evidence to indicate that the grading system has a linear relationship with severity. How has the severity grading been validated? The estimation of severity will vary from primary care physician to gynaecologist to specialist. Further, the prognosis of treatment is also dependent on local factors (e.g. skill of the physician and the success rates in the clinic) and may change over time.

Changing definitions of infertility at this stage will make it difficult to incorporate evidence from the existing literature in any future systematic reviews. We already have problems with poor quality evidence. We should not create a void of evidence while new evidence is being accumulated using this new proposed approach. Instead we suggest retaining the term ‘infertility’ as a presenting symptom, which is a universally accepted term that identifies the problem, but qualify it with more details. Prognostic statements should be produced dynamically for discussion with the couple using all relevant current information available at the time. Computerization and the Internet may provide an opportunity to take forward the concepts suggested by Habbema et al. to develop an improved terminology for reproductive medicine. For instance, electronic patient records may hold a record of the care of infertile patients providing on request descriptive statements and diagnostic statements. The information from these statements may be entered into a local prognostic computer programme or one held on the Internet (e.g. http://www.repromed.co.uk/infertility/interactive/Fertility Calculator.htm).

The ESHRE has formed a European Classification of Infertility Taskforce (ECIT) with the aim of producing a set of codes appropriate for computerization that may address some of the weaknesses Habbema et al. have identified in current terminology. Essentially ECIT builds on existing terminology (World Health Organization, 2001; Rutherford and Jenkins, 2002) taking advantage of computerization to extend the meaning of the terminology. For instance, the term infertility may be qualified in a structured computerized statement with relevant attributes of both partners such as duration of infertility, thereby removing some degree of ambiguity. The nature of a structured computerized statement is that it is indefinitely extensible and configurable, thus may both accommodate Habbema et al.’s concepts and provide methods of electronically transferring infertility-related information for many uses such as national data registries. The details of the ECIT approach will be published in a later article in Human Reproduction, but meanwhile further information may be obtained at the taskforce website (http://www.ecit.info).

References

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