Letters to the Editor

One-stop recurrent miscarriage clinic and hysteroscopy—an urgent combination?

Sir,

We read the paper by Habayeb and Konje (2004) and would like to make some critical comments on some details of their concept. The authors described their management to increase the efficacy of investigations in women with recurrent miscarriages. They could reduce either the interval or the number of visits.

One main problem with the study is the inclusion of patients after only two miscarriages. It was critically discussed, but we cannot understand how the older publications cited can refute the accepted definition of recurrent miscarriages reviewed in an more recent publication (Li et al., 2002). If we speak about efficacy it is also necessary to think about the costs resulting from the inclusion of patients with only two miscarriages. This subgroup is 40% (!) of all patients with miscarriages in this study.

However, the most important point of criticism is the evaluation of the uterine cavity. Hysteroscopy was performed only in a ‘selected group’ of patients (2/189; 4% !). What were the selection criteria? There are different studies showing a high incidence of intrauterine pathology after only one (!) first trimester abortion with dilatation and curettage. Fiedler et al. (1993) performed post-abortion hysteroscopy in 147 patients and found intrauterine pathology in 38 (25.9%), mainly intrauterine adhesions. This was confirmed by Römer (1994) with intrauterine adhesions in 18.8% after the first abortion and 47.6% after two or more abortions. Interestingly, intrauterine abnormalities in 38 patients (10.1%), mainly adhesions (26/38), were found during a screening hysteroscopy of 379 asymptomatic patients with primary infertility and without any risk factor (Nawroth et al., 2003). From these data it is not justifiable to exclude 99% of patients with recurrent abortions from intrauterine hysteroscopic evaluation. One can discuss whether hysteroscopy will remain the ‘gold standard’ in the future. Preliminary studies show excellent results in regard to the evaluation of uterine cavity with three-dimensional ultrasound in 379 asymptomatic patients with primary infertility and without any risk factor (Nawroth et al., 2003). From these data it is not justifiable to exclude 99% of patients with recurrent abortions from intrauterine hysteroscopic evaluation. One can discuss whether hysteroscopy will remain the ‘gold standard’ in the future. Preliminary studies show excellent results in regard to the evaluation of uterine cavity with three-dimensional ultrasound (Kupesic et al., 2002; Hartman et al., 2004). Different studies comparing hysteroscopy with other methods (hydrosalpingography, sonohysterography) have shown no equal efficiency in regard to evaluation of intrauterine pathology. Hysteroscopy is an invasive procedure but we and other authors found only a minimal and tolerable discomfort performing minihysteroscopy with optics <3 mm in diameter without any anaesthesia (De Iaco et al., 2000; Nawroth et al., 2003). Therefore it is unproblematic to include minihysteroscopy in the suggested one-stop evaluation.

In conclusion, we appreciate the attempt to rationalize the diagnostic approach to patients with recurrent miscarriages. This will make diagnosis possible, especially for women living a long distance from the specialized centre. But with the knowledge of the above-mentioned data one can assume that the inclusion of routine hysteroscopy (or perhaps in the future 3D sonography) will increase reproductive outcome. It could further decrease the reported 54% of the patients with no cause for recurrent miscarriage in favour of uterine causes which are operable.

References


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Should spontaneous or timed intercourse guide couples trying to conceive?

Sir,

Natural family planning (NFP) methods to conceive, based on timed intercourse in the fertile window, are promoted as reducing the time to pregnancy and improving the chances of conception.

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This view is promoted in the lay press and in a multitude of websites and was recently put forward in this Journal (Brosens et al., 2004; Gnoth et al., 2003, 2005). The view is based on observational studies without a comparison group (Hilgers et al., 1992; Gnoth et al., 2003).

Observational studies without a comparison group do not allow assessment of associations (Grimes and Schulz, 2002). Nevertheless, the authors claimed that the higher cumulative probability of conception, compared with previously published studies, accounts for the effects of information on the fertile period and of repeated timed intercourse. The question arises if these observations are sufficient evidence to replace spontaneous coital habits among couples who want children.

In 1994 we investigated in Walcheren, The Netherlands, the time to pregnancy in the general population. Walcheren GPs and independent midwives, the main caregivers of obstetrics in The Netherlands, and all four gynaecologists working in Walcheren, asked successive consulting pregnant women how much time had passed between the cessation of contraceptive activities and the onset of their pregnancy. Of the 729 registered pregnancies, nearly half of the annual number in Walcheren, 10 occurred during oral contraception and were not contraceptive activities and the onset of their pregnancy. Of the 729 registered pregnancies, nearly half of the annual number in Walcheren, 10 occurred during oral contraception and were excluded. The cumulative conception rate after 1, 3, 6 and 12 months was 40, 75, 89 and 97% respectively in the 719 included couples.

Our results are nearly identical to those described by Gnoth et al. in couples using the NFP method of fertility oriented intercourse (Figure 1).

In the NFP population study, only cycles with the intention to become pregnant and with at least one episode of unprotected intercourse in the fertile window were taken into account. Couples with ovulatory problems were excluded, as were couples with previous fertility problems. The women in the German NFP population were trained and instructed by experienced NFP teachers and the higher social class levels were over-represented in the sample. These inclusion criteria tend toward higher fertility.

In contrast, the Walcheren study included consecutively pregnant women from the entire general population, whether or not they ovulated regularly, had regular coital activities or intended to become pregnant. Couples currently under subfertility investigation were not included.

The age of the women was comparable in both populations, as was the definition of pregnancy and the degree of subfertility. Gnoth et al. reported the time to pregnancy in cycles, the Walcheren study did it in months; they registered the time to pregnancy prospectively, whereas the Walcheren study was retrospective. Unintended pregnancies are not included in prospective studies. Juul et al., (1999) found that 42.5% of pregnancies in West Germany were unplanned.

We realize that the differences between the samples preclude definite conclusions. Nevertheless, we believe that the results presented suggest strongly that the effectiveness of the NFP methods in enhancing the chance to conceive is not proven.

The NFP concept seems attractive, but there is a need for better evidence of benefit. Meanwhile, the National Institute for Clinical Excellence (NICE) Guidelines (2004) conclude: ‘Timing intercourse to coincide with ovulation causes stress and is not recommended.’

Given the enormous impact of NFP methods, with $4 \times 10^6$ hits in the Google search engine, the promoters of NFP methods for use among fertile couples have a duty to demonstrate the efficacy of their method in well-designed clinical trials. While waiting for those trial results, use of these methods is not justifiable.

References


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