Reply to ‘Olfactometric and rhinomanometric outcomes in post-menopausal women treated with hormone therapy: a prospective study’

Sirs,

The comment of Attilio Di Spiezio Sardo et al. was very interesting. They reported the results of their studies on the effects of intranasal and transdermal estradiol on nasal mucosa of post-menopausal women, underlining the trophic improvement of the nasal respiratory epithelium during the usage of hormone replacement therapy (HRT), that could contribute to a significant reduction of the olfactory threshold. Interestingly, our previous data have shown changes in the nasal epithelium either throughout the menstrual cycle—with better trophy during the periovular phase—(Serra et al., 2004) or in post-menopausal women treated with HRT, during which the trophism of nasal epithelium improved (Caruso et al., 2003). Moreover, in women taking oral contraceptives, unlike the rhinomanometric airflow and transnasal pressure, the olfactory threshold to odours seemed to depend on the variation of the ovarian steroids during the menstrual cycle and on the iatrogenic effects of the contraceptive pill (Caruso et al., 2001). We reported our previous results in this paper, hypothesizing—among others—that HRT could also act directly on neuronal transmission and affirmed that ‘this will be the basis of a future study using olfactory evoked potential in order to verify this hypothesis’. In fact, due to the complexity of the matter (i.e. we obtained changes in rhinomanometry on post-menopausal women, but not on women taking the contraceptive pill), up to now we cannot affirm that steroids act on one specific olfactory pathway. On the other hand, the olfactory threshold seems to depend on cyclic modulation of ovarian steroids. In our opinion, we have to study a lot of olfactory pathways to understand the role of olfaction in human reproduction.

References


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Fertility outcome after a randomized trial comparing curettage with misoprostol for treatment of early pregnancy failure

Sirs,

Dilatation and curettage is currently the cornerstone in the treatment of women with early pregnancy failure. Misoprostol has been presented as a non-surgical alternative for curettage in these women. We previously reported on a randomized trial which showed that women treated with misoprostol had a 53% complete evacuation rate without additional surgery, whereas in the curettage group 96% had complete evacuation after the initial procedure (Graziosi et al., 2004). Since most women with early pregnancy failure aim for a renewed pregnancy, a study was performed on fertility outcome. During the end of 2004, we contacted the 154 women included in this study that had been run from November 2001 to June 2003. We excluded eight women who had had early pregnancy failure after treatment with assisted reproductive technology. Follow-up data were lacking in five women who could not be contacted since they had moved to another location. Fifteen women had not tried to conceive since their early pregnancy failure.

In a telephone survey, women were asked about the time they had been trying to conceive, and on the occurrence and outcome of subsequent pregnancies (renewed pregnancy failure, occurrence of preterm delivery, form of delivery, difficulties in placental removal and haemorrhage). Of the 126 women who had tried to conceive, 69 had been allocated to misoprostol (37 needed additional curettage) and 57 allocated to curettage (two needed recurettage).

Cox’s proportional hazards estimates of the relative risks (RRs) were 0.98 [95% confidence interval (CI) 0.68–1.4] for conception and 0.98 (95% CI 0.66–1.5) for ongoing pregnancy at 12 weeks. Kaplan–Meier curves of the ongoing pregnancy rates are shown in Figure 1. The cumulative conception rates were 94% in each of the groups, whereas cumu-

Figure 1. Time since child wish after therapy for early pregnancy failure: misoprostol versus curettage.
relative ongoing pregnancy rates were 87% in both groups. Most of the women conceived within 6 months after trying to conceive. There were 5% (three out of 60) pregnancy complications (i.e., haemorrhage post-partum, operative removal of placenta, rhesus sensitisation and preterm delivery) in the misoprostol group versus 14% (seven out of 50) in the curettage group (RR 0.68; 95% CI 0.31–1.5). The caesarean rate was comparable in both groups (7.3 versus 6.5%, respectively).

Previous studies reporting on fertility after curettage as compared with conservative management for early pregnancy showed no differences between these treatment strategies (Kaplan et al., 1996; Blohm et al., 1997). This follow-up study shows that a strategy starting with misoprostol or curettage for early pregnancy failure does not affect future fertility. Moreover, fertility rates are similar to those reported among the normal population (Speroff et al., 1994).

References

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