firm the absence of viral contamination in selected sperm used for assisted reproduction by ICSI in order to assess the infectious status of a single sperm. As reported in previous papers, quoted in our article, a percentage of sperm cells may be infected by the HIV virus (Dussaix et al., 1993; Baccetti et al., 1994) and unlike peripheral blood testing, we cannot be sure that the single injected sperm cell is free of infection by extrapolation from the absence of HIV in half of a selected semen sample. The risk of transmission is therefore only ‘theoretically’ zero, even after many tests.

In the same period, another group (Pena et al., 2003) expressed some doubts about HIV tests in sperm before assisted reproduction. Semprini et al. (2000) reported over two thousand intra-uterine insemination and more than one hundred ICSI/IVF-ET cycles with washed sperm without seroconversion or viral contamination of babies.

We therefore considered that sperm washing and ICSI ensured a substantial decrease in the risk of infection. Patients were of course informed about the efficacy of sperm washing and ICSI in reducing the risk of contamination, and they accepted ICSI without any attempt to detect viral presence in selected sperm samples.

Our published data increased the number of HIV serodiscordant couples treated by sperm washing and ICSI without viral contamination, irrespective of testing for HIV in selected sperm samples.

Nowadays, we agree with Dr Garrido and Dr Meseguer that excellence in assisted reproduction includes testing sperm samples before ICSI.

Since the year 2004, washed sperm samples of all serodiscordant couples treated in our reproductive centre have undergone viral tests, in collaboration with the Molecular Biology Department, Virology Section, Siena University.

References


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Comment on ‘Season of birth influences the timing of menopause’

Sir,

We read with great interest the article by Cagnacci et al. (2005a), which related that season and month of birth influenced the timing of menopause. Cagnacci simultaneously published an article, which also examined the seasonal onset of menopause, in another journal (Cagnacci et al., 2005b). In the latter article, which retrospectively researched 2436 post-menopausal women, the onset of menopause was more frequent ($P < 0.0001$) in winter (32.5%) than in spring (20.8%), autumn (20.3%) and summer (26.2%); a minor peak was also observed ($P < 0.0001$ versus spring and autumn).

Cagnacci et al.’s study would have been more useful if opinions about the seasonal onset of menopause had been included with that former study to reduce the bias.

References

Sir,

The letter of Shukunami and colleagues refers to two papers published almost simultaneously by us on the timing of menopause. The two papers were obtained by the same database. The paper on the seasonal onset of menopause (Cagnacci et al., 2005b) was written earlier, although published later, and the analysis was performed on 2432 post-menopausal women. The data in this paper indicate that the onset of menopause is not evenly distributed throughout the year, but occurs preferentially in some seasons (in winter and to a lesser degree in summer) compared with others. The data emphasize the important role that environmental factors linked to season play in the regulation of reproductive life including its termination. The paper on the effect of the season of birth on the timing of menopause (Cagnacci et al., 2005a) was written later, although published earlier. Between the two analyses, we were able to retrieve additional information from the paper records of our patients, which were entered into the electronic databases. Accordingly, the analysis was performed in 2822 women. The results indicate that the timing of menopause is influenced by the season in which a woman is born. The data are interesting because they point to the role that prenatal environmental factors exert on postnatal events including a woman’s ovarian exhaustion. Accordingly, the two papers relate to two different and separate issues—the former to season and reproduction, the latter to environment and fetal development. However, we understand the point made by Shukunami and colleagues. It may be that the analysis showing a different timing of menopause on the basis of season of birth is influenced by the seasonal onset of menopause. For example, birth in a season distant from the preferential season for the onset of menopause, may prolong the reproductive period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because the preferential season for the onset of menopause, may prolong the reproductive period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before the woman reaches that critical period and delay menopause, simply because almost 1 year has to pass before

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Is 250 μg rHCG always better and safer than 500 μg rHCG?

Sir,

We read with interest the recent article written by Al-Inany et al. (2005). Amongst the four trials included in this meta-analysis, only one compared the effect of two different doses of recombinant (r)HCG (Chang et al., 2001). Ovarian hyper-stimulation syndrome (OHSS) was more commonly reported in patients treated with 500 μg rHCG (9.0%) as compared to the group receiving 250 μg rHCG (3.2%), although this was not statistically significant. A recommendation was made by Al-Inany et al. (2005) that ‘increasing the dose of rHCG