(ii) No seroconversions occurred in our large series. The system employed to follow-up patients was to obtain from the woman an HIV negative result either performed by ELISA (HIV antibody) nor by a PCR method (see Materials and Methods page 2, last paragraph). As most of our treated women (88%) are not resident in our region, they were referred to their local HIV physicians and laboratories to perform the tests. Every treated woman was serologically assessed and all HIV-1 blood tests performed by PCR assays were negative. Not every woman was assessed by PCR, but in some cases the local physician decided to use this method, for example, if the woman successfully conceived. The use of PCR method to assess the presence of HIV in a seronegative individual who was exposed to uninfected semen is still to be discussed. In fact, as reported in our paper we only used negative semen, tested for detectable HIV RNA by real-time PCR assay. The potentiality of a stored blood bank remains at our centre. Unfortunately, the ‘500 cases’ quoted in his letter, have not been published and cannot properly be added to other reported scientific series which adopted criteria similar to our protocol in order to confirm the efficacy of sperm washing.

(iii) Safety is indeed an ambitious statement in clinical research. Safety could be defined as ‘a judgment of the acceptability of risk, i.e. a measure of the probability of an adverse outcome and its severity, associated with using a technology, for a given patient with a particular health problem, by a trained clinician’ (www.gulfwar.osd.mil/medsearch). In the HIV era, we also discuss the safety of Caesarean section in reducing HIV mother to child transmission to an acceptable risk (Read and Newell, 2005). As stated in our paper (Discussion page 5, line 22) ‘safety issues require a large multicentre trials and until then participants need to understand that no procedure is risk free as all carry a possibility for transmitting infection. The CDC statement of ‘lack of best available evidence’ (Duerr and Jamieson, 2003), should still be compared to the natural transmission risk (Mandelbrot et al., 1997).

References
www.gulfwar.osd.mil/medsearch/glossary (14 March 2007, date last accessed)

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Effect of GnRH antagonists in FSH mildly stimulated intrauterine insemination cycles: a multicentre randomized trial

Sir,
We read with interest the paper by Crosignani et al. (2007) on effect of GnRH antagonists in mildly stimulated intrauterine insemination (IUI) cycles and agree with the authors that, further large studies and meta-analyses are required to determine the effects of GnRH antagonist in mild controlled ovarian hyperstimulation (COH). We have the following comments:

(i) The authors in their study used single IUI. Double IUI increases the pregnancy rate significantly compared with single IUI in COH (Matilsky et al., 1998; Ragni et al., 1999; Liu et al., 2006). Perhaps when estradiol (E2) levels are at threshold for multiple pregnancies (MP), one-day IUI cycles can be considered to reduce the risk of MP instead of cancelling the cycle.

(ii) ‘Soft’ stimulation protocols for COH are gaining in popularity these days to prevent MP. COH with clomiphene citrate and gonadotropins (Ragni et al., 1999) is another option for COH, which is cost effective also.

(iii) We would ask the authors to kindly comment on what the other possibilities are if E2 levels are beyond the stated threshold level for MP, apart from cancelling the cycle to achieve single pregnancy?

We hope further discussion and suggestions will contribute to the advancement and popularity of the author’s findings.

References

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