BACKGROUND: The aim was to ascertain whether using ultrasound guidance during intrauterine insemination (IUI) could increase pregnancy rates (PRs).

METHODS: The population under study consisted of 73 consecutive couples subjected to IUI in our Human Reproduction Unit, between June and December 2006, with a total of 231 IUI cycles performed. The patients were randomized using a computer-generated random numeric table into two groups: ultrasound-guided IUI group (n = 33) and clinical IUI group (n = 40).

RESULTS: The PR was 16.0% per cycle in ultrasound-guided IUI and 16.8% in the control group, no statistically significant differences being observed between the groups. The 95% confidence interval for the difference in PRs of 0.8% was -8.8 to 10. There were no differences in PR per woman, nor in first-cycle PR. The cumulative PR was also similar in both populations. Although the initial intention was to perform a study involving a larger number of cases, after a first interim analysis, the study was interrupted due to its futility. There were no differences in PR according to the different cervico-uterine angles.

CONCLUSIONS: Ultrasound-guided IUI does not produce better results than blind insemination, because the PR per cycle is similar.

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Key words: intrauterine insemination / pregnancy rate / ultrasound
The objective of this study was to determine the potential benefits of using abdominal ultrasound during IUI, by comparing the PRs of ultrasound-guided with non-ultrasound-guided inseminations.

Materials and Methods

The sample under study consisted of 73 consecutive couples subjected to IUI in our Human Reproduction Unit, between June and December 2006, with a total of 231 IUI cycles performed. All couples were subjected to the infertility work-up as follows: transvaginal ultrasonography, basal hormone tests (third day of the cycle), hysterosalpingography and sperm analysis. The woman’s inclusion criteria in our IUI program were at least one patent tube, normal cavity, basal follicle stimulating hormone (FSH) < 10 mIU/ml and age under 40 years. IUI with husband’s sperm (IUI-H) was indicated when, after sperm preparation, at least 5 million motile spermatozoa were recovered; this was performed in 58 cases (79.45%). In the remaining 15 cases (20.55%), IUI was performed with donor sperm (IUI-D) either because of azoospermia (n = 6), failure to recover spermatozoa during testicular biopsy (n = 5), or in women without a male partner (n = 4). No previous infertility treatments had been carried out.

The stimulation protocol was the same for all patients, consisting of a daily subcutaneous injection of 150 IU of recombinant FSH (Gonal F®, Serono Laboratories, Spain), started on Day 2 of the menstrual cycle. The ovarian response to stimulation was regulated by adjusting the dose according to transvaginal folliculometry and plasma estradiol assay, as previously reported (Matorras et al., 1995, 1997). When at least one follicle had a diameter of 16–20 mm, we administered one subcutaneous dose of 0.25 mg/day of cetrorelix (Cetrotide®, Serono Laboratories), maintaining this dose until the day on which hCG was administered.

From the start of antagonist administration, we added 75 IU/day of recombinant LH to the FSH stimulation protocol (Luvers®, Serono Laboratories). We administered 250 mcg of rHCG (Ovitrelle, Serono Laboratories) when there were at least two follicles with a diameter of ≥ 18 mm, with estradiol level ≥600 pg/ml (≥2200 pmol/l). The treatment cycle was cancelled if there were <2 or >5 follicles. We carried out one single insemination per cycle at 37–39 h after hCG injection, with a maximum of six insemination cycles per patient (Matorras et al., 2000; Osuna et al., 2004).

All the semen samples were prepared with density gradients of Pure-sperm (NidaCom Laboratories, Sweden) as described previously (Matorras et al., 2000, 2003, 2006). The luteal phase was supplemented with vaginal micronized progesterone (Utrogestan®, Besins-Iscovesco Laboratories, Paris, France) at doses of 200 mg every 12 h. Institutional Board approval and informed consent were obtained.

Patients were randomized using a computer-generated random numeric table and the numbers entered into closed envelopes. Group I (n = 33) corresponded to ultrasound-guided insemination and Group II (n = 40) to insemination using clinical criteria. After randomization there were no women who refused to participate in the study. In both groups, the patients attended the appointment with a full bladder, and the same catheter model was used for the procedure in both instances: the Frydman Soft model (Prodimed, France), which has two channels: rigid outer (with a cap) and flexible inner; all IUIs (both ultrasound IUI and clinical IUI) were performed by staff gynaecologists and the majority (90%) were carried out by the same gynaecologist (O.R.).

In patients undergoing ultrasound-guided insemination, prior to insemination, the cervico-uterine angle (the angle formed between a line joining the external and internal cervical orifices and another line joining the internal cervical orifice to the uterine fundus) was measured on a longitudinal uterine image, obtained via abdominal ultrasound. Patients were then assigned to one of the following four categories: (i) no angle or narrow angle (<30°); (ii) moderate angle (30–60°); (iii) wide angle (>60°) and (iv) retroflexed uterus.

In patients undergoing ultrasound-guided insemination, the external (rigid) sheath of the catheter was moulded in advance according to the angle, and introduced into the cervical cavity to 1 cm past the internal cervical orifice. Via this sheath, under abdominal ultrasound guidance, we introduced the flexible inner catheter into the uterine cavity, until the tip was located at a distance of 1 cm from the fundus. Abdominal ultrasound was performed by mean of a General Electric Medical Systems Logic 3 ultrasound machine with the 3.5C abdominal probe.

In patients undergoing non-ultrasound-guided insemination, cervical catheterization was performed, until the resistance of the internal cervical orifice was passed, introducing the internal catheter according to clinical criteria, based on a hysteroscopy carried out during the infertility work-up. In no cases, was cervical tenaculum or hysterometer needed at the time of the procedure (either in ultrasound IUI or in classical IUI). Pregnancy was defined by visualization of the gestational sac at vaginal ultrasound 3–4 weeks after insemination.

For statistical analysis, we used the χ² and ANOVA tests, following the standard applicability criteria. The Statistical Package for Social Science (SPSS) version 13.0 was used. Alpha value was defined as α ≤ 0.05. Cumulative PR was calculated according to Cramer et al. (1979).

Sample size predetermination was calculated as follows: assuming a per cycle PR of 12% (on the basis of the Spanish Insemination Register results) (Hernandez et al., 2006), an alpha of 0.05 and a 0.20 β risk in a bilateral contrast; 551 cycles in each group would be needed to detect a 6% difference between the groups, employing the arcsin calculation method. Intermediate cut-offs for analysis were defined at 20, 50 and 80% of the estimated sample size, to eventually redefine the size of the population.

Results

In the first cut-off, a total of 231 stimulated cycles in 73 patients were included. In 58 patients, the sperm sample was the husband’s sperm (190 cycles) and in 15 patients donor sperm was used (41 cycles). In the ultrasound-guided group, 106 cycles were carried out and the non-ultrasound-guided group, 125 cycles. The main characteristics of the ultrasound-guided IUI and classical IUI populations were similar with regard to age, hormonal status, ovarian stimulation and sperm parameters (Table I). The number of women completing six cycles of treatment was similar in both groups: seven in ultrasound-guided IUI (seven with husband’s sperm and zero donor) and nine in classical IUI (seven with husband’s sperm and zero donor).

The PR per cycle was 16.0% (17/106) in the ultrasound-guided group, very similar to the 16.8% (21/125) in the classical IUI group (Table II); 95% confidence interval for the difference in PRs was 0.8% (−8.8/10), P = 0.8763. There were no differences in PR per woman, nor in first-cycle PR between both groups. The cumulative PR was also similar in both populations (Fig. 1). There were no differences in the PR between ultrasound and non-ultrasound groups when analyzed according to the indication for IUI. Since the PR was essentially the same, the study was interrupted after recruitment and analysis of these 73 patients, who represented 20% of the estimated required number of cycles.

Miscarriage rate was similar in both groups, as was multiple PR. High-order multiple pregnancy was also similar (two triplets in the ultrasound-guided group versus one triplet in the non-ultrasound-guided group).
The ultrasound measurement performed before IUI showed a cervico-uterine angle between 30 and 60° in 57.7% of cases. After insertion of the speculum, the cervico-uterine angle was between 30 and 60° in 69.8% of cases, with a consequent decrease in the proportions of all the remaining cervico-uterine angle groups. There were no differences in PR according to the different cervico-uterine angles.

In the 97 cycles (including both ultrasound-guided IUI and classical IUI) where the cervico-uterine angle was recorded, the PR was similar according to the different cervico-uterine angles.

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### Discussion

IUI is a widespread technique requiring cervical catheterization to access the uterus, similar to embryo transfer in IVF. However, although in recent years, a number of authors have studied the different conditions associated with embryo transfer prognosis, the effect of IUI insemination technique has received little attention. Theoretically, IUI performed under ultrasound guidance could be associated with increased PR, since this may reduce cervical and endometrial damage as well as bleeding, thus reducing the release of prostaglandins as well as uterine contractions.

The use of ultrasonography as a support for assisted reproduction techniques has been widely used in IVF. Embryo transfer is usually associated with higher PRs, although no differences have been reported in a recent work (Drakeley et al., 2008). Difficulty of transfer, presence of blood in the catheter and uterine contractions all reduce implantation rates (Alvero et al., 2003). The use of abdominal ultrasound during transfer provides direct visualization of the movement of the catheter inside the endometrial cavity, reducing the frequency of difficult transfers and minimizing endometrial damage. However, its use in IUI has not been tested. Both IUI and embryo transfer require cervical catheterization and deposition of the end product of the reproductive technique inside the endometrial cavity.

IUI results are influenced by a number of parameters: female and male conditions, sperm characteristics and preparation, infertility status, ovarian stimulation and methodology, as has been demonstrated in a number of studies (Matorras et al., 1995; Osuna et al., 2004). However, the methodology of IUI technique has received scarce attention.

In IUI, the processed specimen is deposited using a blind technique, dependent on the skill of the physician. In IVF, it has been shown that blind transfer leads to inadvertent contact of the tip of the catheter...
with the uterine fundus in 17.4% of cases (Woolcott and Stanger, 1997), provoking an increase in uterine contractions (Lesny et al., 1998); expulsion of >40% of the volume introduced into the uterine cavity has been reported (Harper et al., 1961; Mansour et al., 1994). Another cause of uterine contractions is the handling of the cervix in achieving catheterization. In IVF, ultrasound visualization of the cervico-uterine angle allows the catheter to be adapted to the angle, thus avoiding excessive manipulations and resulting in atraumatic catheterization. Rapid transfer also increases the chance of pregnancy in IVF (Matorras et al., 2004). One of the prognostic factors for IUI is the number of motile spermatozoa deposited in the uterus. The presence of contractions may eliminate almost half of the spermatozoa, unbeknown to the clinician, and thereby limiting the results (Wainer et al., 2004). The object of our study was therefore to ascertain whether using ultrasound guidance during IUI could increase the PRs. The control and study populations proved to be comparable regarding the main demographic and clinical parameters.

However, our study failed to find any differences between ultrasound-guided IUI and conventional IUI. In fact, PRs were very similar in the two groups, with regard to both PR per cycle (16.0 and 16.8%) and PR per woman (51.5 and 52.5%). Two explanations can be given. First of all, it is possible that filling the bladder alone could have the same insemination-facilitating effect as ultrasound-guided IUI insemination with a full bladder. In a number of the studies regarding ultrasound-guided embryo transfer, a full bladder was not required in the control group. The hypothesis of the insemination-facilitating effect of a full bladder seems to be supported by the fact that cervical manipulation was not required in any of the classical IUI cases.

On the other hand, the processes that follow the release of embryo/spermatozoa into the uterine cavity differ between IVF and IUI. In IVF, it has been reported that it is important to deposit the embryos in a specific place in the uterine cavity (Lewin et al., 1997; Coroleu et al., 2002), which is in many cases close to the site of implantation. However, in IUI, spermatozoa must still ascend through the fallopian tube, as far as the ampullary portion, where fertilization occurs. In IVF, cervical and endometrial damage could interfere with implantation, either directly or via prostaglandin release. However, in IUI, since implantation occurs approximately 7 days after insemination, cervical and endometrial damage are likely to have been repaired by this time.

The stimulation protocol employed during the study is more aggressive than is usual, and was associated with a high rate of high-order multiple pregnancy. In our unit, this has now been replaced by a lower starting dose of FSH.

In our study, we performed an intermediate analysis of results to redefine the sample size of the population, if necessary. Such analyses are relatively common when deciding whether to discontinue a study if clearly significant differences have been found with a smaller sample size than initially calculated. They are also useful for recalculating the size of the required sample if the observed differences are smaller than expected and a larger population is judged necessary. In our case, the differences in results were not only much lower than expected, but were practically non-existent. Only a 0.8% difference in per cycle PR was observed, and in favor of the non-ultrasound group, consequently the study was interrupted due to its futility.

With regard to the cervico-uterine angle, the majority of patients displayed an angle between 30 and 60°, especially after speculum insertion. In our experience, the cervico-uterine angle was not a prognostic factor, contrary to results published previously in IVF (Sallam et al., 2002).

According to our experience, the use of ultrasonography during IUI complicates the technique, requiring an ultrasound probe and specialized personnel (ultrasound technician) and increases the amount of time required while obtaining similar results to the control group of patients for whom ultrasonography was not used. We consider atraumatic catheterization necessary for preventing uterine contractions, but this can be achieved both by requesting a moderately full bladder in order to reduce the cervico-uterine angle and by moulding the catheter to an angle of 30–60°, which corresponds to the angle observed in 70% of all patients. However, in our opinion, ultrasound-guided IUI should be recommended in cases where problematic cervical catheterization is expected.

In conclusion, our results indicate that ultrasound-guided IUI does not produce better results than blind insemination, since the PR per cycle is similar. Thus, we do not recommend the systematic use of ultrasound guidance during IUI.

References


