

CDC's protocol allows ART clinics to game the system

In his July editorial, "Too many embryos for one woman," Dr. Robert L. Barbieri questioned how we define success in assisted reproduction. I agree that this issue needs to be addressed. The system for reporting assisted reproductive clinic outcomes to the Centers for Disease Control and Prevention (CDC) offers the wrong incentives. As long as the CDC makes overall live birth rates the standard, too many embryos will continue to be transferred.

I suggest using the rate of live births per embryo implanted. This would offer patients a more controlled means of comparing programs and would not encourage programs to "improve" their numbers by transferring too many embryos. We have come a long way since the first IVF baby was born in 1978, and our specialty is a leader in informing patients about treatment outcomes. The American Society for Reproductive Medicine, the Society for Assisted Reproductive Technology, and the CDC have worked to give infertility patients access to more comparative data and information than patients in any other field of medicine. However, we have a long way to go—and no good reason to avoid a simple, logical next step.

Serena H. Chen, MD

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Make the mother and doctor culpable for IVF multiples

I applaud Dr. Barbieri's efforts to address the troublesome issue of iatrogenic multiple gestations. Like him, I would hate to see government regulation of assisted reproduction, but it seems clear something should be done to limit the number of preventable multiple gestations. I have 2 suggestions, either of which would result in a dramatic decrease in multiple gestations:

- Women usually pay for assisted reproduction themselves because few insurance companies cover IVF. When they do become pregnant, they use health insurance to cover the costs of the resultant pregnancy. If insurance companies were allowed to deny coverage for costs associated with high-order multiple gestations (3 or more) resulting from IVF, few women would allow their doctor to implant multiple embryos, and the

rate of multiple gestations would immediately drop.

- If the implanting doctor were required to indemnify the woman and pay for the maternity expenses of any high-order multiple gestation (3 or more) resulting from embryo transfers, you would see an immediate drop in the number of transfers.

Self-regulation is the surest way to prevent government interference. Too often patients and doctors are insulated from the economic consequences of their decisions. Either one of these measures would remove that insulation and make doctors



"If rate of live births per implanted embryo were the standard, clinics would avoid transferring too many embryos"

and patients financially responsible for their actions regarding embryo transfer.

Michael Robinson, MD
Fountain Valley, Calif

Overzealous ART: Editor was "too kind"

Thanks to Dr. Barbieri for taking a stand on the "non-sense" that has become common practice for some practitioners of reproductive endocrinology: the implantation of multiple (more than 2) embryos. Though it can be truly rewarding and joyous to help an IVF patient conceive, these pregnancies contribute significantly to the incidence of premature births, neurodevelopmental disorders, chronic lung disease, deafness and blindness, infant mortality, and long-term behavioral abnormalities.

We must remember the admonition to "do no harm." In my opinion, the creation of higher-order multiple gestations as a consequence of infertility care is inappropriate.

Dr. Barbieri, I couldn't agree more with your editorial—though I do think you were actually too kind.

Jordan H. Perlow, MD
Phoenix, Ariz

Dr. Barbieri responds:

I thank Drs. Chen, Robinson, and Perlow for their thoughtful comments and deep commitment to trying to identify a constructive approach to the complex and common problem of multiple gestations resulting from fertility treatments. From my perspective, our field needs to try harder to mobilize experienced ObGyn clinicians such as them to help solve this problem.

Uterine artery embolization poses no excessive risk

In their July article ("Uterine artery embolization for abnormal bleeding"),

Drs. Ducksoo Kim and Stephen D. Baer provide critical information about this procedure, which represents an important new option for women who experience diminished quality of life as a result of fibroids.

However, in the discussion of mortality, they noted that 2 deaths had been reported: 1 described in a letter to the editor in the form of a case study¹ and the other in a 2003 report by de Blok et al.²

I would like to point out that no deaths have occurred in any of the randomized clinical trials to date, which have enrolled well over 1,000 patients. Further, clinicians should keep in mind that the most common alternative to UAE is hysterectomy, which, like any surgery, also carries risk. For example, in a study involving 53,000 US women undergoing hysterectomy, a mortality rate of 19 per 10,000 women was reported.³

Although UAE is not without risk, the procedure does not pose excessive risk. Close collaboration between the ObGyn and the interventional radiologist is important to treat any infections promptly and reduce risk.

Linda D. Bradley, MD
Director of Hysteroscopic Services
Cleveland Clinic Foundation

**"We must
remember
to 'do no harm'
in infertility care"**

REFERENCES

1. Vashisht A, Studd J, Carey A, Burn P. Fatal septicaemia after fibroid embolisation [letter]. *Lancet*. 1999;354:307-308.
2. de Blok S, De Vries C, Prinssen HM, Blaauwgeers HL, Jorna-Meijer LB. Fatal sepsis after uterine artery embolization with microspheres. *J Vasc Interv Radiol*. 2003;14:779-793.
3. Kjerulff K, et al. The socioeconomic correlates of hysterectomies in the United States. *Am J Pub Health*. 1993;83:106-108.

Drs. Kim and Baer respond:

We appreciate Dr. Bradley's further clarification of the 2 cases of fatal sepsis associated with uterine artery embolization (UAE), which occurred before 2003. Since then there have been no other fatal septic complications reported, although more than 50,000 UAE procedures have been performed to date.

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Dr. Bradley correctly noted that there have been no deaths associated with any randomized clinical trials, which have involved more than 1,000 patients. This coincides with our experience with more than 800 cases to date and with the short-term outcomes data of the Fibroid Registry on UAE procedures in more than 3,000 patients at 72 sites in the United States.¹

Dr. Bradley was also right to point out that the risk of mortality is significantly greater with surgical options.

Uterine artery embolization has been the preferred therapeutic option for symptomatic fibroids in our collaborative interventional radiology/ObGyn practice since 1997. We strongly believe that the close interdisciplinary collaboration is essential to achieve favorable technical and clinical outcomes.

REFERENCE

1. Worthington-Kirsh R, Spies JB, Myers ER, et al. The fibroid registry for outcomes data (FIBROID) for uterine embolization: short-term outcomes. *Obstet Gynecol.* 2005;106:52-59.

Let's keep babies on terra firma

One of the legal cases presented in the July installment of Medical Verdicts had this heading: "Is misoprostol wrong for induction?" Misoprostol may not be wrong, but the dose sure was.

The plaintiff claimed that hyperstimulation occurred during induction of labor at term due to excessive doses of misoprostol. The case summary stated that 50 mg of misoprostol was given vaginally and a second 50-mg dose was given 3 hours later.

Each of these doses is approximately 1,000 to 2,000 times the recommended dose of 25 to 50 micrograms (μ g). However, since the baby was apparently not ejected at escape velocity into a low earth orbit I assume this was just a typographical error!

Bruce Flamm, MD
Riverside, Calif

CORRECTION

Dr. Flamm is correct; the 50-mg figure was a typographical error. The doses should have been 50 micrograms.

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