

## Citations from the Literature

**This is a selection of abstracts taken from the literature in the field of obstetrics and gynecology which the Journal's Editors feel may be of interest to our readers\***

### FERTILITY, STERILITY

#### **The role of superovulation with menotropins in ovulatory infertility: A review**

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The risks of menotropin therapy (ovarian hyperstimulation syndrome, multiple gestation, adnexal torsion) are well known and have been previously described. Superovulation should not be considered for the indications described herein until more traditional therapies for infertility have been tried and found unsuccessful and sufficient time has elapsed for conception to occur. The cost of superovulation is high: the medications are expensive, frequent E<sub>2</sub> monitoring and US studies are costly, and pregnancy complications relating to the higher rate of pregnancy loss and multiple gestation may add substantially to the overall cost. Yet, compared with IVF and GIFT, superovulation cycles combined with IUI cost between one third to one sixth that of an IVF cycle. Protocols involving combined CC/hMG/hCG, which reduce the total number of ampules of Pergonal needed per cycle and still provide multiple follicular development, may further reduce costs. There is a growing consensus that superovulation-IUI protocols should be attempted before GIFT and IVF in couples with normal pelvic viscera. There is little doubt that IVF and GIFT cycles are more costly, stressful, and complex. No comparative data have clearly shown IVF and GIFT to be superior to superovulation protocols in ovulatory women with normal pelvic anatomy. In the only study examining this issue published to date, Kaplan et al. retrospectively analyzed all GIFT and superovulation/IUI cycles at a single university center and found GIFT to be three times more efficient. However, the inherent limitations of a nonrandomized, nonprospective study of this kind are obvious as these authors have suggested. Therefore, it may be wise to consider the use of superovulation before assisted reproductive technologies until this issue is settled. It would be interesting to determine if the high PRs

reported for couples with unexplained infertility or mild endometriosis in IVF and GIFT cycles in some centers not incorporating superovulation/IUI protocols would hold up if such an approach was routinely followed. Despite the increasing acceptance of superovulation protocols, we must be aware that many of the studies suggesting a role of hMG in treating ovulatory infertile women with normal pelvic anatomy suffer from deficiencies in experimental design. In a payor-driven system, such as in the United States, the difficulties in designing and carrying out scientifically sound clinical studies examining infertility therapies are obvious. The lack of federal or outside funding for the study of infertility issues contributes to the problem. It is our hope that better designed studies examining the role of superovulation in the treatment of ovulatory infertile women with normal pelvic anatomy will be forthcoming.

#### **Controlled ovarian hyperstimulation and intrauterine insemination for treatment of infertility**

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Empirical therapy for subfertility using assisted reproductive technologies recently has gained popularity; however, the cost-effectiveness of these therapies, compared with an untreated control group, has not been established. Similarly, there has been no comparative cost analysis of the utility of controlled ovarian hyperstimulation and IUI in the management of the same condition. Significant PRs in untreated couples with subfertility mandate the design and execution of controlled trials to ascertain the role of controlled ovarian hyperstimulation and IUI in infertility therapy. Various disorders of subfertility have been treated with controlled ovarian hyperstimulation and IUI. The rationale for this therapy is the increase in gamete density at the site of fertilization, as with GIFT and IVF when used for management of the same problems. The live birth rate per initiated cycle and risk of complications are similar to results recently reported for GIFT and IVF. The utility of controlled ovarian hyperstimulation and IUI still remains controversial. When the relatively low direct and indirect costs of controlled ovarian hyperstimulation and IUI are considered, acknowledging the lack of prospective, controlled studies this procedure appears to be at least as cost-effective as GIFT and IVF.

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