



NEWSLETTER

INTERNATIONAL FEDERATION
OF FERTILITY SOCIETIES

AUTUMN 2010

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the German Society of Reproductive
Medicine (DGRM)

Message from the President

Basil C. Tarlatzis MD, PhD
President of IFFS



EVERY THREE YEARS

The tri-annual periodicity is essential for IFFS, since every three years the Federation has its World Congress in a different continent and, at the same time, its leadership changes hands.

Hence, we are now heading for the 20th World Congress on Fertility & Sterility which will be held in Munich, Germany next September and promises to be one of our best scientific events. Also in Munich, my presidency comes to an end and Professor David Healy from Melbourne, Australia takes over, together with the new Executive Committee that will be voted there. This gives me the opportunity to look back and reflect on what was accomplished during these last three years.

One of our most crucial tasks was to collaborate closely with our German colleagues, aiming to organize a very successful Congress. I am confident that the outcome will satisfy all the participants and will be a great precedence for the meetings to come. At the same time, we decided to take over the responsibility of organizing our future Congresses. This will be partly implemented in the 2013 Joint IFFS-ASRM Congress and fully in the 2016 one. Another area of highest priority that we pursued was education. Thanks to the great work of our Director of Education Ian Cooke, we were able to organize numerous courses in many different parts of the world and especially in the developing countries. The Federation is indebted to Ian for the time, energy and efforts he devoted to this important project. Our Standards and Practice Committee, under the leadership of our Secretary General Richard Kennedy, prepared five IFFS Practice Standards and two Policy Statements, while three more standards are in preparation. These documents are extremely important, since they fulfill the IFFS goal to promote high quality care for patients around the globe. In addition, we initiated the process to revise our by-laws, so that they will be more consistent with the current operation and mission of the Federation. The proposed changes have been approved by the Executive Committee and will be presented for ratification in the General Assembly in Munich, according to our Constitution. Last but certainly not least, we started our collaboration with Tom Parkhill, who as our communications advisor, is helping us to establish contacts with the international press, aiming to make IFFS and its initiatives more visible.

These have been three exciting and challenging years and I feel very privileged and honored that I had the opportunity to serve our Federation. Moreover, I was extremely fortunate to have a dedicated and highly efficient team of colleagues and friends, who guided me with their experience and wisdom. Now, time has come for me to step down and hand over the leadership of IFFS to our next President, Professor David Healy. Having worked closely with him, I had the opportunity to appreciate his great intellectual qualities as well as his large experience. Thus, I am absolutely confident that he will be a superb leader of IFFS for the next three years.

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Member Societies and readers are invited to send all comments, reports or articles of 800 – 1200 words no later than 1st February for the Spring Issue and 1st July for the Autumn Issue.

The views expressed in articles in the IFFS Newsletter are those of the authors and do not necessarily reflect the official viewpoint of IFFS.

Endometriosis and Infertility

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Endometriosis is estimated to affect 6-10% of reproductive-age women, or approximately 186 million women around the world, causing pelvic pain, infertility and ovarian cysts (endometriomas). The specific role of endometriosis in infertility is unknown. Anatomic distortion created by scarring and adhesions offers a clear mechanism for reduced pregnancy rates. However, in the absence of anatomic distortion, the cause of subfertility is uncertain, possibly involving hormonal disruption, local inflammation, altered immune response and/or other unknown mechanisms.

Diagnosis

Pelvic pain is the most common presenting symptom of endometriosis, occurring in 80% of patients. Dyspareunia and dysmenorrhea are both common, though endometriosis-associated pain can be seen throughout the menstrual cycle. Pain can vary in character and location, may be associated with bowel activity and micturation, and is often not related to extent or type of lesion.

This variability in presentation contributes to the difficulty in diagnosing endometriosis and helps account for the significant delay in diagnosis experienced by many patients, which averages eight to nine years. Diagnosis requires a thorough history and physical exam. Mass lesions are often seen on ultrasonography and MRI, while diagnostic laparoscopy or laparotomy with biopsy remain the only definitive diagnostic modalities.

Various endometriosis staging systems have been proposed. While the most popular is the American Society for Reproductive Medicine system, it is unable to predict clinical outcomes such as pregnancy rate. However, a new validated staging system, the Endometriosis Fertility Index (EFI) incorporates historical, surgical, and functional data to assign a score which is then used to predict pregnancy rates. (Figure 1)

Treatment

Treatment options for patients with endometriosis are dictated by both current and long-term reproductive goals, pain symptoms and the extent of disease. In patients not actively interested in conception, medical management with progestins, gonadotropin-releasing hormone agonists and aromatase inhibitors as well as surgical resection/ablation and neurectomy offer variable control of symptoms. Comprehensive pain management interventions are important. However, in those patients whose reproductive goals are to restore or improve fertility, ovarian suppression has not been shown to improve pregnancy rates. Interventions in fertility patients instead focus on destruction of pelvic implants and restoration of anatomy, enhancement of fertility with the aid of ovarian stimula-

tion drugs and assisted reproductive technologies (ART) or some combination of these.

Surgery provides diagnostic information regarding the extent of disease and can treat both endometriosis lesions and the anatomic distortion caused by adhesions and scarring. Laparoscopy offers improved visualization, reduced tissue trauma and reduced new adhesion formation, as well as quicker recovery, compared with laparotomy. Different laparoscopic techniques for the destruction of endometriosis lesions are equivalent, surgical expertise being the most important technical determinant of outcome. Surgical management may also address multiple components of the reproductive process, such as immunobiological, inflammatory and other changes, thereby contributing to the increased pregnancy rates after surgery.

While surgery can address pain or anatomical distortion, it is of limited value in cases of minimal to mild disease, with the number needed to treat (NNT) for one extra pregnancy being about 7-8 endometriosis patients. Thus, in at least some young, otherwise-good prognosis patients

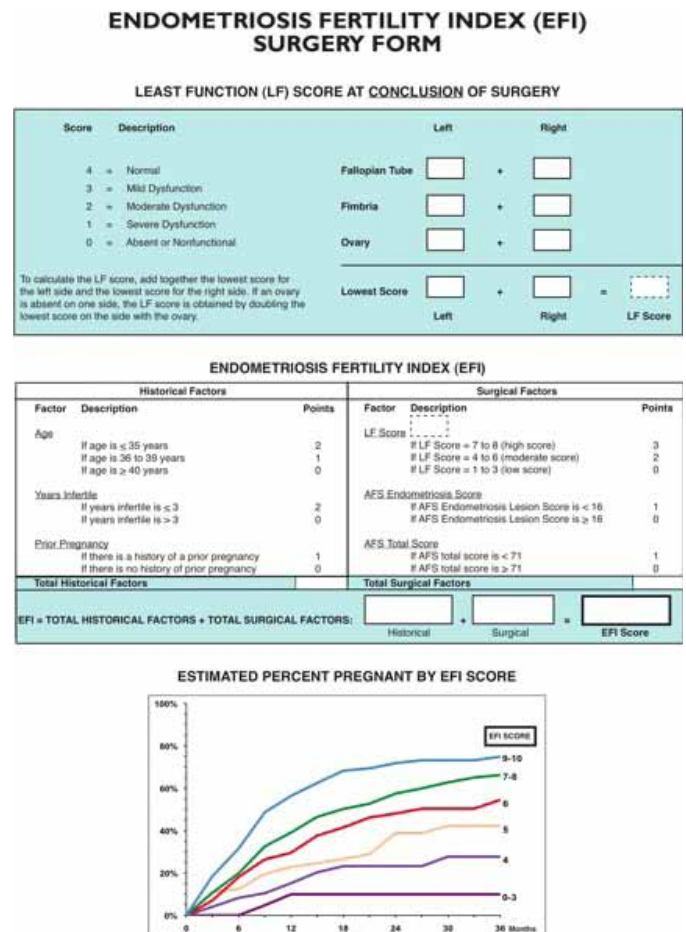


Figure 1.

Adamson GD, Pasta DJ. Endometriosis Fertility Index (EFI). *Fertility and Sterility* Nov 19, 2009. DOI: 10.1016/j.fertnstert.2009.09.035

with minimal to mild disease and no symptoms other than infertility, observation for 3-12 months is a reasonable option, often followed by 3-6 months of controlled ovarian stimulation with clomiphene citrate.

Moderate to severe endometriosis is most often associated with significant anatomic distortion and a low spontaneous pregnancy rate if left untreated. It is widely believed that surgical intervention improves pregnancy rates by restoring anatomic relationships and reducing the impact of endometriosis lesions as addressed above. Ovarian endometriomas can be managed with either laparoscopy or laparotomy, with cyst wall removal being the best technique for diagnosis, prognosis and lowest recurrence. The number and/or size of the endometriomas do not generally affect pregnancy rates, the most important factor being preservation of the maximum amount of viable ovarian tissue. The Endometriosis Fertility Index (EFI) is a tool that can be used to help determine optimal management following laparoscopy.

While there are some theoretical advantages of ovarian suppression prior to surgical treatment of endome-

triosis, there are no data that conclusively show benefit. Post-operative suppression treatment has been shown to be of no benefit.

The length of time a patient should attempt conception post surgery depends on prognosis, which can be predicted by the EFI. Controlled ovarian stimulation, sometimes with intrauterine insemination, can increase pregnancy rates. Since repeat surgery is generally not effective, after 9 to 18 months IVF becomes the best option for almost all patients. Endometriosis does not have a significant impact on IVF outcomes. Even with endometriomas, it is still not known whether cystectomy, especially for those less than 4cm in diameter, is beneficial before IVF.

Conclusion

Endometriosis can be a debilitating condition causing pain, infertility and pelvic masses. Laparoscopy enables diagnosis, estimation of prognosis using the EFI, and concomitant, often successful, treatment. Patients not conceiving can often become pregnant through IVF. With expert management, the overall prognosis for pregnancy in women with endometriosis is very favorable.



History of the International Federation of Fertility Societies

Roger D. Kempers, MD

Professor of Obstetrics and Gynecology, Emeritus
Mayo Clinic School of Medicine

#6

The IV World Congress was held in Rio de Janeiro, Brazil August 8-15, 1962. The IFA President was Carlos Guerrero, Mexico D.F. and host congress president was A. Campos da Paz, Rio de Janeiro, Brazil. The congress was well attended as were the memorable social events. For the first time, a delegation came from the USSR. Tragically on leaving to return to Russia the airplane carrying most of these delegates crashed into the bay during take off and many died from the crash and the fires surrounding the floating aircraft.

First, G. Tesauro of Naples, Italy the IFA President at that time, was determined to uphold the agreement made with the Vatican during the congress held in Naples that certain topics such as contraception would not be discussed in IFA congresses. The congress organizers on the other hand were equally determined to develop a well rounded scientific program. This was particularly critical because at that time research and use of oral contraceptives was a timely subject as was investigation into various types of intrauterine devices. The matter was resolved by holding dual programs. The official congress scientific program was conducted in one area of the building excluding topics unacceptable to the Vatican while a second section of the congress with topics such as contraception and donor insemination was held in a separate section of

the same building. The printed program acknowledged two separate sections of the congress.

The second event was the holding of preliminary discussions on the concept of an international federation of national fertility societies. These discussions were spearheaded by H. DeWatteville of Switzerland, Raoul Palmer of France and C. Guerrero of Mexico. By that time 10 more countries in addition to the original 8 in existence at the time IFA was founded now had national fertility societies. Provisional by-laws for such an IFFS were drafted and provision was made for the continuation of the IFA for individual physicians from countries without national societies. DeWatteville had a great deal of experience in federations having been Secretary General of the International Federation of Gynecologists and Obstetricians (FIGO). He contacted all the national fertility societies and they accepted the transition to IFFS. The change was proposed to the General Assembly in Stockholm in June 1966 and ratified during the subsequent congress in Tel Aviv, Israel in May 1968.

Education Committee

Ian Cooke MD

Emeritus Professor
University of Sheffield



On November 5-6 last year Prof Bernard Hedon conducted a Workshop in Abidjan, Ivory Coast with the Ivory Coast Fertility Society under the umbrella of IFFS, the French college of Ob-Gyn (CNGOF) and the West African Society of Reproductive Medicine (GIERAF) with 60 participants. Dr Myriam Kadio-Morokro was able to include all local groups. The opening ceremony was held in the presence of the representative of the first lady of Ivory Coast and of the Ivorian Director of Health. The external speakers were Benoit Schubert from Paris, Monique Commenges from Bordeaux, Marc Bailly from Paris, Professor Cheikh Cisse from Dakar, Senegal and Dr Moise Fiadjoe, from Togo. This was one of the first meetings on ART in the country and went extremely well, showing the development of this subject in West Africa.

A new style Workshop was held in Alexandria on 21-23 March on Evidence Based Medicine with practical online experience for the 25 delegates. Local experts were Professors Anna and Suzanne Abou-Raya and the event was held in the Suzanne Mubarak Regional Center for Women's Health and Development with Prof Hassan Sallam and myself.

Somewhat later in the same month another experiment was held, where streaming video was sent from the Royal College of Obstetricians and Gynaecologists for 5 days to the Suzanne Mubarak Center, organised by Dr Luciano Nardo, Chair of the Training Committee of the British Fertility Society and Co-ordinator of the FACE (Fertility and Assisted Conception Education) Consortium. After initial technical difficulties the experience was excellent with dialogue between the two centres promoting discussion. An audience of more than 60 contained a



Part of the audience watching screens at the streaming video conference transmitted from the Royal College of Obstetricians and Gynaecologists in London at the Suzanne Mubarak Center, Alexandria, Egypt.



On top: Participants in the Evidence Based Medicine Workshop on line at PubMed in the Library of the the Suzanne Mubarak Center, Alexandria, Egypt. Above: Prof. Guido Pennings speaking in Warsaw

large group from francophone Africa. Discussions are in progress to do a similar event in Moscow next year. The success of this meeting showed that a new paradigm was possible, where high quality meetings could be beamed to more distant parts of the world, enabling access for a much greater number of persons who could not possibly travel to the primary site. This activity was strongly supported by Merck Serono.

From 27-29 May 2010 two Workshops were held in Warsaw. One was on Ethics and legal aspects and the other was on Gamete and embryo cryopreservation, reflecting current concerns in the co-host organisations of the national meeting of the Polish Society for Reproductive Medicine and the Fertility and Sterility Special Interest Group of the Polish Gynecological Society. Our external speakers were Professor Guido Pennings (Ghent, Belgium), Professor Juan Garcia-Velasco (Madrid, Spain), Dr Safaa Al-Hasani (Lubeck, Germany), Dr Petra Thorn (Frankfurt, Germany) and myself. The debate helped to stimulate discussion of matters that were currently being considered for legislation.

The organisational structure of Education in IFFS will be progressively developed by a new Director of Education, who will be appointed in September this year. It is hoped that the work can be increased effectively by appointing Regional Directors to promote closer links with the regions as demand continues to increase. It has been a great privilege to have been able to start this activity. I am sure that the 35 Workshops that the programme has held has been a means of stimulating greater knowledge of our subject, expanding interest in IFFS and making better links around the world to develop the careers of the young people starting out on their chosen paths.

Reproductive Tourism Cross Border Infertility Treatment

Richard Kennedy

Medical Director, University Hospital Coventry



Much has been commented on recently in the international media about so called “reproductive tourism” a phenomenon which has also attracted the attention of the European Society for Human Reproduction and Embryology (ESHRE) and the World Health Organisation. The term “reproductive tourism” is regarded as unnecessarily stigmatising to those who do no more than seek solutions to their healthcare needs by obtaining care in countries other than their own and has been replaced by the more sensitive term “Cross Border Reproductive Healthcare”. In a recent publication¹ it was estimated that in Europe alone 11-14,000 women seek infertility treatment each year across international borders. Such is now the extent of this practice that in order to establish its full impact ESHRE has established a group tasked with the aim of assessing in detail its scope and extent.

Cross border treatment is defined as patients crossing international boundaries for the purposes of obtaining infertility treatment. This process is not unique to this area of medical treatment and is normally driven by the lack of availability of the required treatment in the patient’s own country. In infertility practice the most common reasons for couples to seek treatment outside their own country are to obtain treatments which for ethical or access reasons are not available in their own or to seek novel treatments which are not widely available e.g. pre-implantation genetic diagnosis. In the Shenfield et al study, referenced above, the majority of cross border treatments were undertaken for “legal” reasons (70%). In the last decade Italy and Germany have introduced legislation to prohibit egg donation and recruitment limits the availability of this treatment in France and the UK. Currently a national debate is taking place in Poland which could have similar consequences for access and we have heard recently of plans in Denmark to pull back from current levels of access. The IFFS monitors the availability of assisted conception treatments globally and the national frameworks within which these treatments are provided and will be

publishing its latest Surveillance in September 2010 at the World Congress in Munich.

The increasing trend to cross border treatment gives rise to several concerns. In part these relate to the variable application of politically driven reproductive ethics and in part to variable prioritisation of assisted conception within the allocation of healthcare resources. Whilst international uniformity in the acceptance of gamete and embryo donation is an unlikely goal, the IFFS supports uniform access to assisted reproduction within available resources and a common understanding of the place for its components including embryo cryopreservation.

Of more immediate clinical concern are the downstream consequences of cross border treatment. Women recipients inevitably return to their native country, often immediately after embryo or gamete placement, therefore raising the question of responsibility for the management of adverse effects of treatment such as ovarian stimulation and egg harvesting. Furthermore, there is significant international variation in practice of the upper female age limit for treatment and the number of embryos that are transferred in an IVF cycle that result in high risk and high order multiple pregnancy and their potential for adverse maternal and fetal outcomes. The burden of these adverse outcomes is borne by the native healthcare system which has no control over their likelihood.

Whilst acknowledging the motives which cause patients to seek help outside their own national boundaries, the IFFS regards patient safety as paramount and calls for international collaboration to develop uniform clinical and safety standards in the practice of assisted reproduction that will safeguard women and provide assurance to practitioners providing guidance to their patients. The IFFS will work with its international partners and professional societies to develop a consensus on the practice of cross border treatment and uniformity of clinical standards.

¹ F Shenfield, J de mouzon, G Pennings, AP Ferraretti, A Nyboe Andersen, G de Wert and V Goossens the ESHRE Taskforce on Cross Border Reproductive Care. Cross border reproductive care in six countries. Human Reproduction, 2010; 6: 1361-1368

International Calendar

IFFS 20th World Congress on Fertility & Sterility
September 12-16, 2010
Munich, Germany
www.iffs2010.com

66th Annual Meeting of the ASRM
October 23-27, 2010
Denver, Colorado, USA
www.asrm.org

27th Annual Meeting of ESHRE
July 3-6, 2011
Stockholm, Sweden
www.eshre.com

50th anniversary of the German Society of Reproductive Medicine (DGRM)



Professor Hans R. Tinneberg

Chair of the German Local Organizing Committee of the Munich IFFS meeting

Professor Liselotte Mettler

Chair of the German Local Scientific Committee of the Munich IFFS meeting

The German Society of Reproductive Medicine (DGRM) celebrated its 50th anniversary in 2008. Our society is a child of the International Fertility Association (IFA). IFA, the predecessor of IFFS, was founded in 1951 in Rio de Janeiro, Brazil and from the beginning it supported the foundation of national fertility societies.



Kurt Semm

International meetings took place every three years. In 1968 in Tel Aviv the IFFS evolved from the IFA. Kurt Semm provided a tremendous German input into IFFS and served as general secretary for 20 years and later as president of IFFS from 1986 – 1990. The German society is proud to host for the first time the IFFS World Congress on Fertility and Sterility in Munich from September 12-16th 2010.

Based on the broad spectrum of our activities in the field of fertility and sterility, the four columns of our society are gynaecology, andrology, veterinary medicine and basic sciences. For the last 25 years we have held scientific meetings of doctors working in veterinarian and human medicine. This scientifically interesting platform has initiated many interdisciplinary working groups in biotechnology and other fields. In 1980 the German society initiated the first world conference on in vitro fertilization and embryo transfer in Kiel. Since then, IVF world conferences take place every second year; the last one was held in Geneva in 2009.

After the founding of our society in 1958 the scientific interaction of the members was well documented in the journals "Fertilität", "Reproductive Medicine", and in the current "Journal for Reproductive Medicine and Endocrinology". The fall of the German wall in 1989 led to unity in reproductive medicine spreading throughout Germany. Different groups have split away and formed their own societies to promote their specific interests in the field of reproductive medicine. e.g. Arbeitsgemeinschaft Reproduktionsbiologie des Menschen (AGRBM), Bundesverband Reproduktionsmedizinischer Zentren Deutschlands

(BRZ), Deutsche Gesellschaft für Andrologie (DGA), Deutsche Gesellschaft für Gynäkologische Endokrinologie und Fortpflanzungsmedizin (DGGEF), Österreichische Gesellschaft für Reproduktionsmedizin (OEGRM), Sektion Reproduktionsbiologie und –medizin der Deutschen Gesellschaft für Endokrinologie (SRBM/DGE).

Highlights of our 50th anniversary meeting were: current developments in reproductive biology, traditional Chinese medicine (TCM), video workshops on the adnexa and uterus, organizational changes in the field of reproductive medicine, IVF globalization and economizing measures, and the presentation of the results of the German in vitro fertilization registry (DIR).

In addition to our annual meetings, our society also founded the School of Reproductive Medicine and Endocrinology in 2006. We have an interdisciplinary working group on biotechnology, a German network of paramedical staff working in reproductive medicine, a working group of geneticists in reproduction, a working group of female doctors active in reproductive medicine and endocrinology, an andrological working group, a study group on fertility protection for oncologic patients and regular study groups on specific topics, such as fertilization to implantation, endoscopic surgery, cryopreservation of gametes, veterinarian medicine as well as philosophical, social and ethical questions, etc.



Hans Tinneberg and Lilo Mettler

Lilo Mettler and Hans Tinneberg have both served as president of the German society and are very much looking forward to hosting the 20th Annual Meeting of IFFS from 12-16th September 2010 in Munich, the city where our society was founded in 1958. IFFS 2010 offers an inspiring scientific programme and exceptional social activities(www.iffs2010.com).

Join us in Boston!

October 12-17, 2013



IFFS/ASRM

*A Conjoint Meeting of the
International Federation of Fertility Societies and
the American Society for Reproductive Medicine*

Boston, Massachusetts, USA, 2013



Photographs courtesy of the Greater Boston Convention & Visitors Bureau.



Contact Information for IFFS Secretariat



International Federation of Fertility Societies

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