Infertility Studies Support Anastrozole, Letrozole

**BY JANE SALODOF McNEIL**

**Southwest Bureau**

**LOS ANGELES —** New data from two pilot studies support the use of aromatase inhibitors to promote pregnancy in women with ovulatory dysfunction or unexplained infertility, according to poster presentations at the annual meeting of the Society for Gynecologic Investigation.

In the first randomized study to test anastrozole as an infertility treatment, women who took the aromatase inhibitor before undergoing intrauterine insemination (IUI) had a pregnancy rate comparable overall with those undergoing standard treatment with clomiphene and IUI. Anastrozole cycles appeared to offer an advantage, however, in that they led to more pregnancies in women with polycystic ovary syndrome and generated three times fewer follicles overall.

In the second study, women taking letrozole before undergoing in vitro fertilization (IVF) produced more oocytes and had higher pregnancy rates than those who were treated with a standard protocol of gonadotropins, although the differences between groups were not statistically significant. This study was a randomized feasibility trial in low responders who had failed previous treatments and were scheduled for an aggressive IVF protocol.

**Infertility Work-Up Should Include Examination With TVL, Expert Says**

**BY KATE JOHNSON**

**Montreal Bureau**

**LONDON —** The modern infertility work-up should include a transvaginal hydroalparoscopic exploration of the tubes and ovaries, said Stephan Gordts, M.D., of the Leuven (Belgium) Institute for Fertility and Embryology.

He pioneered transvaginal hydrolaroparoscopy (TVL) in 1998 (later, another group named the procedure “tertiology”) and said he’s since abandoned tubal assessment by hysterosalpingogram (HSG). Whereas the HSG can explore tubal patency only, “with TVL you have a more complete exploration of the patient,” he told this newspaper.

Speaking at the annual congress of the International Society for Gynecologic Endoscopy, Dr. Gordts explained that TVL can evaluate both the tube itself and outside of a patient’s reproductive organs and can evaluate adhesions and endometriosis by incorporating hysteroscopy, transcervical hydrolaroparoscopy, salpingoscopy, and tubal patency testing. TVL can be done in an ambulatory setting, under local anesthetic, and requires only an oocyte aspiration room, rather than a full operating theater. The procedure is performed with the insertion of a needle transmurally into the pouch of Douglas followed by infusion with saline. An endoscope can be introduced, allowing visualization of the outside of the uterus, the ovaries, and the distal part of the fallopian tubes. The scope can be introduced a few centimeters into the distal end of the fallopian tube for evaluation of the ampulla and the inside of the tube. A biopsy can be removed for evaluation of normal cilia movement.

At the same time, a hysteroscope through the cervix, allowing evaluation of the inside of the uterus, and infusion of dye through the fallopian tubes to assess the tube’s patency. The preparation of saline makes adhesions and sub-endometriotic lesions float, allowing for easier identification. The procedure is often masked under the high intra-abdominal pressure of laparoscopy,” said Dr. Gordts.

Although it’s primarily a diagnostic procedure, TVL can be used to perform adhesiolysis, treat mild to moderate endometriosis, and drill ovaries in patients with polycystic ovarian disease.

Unlike Dr. Gordts, Jacques Donnez, M.D., said he believes there is still a place for HSG in the fertility work-up—and the combination of HSG and TVL might offer the most thorough tubal assessment. Although TVL can visualize a few centimeters of the inner distal fallopian tube, and evaluate patency by confirming spillage of dye infused through the cervix, it offers no other information about the status of the proximal tube, said the professor and head of gynecology at Catholic University of Louvain in Brussels.

“You can see if the dye is not going through, but if this happens you have no idea of the location of the blockage or if there is some diverticulosis or anomalies in the proximal tube,” he said in an interview. “When you do HSG, you identify the severe obstruction of proximal blockages, some of which can be easily catheterized.”

**Smoking, Estrogen Bad Combination for Alzheimer’s**

**BY MICHELE G. SULLIVAN**

**Mid-Atlantic Bureau**

**MIAMI BEACH —** The risk of Alzheimer’s disease declines by almost half among postmenopausal nonsmokers who use estrogen therapy, according to a study presented at the annual meeting of the American Academy of Neurology.

Dr. Roberts, an epidemiologist at the Mayo Clinic, Rochester, Minn., also found that early estrogen therapy might be a predictor for Alzheimer’s in postmenopausal women; in contrast, estrogen therapy, but nearly doubles among those who both smoke and use estrogen therapy, Rosebud O. Roberts, M.B., said in a poster presented at the annual meeting of the American Academy of Neurology.

“Smoking was a major confounder in the study,” said Dr. Roberts, who also noted that their sample was small but the results were statistically significant. She and her associates conducted a case-control study that included 216 women with natural menopause who developed Alzheimer’s disease during 1985-1989. They were compared with 210 cognitively intact controls who had similar ages at menarche and menopause.

A similar percentage of women in both groups used estrogen therapy for at least 6 months (11.6% of cases, 14% of controls). Of the 54 women on estrogen, the 25 with Alzheimer’s started estrogen therapy earlier than the 29 controls (50 years vs. 53 years), and had a shorter lag time between menopause and the initiation of estrogen therapy (1 year vs. 4 years). Estrogen users had a 20% reduced risk of Alzheimer’s disease, but this was not statistically significant.

The investigators did see significant differences in estrogen therapy and the risk of Alzheimer’s disease in postmenopausal smokers, however. The odds ratio of Alzheimer’s was 1.93 in smokers who used estrogen therapy and only 0.54 in nonsmokers who used estrogen therapy. Those who initiated estrogen therapy earlier probably had less endogenous estrogen, and more symptoms, while those who initiated therapy at a later age may have had fewer symptoms or less severe symptoms—probably had more premenopausal estrogen.