

References

1. Vercellini P, De Giorgi O, Mosconi P, Stellato G, Vicentini S, Crosignani PG. Cyproterone acetate versus a continuous monophasic oral contraceptive in the treatment of recurrent pelvic pain after conservative surgery for symptomatic endometriosis. *Fertil Steril* 2002;77:52–61.
2. Brosens IA. Endometriosis—A disease because it is characterized by bleeding. *Am J Obstet Gynecol* 1997;176:263–7.
3. Moran C, Alcivia JC, Garcia-Hernandez E, Castro J. Treatment of endometriosis with cyproterone acetate. Preliminary report. *Arch Med Res* 1996;27:535–8.
4. Evers JL. The second-look laparoscopy for evaluation of the result of medical treatment of endometriosis should not be performed during ovarian suppression. *Fertil Steril* 1987;47:502–4.
5. Nisolle-Pochet M, Casanas-Roux F, Donnez J. Histologic study of ovarian endometriosis after hormonal therapy. *Fertil Steril* 1988;49:423–6.

PII S0015-0282(02)03356-3

The spectrum of embryo transfer days

To the Editor:

The article by Wilson et al. (1) regarding integration of blastocyst transfer for all patients confirms that, as shown by other researchers, this is a viable option for an in vitro program. However, their conclusions that day 5 ETs improve success rates cannot be specifically supported by their data. Their day 3 data is from January 1997 to December 1998; their day 5 data is from June 1998 to December 2000. It is very likely (and hopefully the case) that pregnancy rates would have improved over that time without any change in day of transfer. In addition, there is a difference in stimulation protocols used during the time periods. Although they indicate that they saw no differences, meta-analysis (2) has shown that pregnancy rates are higher with recombinant gonadotropins (used exclusively in the later time period) than with urinary products (partially used in the earlier time period).

We have looked at our data regarding day 3 vs. day 5 transfer over a time period in which the earlier transfers tended to be on day 5 and the later transfers tended to be on day 3. Patients less than 36 years for whom we electively replaced two embryos (the patients who seemed to benefit most from blastocyst transfer in the report by Wilson et al. (1)) had comparable clinical pregnancy rates with day 3 and day 5 transfers (73% and 67%, respectively). Clearly, our data has the same shortcomings as that of Wilson et al. However, if comparable pregnancy rates can be shown, day 3 transfer is advantageous in that it seems to result in a lower incidence of monozygotic twins and thus, a lower incidence of triplets (5.6% in Wilson et al. (1)) after transfer of two embryos.

James M. Goldfarb, M.D.
Nina Desai, Ph.D.
*Cleveland Clinic Fertility Center
Beachwood, Ohio
May 7, 2002*

References

1. Wilson M, Hartke K, Kiehl M, Rodgers J, Brabec C, Lyles R. Integration of blastocyst transfer for all patients. *Fertil Steril* 2002;77:693–6.
2. Daya S. Updated meta-analysis of recombinant follicle-stimulating hormone (FSH) versus urinary FSH for ovarian stimulation in assisted reproduction. *Fertil Steril* 2002;77:711–4.

PII S0015-0282(02)03350-2

Reply of the Authors:

We thank Goldfarb and Desai for their interest in our paper (1). When day 3 ET data were compared between years (1997-FSH and 1998-recombinant FSH), there was no difference in all parameters measured, for our program. Therefore, those data were combined.

After the initial preliminary trial during 1998, both day 3 ET and day 5 ET were performed in two comparable patient populations. Day 5 ET resulted in clinical pregnancy rates that were numerically higher (day 3 ET:55%, day 5 ET:64%), but not significant. However, the number of embryos transferred (2.0) was significantly less for patients having day 5 ET.

We cannot comment on the shortcomings of data from the program of Drs. Goldfarb and Desai, as it has not been published. Our data (1, 2) have shown that, at a minimum, we were able to reduce the number of embryos transferred for all patients and maintain or improve pregnancy rates within each age group using day 5 ET for all patients. In addition, we cannot comment on the incidence of monozygotic twins with regard to day 3 ET and day 5 ET, as to date no controlled studies have been published.

Michael Wilson, Ph.D.
*Reproductive Resource Center of Greater Kansas City, P.A.
Overland Park, Kansas
May 31, 2002*

References

1. Wilson M, Hartke K, Kiehl M, Rodgers J, Brabec C, Lyles R. Integration of blastocyst transfer for all patients. *Fertil Steril* 2002;77:693–6.
2. 1999 Assisted Reproductive Technology Success Rates. U.S. Department of Health and Human Services, Center for Disease Control and Prevention. December 2001.

PII S0015-0282(02)03351-4

Estrogen levels and thrombophilia—An intervening variable or a confounder?

To the Editor:

We read with great interest the manuscript of Dulitzky et al. (1) investigating the prevalence of different types of thrombophilia in women suffering from severe ovarian hyperstimulation syndrome (OHSS). We were really surprised about the high frequency of different markers of thrombophilia found in the studied population. These investigators