

How members of the Society for Reproductive Endocrinology and Infertility and Society of Reproductive Surgeons evaluate, define, and manage hydrosalpinges

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Objective: To describe the management of hydrosalpinges among Society for Reproduction Endocrinology and Infertility (SREI)/Society of Reproductive Surgeons (SRS) members.

Design: Cross-sectional survey of SREI/SRS members.

Setting: Academic and private practice-based reproductive medicine physicians.

Participant(s): A total of 442 SREI and/or SRS members.

Intervention(s): Internet-based survey.

Main Outcome Measure(s): To understand how respondents evaluate, define, and manage hydrosalpinges.

Result(s): Of 1,070 SREI and SRS members surveyed, 442 responded to all items, for a 41% response rate. Respondents represented both academic and private practice settings, and differences existed in the evaluation and management of hydrosalpinges. More than one-half (57%) perform their own hysterosalpingograms (HSGs), and 54.5% involve radiologists in their interpretation of tubal disease. Most respondents thought that a clinically significant hydrosalpinx on HSG is one that is distally occluded (80.4%) or visible on ultrasound (60%). Approximately one in four respondents remove a unilateral hydrosalpinx before controlled ovarian hyperstimulation (COH)/intrauterine insemination (IUI) and clomiphene citrate (CC)/IUI (29.3% and 22.8%, respectively), and physicians in private practice were more likely to intervene (COH: risk ratio [RR] 1.81, 95% confidence interval [CI] 1.31–2.51; CC: RR 1.98, 95% CI 1.33–2.95). Although laparoscopic salpingectomy was the preferred method of surgical management, nearly one-half responded that hysteroscopic tubal occlusion should have a role as a primary method of intervention.

Conclusion(s): SREI/SRS members define a “clinically significant hydrosalpinx” consistently, and actual practice among members reflects American Society for Reproductive Medicine/SRS recommendations, with variation attributed to individual patient needs. Additionally, one in four members intervene before other infertility treatments when there is a unilateral hydrosalpinx present. (Fertil Steril® 2012;97:1095–100. ©2012 by American Society for Reproductive Medicine.)

Key Words: Hydrosalpinx, salpingectomy, tubal disease, hysteroscopic tubal occlusion, SREI, ASRM, in vitro fertilization

Although the proposed toxic mechanisms of hydrosalpinges on fertility are not well understood (1), the deleterious effects of hydrosalpinges diagnosed by HSG, ul-

trasound, or laparoscopy on various IVF outcomes have been documented in several observational studies (2–12) and subsequent meta-analyses (13, 14). The American Society for

Reproductive Medicine (ASRM), along with the Society of Reproductive Surgeons (SRS), citing three randomized controlled trials (15–17), recommends salpingectomy or proximal tubal occlusion (PTO) before in vitro fertilization (IVF) in patients with hydrosalpinges to improve pregnancy and live birth rates (18). These studies show that the ongoing pregnancy rate for patients with hydrosalpinges that are managed by laparoscopic salpingectomy or PTO is more than twofold higher than in the nonintervention controls (34% vs. 17%) (18, 19).

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Hysterosalpingography (HSG), first described in 1910, is the most common tool used for the evaluation of tubal patency and typically provides the first sign of existing tubal pathology, such as a hydrosalpinx (20, 21). Despite its interobserver variability and sensitivity/specificity regarding interpretation and screening, HSG remains a staple of the initial infertility workup (22–27). Detection of hydrosalpinx by HSG was first described in 1931 and refers to two classifications of hydrosalpinx: “hydrops tubae fallopiae occlusae (distal and proximal occlusion)” and “hydrops tubae fallopiae apertae (only distal occlusion)” (28). Hydrosalpinx, literally “water/swollen tube,” has been defined as “accumulation of serous fluid in the fallopian tube” (29, 30). Another definition of hydrosalpinx refers specifically to the “dilation of the ampullary segment of the tube that accompanies distal obstruction” usually from sequelae of pelvic infection by gonorrhea and/or *Chlamydia* (31).

Much progress has been made in the evaluation, management, and treatment of hydrosalpinges, but some questions remain: “Is a hydrosalpinx that is distally patent clinically significant, warranting removal before any infertility treatment?” “Does ovarian response and pregnancy rate/live birth rate change when salpingectomy is performed, and does the surgical instrument type matter?” “Does hysteroscopic tubal occlusion have a role as a primary method of occlusion in patients with hydrosalpinges?”

To better understand the individual approach to hydrosalpinges by reproductive physicians, we sought to assess current evaluation, definition, and management of hydrosalpinges by surveying practicing Society for Reproduction Endocrinology and Infertility (SREI) and SRS members. We also aimed to compare responses from participants who identify themselves as being in “private” or “academic” practice.

MATERIALS AND METHODS

Participants

This cross-sectional survey (Supplemental Material) was approved by the Washington University Institutional Review Board (IRB). We used the SREI member directory (www.socrei.org)—which links to the ASRM member directory—to identify survey participants. We identified 896 SREI members who described their practice as: “gynecology,” “gynecology/infertility,” “infertility only,” “obstetrics and gynecology,” or “reproductive endocrinology and fertility.” We identified 476 SRS members with the use of the same filters and then manually checked for duplicates, because many SREI members are also SRS members.

We excluded those who did not have an email address listed and SRS members who identified themselves as “urologists.” We excluded 17 members who had nonfunctional email addresses after a test e-mail. After completion of the survey, respondents were eligible for four \$15 iTunes (Apple) gift cards. Computer-generated randomization of those who had completed the survey was used to pick the winners.

Survey Content

Through expert opinion and literature review, the authors developed a 30-item questionnaire that was piloted at the

TABLE 1

Demographics of survey respondents.

Characteristic	n (%)
Sex	
Male	274 (62.8)
Female	155 (35.6)
Prefer not to answer	7 (1.6)
Country	
USA	413 (94.7)
Practice setting	
In training	21 (4.8)
Private practice	231 (53.0)
Academic/public	82 (18.8)
Academic/private	90 (20.6)
Other	12 (2.8)
Membership	
SREI	245 (56.3)
SREI + SRS	142 (32.6)
SRS	40 (9.2)
Neither	8 (1.8)
Age, y (mean, SD)	50.0 (10.2)
IVF cycles/y, median (range)	300 (10–5,390)
Years in practice (mean, SD)	17.1 (10.6)

Omurtag. How SREI/SRS members manage hydrosalpinges. *Fertil Steril* 2012.

Midwest Reproductive Symposium meeting held in Chicago, Illinois, in June 2011. The questionnaire focused on four areas: 1) demographics; and 2) evaluation; 3) definition; and 4) management of hydrosalpinges (Supplemental Material).

Survey Distribution

An initial e-mail invitation containing a link to an anonymous Web based survey was sent on October 25, 2011. Reminders were sent on October 31, November 4, and November 8, after which time, we checked for any delivery failures and sent a fourth reminder, using available alternative e-mail addresses, on November 16. E-mails that generated an “out of office” reply were also sent a fourth reminder. The investigators were able to track whether a survey was completed but did not have access to individual participant responses to the survey, therefore protecting respondent anonymity.

Data Analysis

The survey was constructed and implemented using DatStat. Student *t* test and χ^2 analysis were used to compare the continuous variables and differences in proportions. Relative risks were estimated using contingency tables (SPSS v16.1; IBM).

RESULTS

Demographics

Our survey went to 1,070 SREI and SRS members, of which 462 clicked on the survey link (43%) and 442 completed it, for a response rate of 41%. Nearly all respondents were SREI members from the United States (Table 1). We received responses from all but four of the 50 states. Respondents

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