Ultra-long administration of GnRH-a before in vitro fertilization does not improve the clinical pregnancy rate in women with mild endometriosis. A prospective, randomized, controlled trial - Apostolos Kaponis (Greece)

Q: One of the few RCTs in endometriosis. Any spontaneous pregnancies in the control group before start of IVF?
A: Thank you. No, there were no spontaneous pregnancies because the mean time between laparoscopy and performance of IVF was short.

Q: ASRM grading based inclusion criteria creating bias as it is not associated with fertility outcomes, one of the biggest limitation of most of studies
A: ASRM grading is a very reliable system to describe the extension of the disease. In 2003, when the current study was designed, it was the most recent and accurate grading system for endometriosis staging. Afterwards, came some limitations but I don’t think that this can affect our results.

Q: Indication of removal of endomeitioma prior to IVF?
A: It was not our goal to remove these small (till 2cm) endometriotic cysts. From the history and ultrasound it was very possible that these women have endometriosis. Therefore, we perform laparoscopy to record the extension of the disease, to check the patency of fallopian tubes, and when small endometriotic cyst recognized we opened and cauterized.

Q: I was wondering during this study lasted many years if any of the patients had ovarian cancer?
A: I can’t have this information. Many women of the study group were lost to follow-up.

Q: Do you recommend GNRHa in moderate-severe endometriosis before IVF treatment?
A: Probably yes. From 2002, Rickes and co-workers have publish that the ultra-long administration of GnRH-a has a beneficial effect in the fertility of women with severe endometriosis.

Q: What is your opinion about GnRH antag stimulation followed by depot agonist suppression and FET in endometrios pt?
A: I agree with this proposal but you need an RCT study to prove it.
A prospective randomized comparative study of laparoscopic ovarian cystectomy and ablation versus transvaginal cyst aspiration in infertile patients with Endometrioma undergoing IVF – ET treatment - Suvasmita Saha (India)

Q: Have you have long term following to patines arteriales endometrio a aspiración in order to diagnosis ovarian abscess??
A: Though I am not able to understand your question exactly but answering as much I can understand we have not done any long term follow up in our study.

Q: Did you use antibiotic treatment as prophylaxis before cyst aspiration? If yes, what substance ?
A: Yes. We have given pre aspiration prophylactic oral antibiotic for 7 days (preferably Quinolone group), injectable antibiotic during the procedure (Ceftriaxone + Sulbactam) followed by oral Coamoxyclav for 5 days post procedure.

Q: How to exclude the cancer risk of patients with endometriosis before COH, especially primary infertility aged patients ?
A: Though the chances of malignancy is extremely rare but in high risk cases we have excluded malignancy by transvaginal colour Doppler study and by tumor marker (CA 125).

Q: Have you considered injecting sclerosing substance - with a safety profile of course - to prevent recurrence?
A: No. We have not used sclerosing substances because our main aim in this study was to assess the ovarian reserve and chances of pregnancy following IVF in these group of patients.

Q: How about the risk of infection and pelvic abscess after transvaginal drainage?
A: We have not come across any case of severe pelvic infection or pelvic abscess in our study as the procedure was done under strict asepsis and proper antibiotic coverage.

Q: What is the minimal size to go for cyst aspiration ? In case of bilateral endometriomas how you planned to do cyst aspiration?
A: Cyst aspiration was done irrespective of number and size ≥3 cm. All cysts were aspirated in the same sitting.

Q: What gauge needle do you use for endomtrioma aspiration. We have found that 17 g OPU needle does not easily aspirate the viscous endometrioma fluid?
A: 16 - 17 G double lumen OPU needle was mostly used in our study for cyst aspiration.

Q: Did you use antibiotic treatment as prophylaxis before/after cyst aspiration?
A: Already I have answered the question in detail above.

Q: How do you do IF the fluid in the endometriom is very sticky/thick when you do the aspiration via vagina?
A: In few cases we have encountered this problem and it was overcome by using sterile saline for flushing.

Q: What is the recurrent rate of transvaginal aspiration vs laparoscopic cystectomy? thank
A: We have not studied this because our main focus was on ovarian reserve and IVF outcome in the two study groups but not the treatment of endometriosis.

Q: On long term follow up, what is the recurrence rate in your experiences?
A: We have not done any long term follow up.

Q: What was the needle gauge and the pressure used for aspiration?
A: 16 -17 G OPU needle with 180-200 mm Hg of pressure was used for cyst aspiration.

Q: With aspiration didn’t you have recurrence and abscess. What about cyst size in both the groups?
A: I have already answered this question above.

Q: What was the incidence of recurrence, abscess and Hematoma formation in cyst aspiration group since these are the common risk factors of aspiration?
A: Incidence of recurrence was not studied as long term follow up has not been done in our study. There was no incidence of severe infection or abscess formation in our study.

Q: So in aspiration group more number of oocytes are related to availability of more ovarian tissue i.e. follicles? In cystectomy - loss of ovarian tissue!
A: Absolutely right. Ovarian cystectomy decreases ovarian reserve by removal of normal ovarian tissue during excision & also by the thermal damage to the cortex during ablation. On HPE normal ovarian tissue is frequently detected adjacent to endometrial cyst wall in patients with laparoscopic cystectomy leading to loss of primordial, primary and secondary follicles.

Q: What were the mean diameter of endometrioma in the group who had endometrioma aspirated? Did any patients had ovarian abscess?
A: Both questions are already answered above.
Q: Which complications do you have with aspiration? Did you do antibiotics prophylaxy before aspiration?
A: Already explained this question above.

Q: How long before the endometrioma refills? Rate of infection post vaginal aspiration?
A: Already answered this query above.

Endometrial scratching in women undergoing their first In Vitro Fertilisation (IVF) cycle: results from the UK Multicentre Endometrial Scratch Randomised Controlled Trial - Mostafa Metwally (United Kingdom)

Q: What about cumulative pregnancy rates for both groups?
A: Not part of our outcome measures

Q: Do you thing based on your study, should endometrial scratch be used in clinical practice?
A: No

Q: Do you think we should stop performing endometrial scratching or do you think more research should be performed (e.g. in certain subgroups)?
A: Yes it should be stopped for those having IVF. The evidence is conclusive

Q: Was the technique of scratch standardised if so how?
A: Pipelle or similar

Q: Do u recommend endometrial scratch in any group of pt in our practice?
A: No

Q: Did you look at cumulative LBR as well?
A: NO=o

Q: Do you offer the scratching to all patients or only with implantation failure?
A: Not anymore