focus on
REPRODUCTION

Much ado about Munich

Embryo selection still tops the agenda

- Look ahead to Lisbon
- ESHRE news
- HR editor on misconduct in scientific publishing

www.eshre.eu
With the Annual Meeting and summer vacations behind us, it’s time to take stock and look ahead to the future. The Annual Meeting in Munich was both scientifically and socially successful. Almost 9000 participants from 118 countries attended the congress, with 2000 taking part in the precongress courses. I would like to express our warm thanks to the local organising committee for taking care of the social programme, Simon Brown and Christine Ruefquis for press activities before and during the congress, Bruno and his team for running the whole show and all of you who were able to attend. Next year we will meet in Lisbon and in 2016 in Helsinki.

The minutes of the Annual Assembly of Members are published on page 12, and I would like to highlight a few items. First, membership continues to increase and now stands at 6300, of which 70% is from Europe. The largest SIGs are Embryology and Reproductive Endocrinology, with 30% of members belonging to either one. ESHRE’s financial situation is good and stable. We have sought to invest our assets in such a way that the world and especially Europe’s economic problems could not pose a threat to the functioning of the Society. ESHRE will continue to invest in education. Internet-based activities such as e-learning, certification and data collections all require substantial financial investment. Twelve Campus courses and four basic semen analysis courses are scheduled for 2014 and several Campus events are in the pipeline for 2015. The success of the ESHRE journals continues, with *Human Reproduction Update* and *Human Reproduction* now sitting in first and second places not only in the impact factor category of Reproductive Biology but also in Obstetrics and Gynecology.

Announcement of the first ESHRE research grant attracted great interest and a total of 259 applications. Such a response highlights the limited sources of funding and serious shortage of research money in our field. The best applications have been selected for the second round and their extended applications will now be sent to the independent reviewers in September. The outcome will be announced by the end of the year.

The next Best of ESHRE and ASRM will be held in New York on 5-7 March 2015. The programme is diverse and follows the traditional format of back-to-back sessions, cutting edge lectures and debates. The topics include among other things implantation, preimplantation genetics, oocyte/embryo cryopreservation, treatment of unexplained infertility and genetics of hypogonadotrophic hypogonadism, which certainly will interest both scientists and clinicians. Remember to mark this event in your diary.

Once more I would like to remind you that your opinion is important for ESHRE, so please use every opportunity to make your thoughts known.

Meanwhile, I wish you all a pleasant Autumn, with success in your work.

Juha Tapanainen

ESHRE Chairman 2013-2015
Invited scientific programme now in place; abstract submissions for free communication must be with ESHRE by 14 January 2015

FOR THE FIRST TIME in 31 years ESHRE’s Annual Meeting - the most important event in our Society’s year - will be staged in Portugal. It’s an honour to be your hosts in this wonderful country, and a chance for you to enjoy the historical city of Lisbon.

The congress venue will be the International Exhibition Centre, located alongside the river Tagus in a modern area of Lisbon which also hosted the Expo 98 World Exposition. The congress centre has excellent amenities for running the multiple events which an ESHRE Annual Meeting now demands. The congress centre is surrounded by many hotels, and is only five minutes from the airport and 15 minutes from downtown Lisbon, with easy access to both by underground and bus. There are also plenty of shopping, dining and entertaining opportunities in the underground and bus. There are also plenty of immediate surroundings, with pleasant walking spaces.

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As usual, the scientific programme will be exciting, entertaining and of high quality, designed to accommodate a wide diversity of participant interests. The invited sessions are now almost confirmed and we can already guarantee an outstanding faculty of speakers on the scientific, clinical and translational aspects of reproduction. Invited sessions are already in place on artificial gametes, semen quality, culture media, telomeres in reproductive ageing, the reproductive effects of childhood cancers, mitochondrial disease, environmental toxins, advances in IVF, oocyte quality, fertility-sparing surgery, ICSI, long-term IVF safety, and stem cells. And of course generous time slots have been allocated to the presentation of new results from many groups.

ESHRE 2015 will be preceded by a day of Precongress Courses, which as ever are sure to attract a huge number of participants. Almost 2000 were in attendance this year in Munich, and numbers are likely to be as great in Lisbon. We are also working to create a memorable social programme, beginning with a Portuguese touch at the Opening Ceremony and continuing with a new twist at the Congress Party on Tuesday evening, this is available to everyone and will be especially appealing to our young participants. Informal interaction among everyone, seniors and non-seniors, remains a very important objective of all ESHRE meetings.

Last, but not least, Lisbon is a very charming and attractive city, full of historic reminders of the Roman, Visigoth, Moorish, Medieval and Romanesque periods. Lisbon was also the point of departure for many of the great voyages of discovery. It was from Lisbon that the Portuguese explorers sailed to establish the first direct European contacts with sub-Saharan Africa, South America and the Far East.

Today, however, Lisbon is a modern and peaceful city, with many attractions - a temperate climate, wonderful clear light, warm hospitality, excellent gastronomy, imposing monuments, interesting museums, and “barrios” of distinct character. The months of June and July are particularly rich in cultural events, which take place in many parts of the city, and we hope you will find the additional time to discover and enjoy their local flavours. There are many other good reasons to extend your stay, either before or after the meeting, not only to discover Lisbon and enjoy its unique character, but also to visit its beautiful surroundings, particularly the towns of Estoril, Cascais and Sintra (the summer residence of past kings and queens). The whole country, although small, is very diverse in landscape and culture and we trust you will enjoy exploring and discovering its secrets.

Carlos Galhac-Jorge
Carlos E. Plancha
Much ado about Munich

Embryo selection still tops the agenda of another memorable Annual Meeting. Almost 9000 present at what is now unquestionably the world’s leading event in reproduction.

Jonathan Tilly at the SIG Stem Cells preconference course. A role for oogonial stem cells in the treatment of age-related infertility?

Nature, these were conclusions - in suggesting that oocyte reserve was not fixed at birth - likely to rewrite the basics of biology. For now, according to Tilly, the female biological clock was not a closed system dependent on the natural (or forced) loss of oocytes from a fixed ovarian reserve, but an open system amenable to ovarian replenition from female oogonial stem cells and new oocytes.

Much of Tilly’s presentation in Munich was allocated to challenging those studies which had challenged his own - by trying but failing to replicate his results. Those failed efforts, however, had also made headlines. Jonathan Tilly defied decades of dogma by suggesting that women can make new eggs throughout their lives, ‘headlined Nature in 2012. ‘Now some of his critics are taking a second look.’

One of those critics to take a long second look has been the Swedish scientist Kui Liu, who in Munich once again bore the brunt of Tilly’s deconstructive onslaught. Liu described his own group’s experiments, which, like others, also concluded that there is still no hard evidence that neo-oogenesis does actually occur in the adult ovary.

For the future, Tilly saw a possible role for oogonial stem cells in developing ‘new tools to combat aging-related infertility’, notably as an adjunct to IVF in autologous mitochondrial transfer, and in the in vitro maturation of stem cells into eggs.

It was also in a preconference course (organised by the SIG Embryology) that the Spanish embryologist Marcos Meseguer for the first time presented the results of a much anticipated randomised trial of the effect of time-lapse microscopy in IVF. The trial, begun in February 2012, had randomised 444 patients to a closed time-lapse system and 412 to standard incubation. Whatever the outcome, results showed that ongoing pregnancy rates were significantly higher in the time-lapse group than in the controls - 51.4% vs 41.7% per cycle, and 54.5% vs 45.3% per transfer. Rates of pregnancy loss were also lower in the time-lapses. Now, applying the time-lapse results to past data, Meseguer calculated that, if 6000 treatments in the conventional incubator had been performed in a time-lapse system, ‘we could have expected about 545 additional pregnancies’.

The results were dramatic and consistent with what Meseguer had predicted from earlier observational studies. However, the study was not without its critics, some arguing that the trial had actually compared two incubation systems, and did not necessarily tease out the precise effect of time-lapse microscopy from that of the system. As Meseguer himself made clear, time-lapse is a complete system which hypothetically allows better embryo selection from more detailed observations and better embryo development because of less disturbance in the incubator.

This was an argument raised by Sebastiaan Mastenbroek in a main-programme debate on time-lapse organised by the Paramedical Group. Referring to Meseguer’s results, Mastenbroek argued that “it was not a trial of time-lapse but a trial of culture systems’ and he insisted that well applied morphology could predict pregnancy just as well as the multiple observations of time-lapse images.

The debate had started with opinions on the benefits of time-lapse equally divided among those packing the lecture hall. But by the end any ‘debate’ had degenerated into a war of words on evidence and how time-lapse trials might be designed to provide an unequivocal result. Mastenbroek’s opponent in the debate, Montse Boada from the Hospital Universitari Joan Trulls in Barcelona, reiterated the well rehearsed advantages of
700 women were randomised to IVF with centres in Europe between 2010 and 2013. More than was a large randomised trial performed in eight IVF performed before further IVF treatment. The study can be improved by routine hysteroscopy finally answered one of IVF’s oldest questions - oral presentation in clinical science. The study also Toukhy from Guy’s and St Thomas Hospital in prior to IVF. It was this study, presented by Tarek El-Toukhy ruefully, who speculated that the more help the patient must be a disappointment, ‘concluded

Outcome results following IVF showed no significant difference between the two groups - a live birth rate per patient of 31% in the hysteroscopy group and 29% in the control group. ‘Any intervention which doesn’t help the patient must be a disappointment’, concluded El-Toukhy ruefully, who speculated that the more favourable results of earlier (but smaller) studies might be explained by endometrial scratching. ‘But’, he told one of ESHEI’s press conferences, ‘based on these findings, outpatient hysteroscopy before IVF doesn’t significantly improve IVF results and cannot be considered essential for women with recurrent IVF failure’.

There were three other large-scale studies presented in Munich. The first came from the USA, which, with funding from the National Cancer Institute, found after a 30-year follow-up ‘little evidence’ that the use of fertility hormones used for ovarian stimulation increases the long-term risk of breast and gynaecological cancers. The study was a retrospective investigation involving 12,193 women treated for infertility between 1965 and 1998 at five US sites. Follow-up lasted until 2010, with evaluation based on questionnaire and linkage to US death and cancer registries. A total of 9,892 women were successfully followed for cancer outcomes. The ever-use of clomiphene - which included most of the cohort was not associated with any increased breast cancer risk, except when subjects had used the drug in 12 or more treatment cycles (hazard ratio of 1.69). Only 10% of the cohort had been treated with gonadotrophins - usually in combination with clomiphene and there was no association with cancer risk identified, except in those who remained childless (HR 1.98). ‘Given that the majority of our women who received gonadotrophins also received clomiphene’, said principal investigator Humberto Scoccia from the University of Illinois at Chicago, ‘it is likely that the increased risk among nulligravid women reflects an effect of their infertility rather than that of drug usage’.

The second large-cohort study came from the UK in an analysis of sperm donor age relative to outcome based on the HFEA database. Results were derived from a review of all UK treatment cycles (donor insemination and IVF) from 1991 and 2012; 39,282 were from a first cycle of treatment and were included in the analysis. As expected, birth rates did show a difference aged the female age - around 29% in the 18-34 recipient age group and 14% in the over-37 age group. However, within these same two recipient age bands no significant differences were found in LBR relative to the age of sperm donor. Thus, in the younger IVF patients LBR was 28.3% with a sperm donor aged under 20 and 30.4% with a donor aged 41-45. In the younger donor insemination patients LBR was 9.7% with a donor aged under 20 and 12% with a donor aged 41-45. Regulatory requirements on the maximum age of sperm donors tend to range between 40 and 45 years.

The Human Reproduction keynote lecture, traditionally the congress’ best attended event, was given this year by Chris Barratt of Dundee for his group’s study on sperm hyperactivation, the most downloaded paper from Human Reproduction in 2013.
achieve induced hyperactivation does affect fertilising capacity in IVF. The data also confirmed that the release of stored calcium is the crucial component of the calcium store may therefore underlie release of stored calcium is the crucial component of IVF. The data also confirmed that the number of eggs used in the treatments. Thus, CLBR was 39.4% when a total of 10 vitrified eggs were used, and 75.9% when a total of 20 eggs were used. But this rapid rate of increase slowed when 30 eggs were used, to 88.7%, and thereafter reached a peak with the use of 40 vitrified eggs at 97.3%. Vitrification is surely set to revolutionise egg donation and enable egg banking similar to sperm banking.

Meanwhile, Annick Dèvigne, speaking on behalf of her absent colleague Dominique Rauck, from Bocourt, Belgium, showed that a policy of single frozen embryo transfer in patients under 36 with good quality blastocysts available achieves pregnancy rates as high as (if not higher than) fresh transfers but with the virtual elimination of twins. Freezing once again was by vitrification. For her part Anja Pinborg from the University of Copenhagen was not yet persuaded by a freeze-all embryo policy, ‘but we might get there soon’, she said. She had no doubts over the efficacy of vitrification, the lowered risks of OHSS, or that transfer in the stimulation cycle might be subject to endometrial effects. However, the literature was still not clear about the benefit of freezing on delivery rate, or whether FET might confer some epigenetic modification.

ESHRE 2014 yet again demonstrated its place as the world’s foremost event in reproductive science and medicine. More than 9,900 attended the meeting’s 14 preconference courses, while 8,866 were registered for the main scientific programme, somewhat fewer than in London last year (10,007) but comparable with Istanbul in 2012 (9,966) and Stockholm in 2011 (8,861).

As ever, the press programme drew much attention from around the world, and the Annual Meeting is clearly a well established source of news and features. Fewer journalists now attend the meeting on site, but the ESHRE press releases are well considered and widely reported. Eight press releases were distributed this year, with the greatest interest in studies of infertility’s link with psychiatric disorders in children and the effect of sperm donor age on outcome.
1. Minutes of the last meeting held in London
- The minutes of the 2013 Annual Assembly of Members (AAM), having been circulated to all members in Focus on Reproduction (September 2013), were approved.

2. There were no matters arising.

3. Membership of the Society
- Membership of the Society now stands at 6352, a substantial increase on last year’s figure of 5823 cycles; the highest membership number ever; almost 70% of members come from Europe. The top European membership countries are UK (467 members), Italy (373), Germany (321), Spain (296), Netherlands (290), and Belgium (265). The USA is represented by 292 members, India 268 and China 153.
- The Chairman reminded members that, according to the Society’s internal rules, the five most numerically represented countries in Europe must always be represented in the Executive Committee.
- Disciplines most prominently represented (according to SIG membership) are embryology (30%) and reproductive endocrinology (27%), but there is strong membership presence in andrology, early pregnancy, safety & quality, and reproductive surgery. By occupation around 40% of the membership is now drawn from basic science, laboratory disciplines and nursing.

4. Society activities
- Guidelines
  - Guidelines on the Management of women with endometriosis were completed, with full text available on the ESHRE website, summary in Human Reproduction, patient information on the website, and a decision-aid as an app for smart phones and tablets. All except the app (for members only) are freely available to everyone.
  - Four other guidelines are in development: on psychosocial care in infertility and medically assisted reproduction; premature ovarian insufficiency; recurrent miscarriage; and as revised guidelines for good practice in IVF laboratories.

Publications
- Since last year’s Annual Meeting ESHRE has produced seven papers for publication in Human Reproduction, including consortium reports and three opinion papers from the Task Force Ethics and Law.
- The ESHRE/ESGE consensus on the classification of female genital tract congenital anomalies was published in Human Reproduction in August 2013.

Training
- The Chairman described 2014 as ‘quite an active year’, with 12 Campus courses and four basic semen analysis courses scheduled. Already six Campus events have been confirmed for 2015.
- The Chairman encouraged all members to check the Campus programme on the recently updated ESHRE website for previews of all Campus events (eshre.eu/campus).

Data collection
- The Chairman praised the work of the European IVF Monitoring Consortium (EIM) and PGD Consortium. The EIM group, under the chairmanship of Markus Kupka, is now monitoring more than 500,000 European ART cycles each year and representing a cumulative total of more than 1 million babies born since the EIM began its work in 1997. Preliminary data for 2011 presented in Munich indicate a continuing slight divergence in pregnancy rates (per aspiration) between IVF and ICSI - at 29.1% for IVF and 26.8% for ICSI. Multiple deliveries continue to decline (from 29.3% in 1997) and are now for the second consecutive year below 20% (to 19.4%).
- The EIM report from 2010 is in press with Human Reproduction, with data derived from 550,296 cycles; the preliminary results for 2011 presented in Munich were from 33 countries and 588,629 cycles.
- Data XIII (for 2010) from the PGD Consortium are ready for publication, derived from 64 centres and 5780 cycles (0.8% sex selection PGD, 47.6% PGT, 51.5% PGS).
- Data XIV (2011) will be published at the end of 2014, from 62 centres and 6291 cycles.

ESTEEM trial
- The ESHRE Study into The Evaluation of oocyte Euploidy by Microarray analysis (ESTEEM) continues as a multicentre RCT with two primary aims: to estimate the likelihood of having no euploid embryos in future ART cycles and to improve live birth rates in women of advanced maternal age by two experimental questions: Does polychorionic biopsy and array CGH increase the likelihood of a live birth within one year; and, in women with no euploid embryos in a first cycle, does it predict the probability of having no euploid oocytes in a subsequent cycle?
- There are eight centres in the study, with 171 patients randomised by June 2014. The trial’s working group chairman, Jörg Geradts, said the aim is to have 350 subjects randomised by the end of 2014, with completion in 2015.

ESHRE accreditation and certification
- ESHRE’s scheme for the accreditation of specialist centres for reproductive medicine has been modernised, with online application and paperless process introduced in 2013. The peer-reviewed syllabus has been upgraded to enable the participation of centres in EU countries without national training agencies. Close collaboration with EBCOG (European Board and College of Obstetrics and Gynaecology), ESHRE’s partner for basic O&G training, continues.
- Certification is now available to ESHRE members in embryology and reproductive endoscopy, with the first exams for nursing/midwife certification scheduled for the 2015 Annual Meeting in Lisbon.

ESHRE research grants
- The Chairman described the introduction of ESHRE’s research grant scheme as ‘one of the most important activities of the year’. There were 259 applications within the deadline, with the majority coming from embryology and reproductive genetics. The first round of assessment has been completed and the reviewers have now to assess a second round short-list of ten submissions. The outcome will be announced before the end of the year.

5. ESHRE journals
- Speaking on behalf of the Publications Sub-committee, Hans Evers, Editor-in-Chief of Human Reproduction, reported that this year’s impact factors (for 2013) will be delayed until the end of July. Impact factors are thus currently as last year: 8.8 for Human Reproduction Update, 4.7 for Human Reproduction, and 4.5 for Molecular Human Reproduction.
- Evers reported that submissions to the ESHRE journals remain steady, with Human Reproduction now attracting more than 2000 manuscripts per year. Reviewing times (to a first decision for new submissions) are now down to 28 days, but the large number of submissions means that the rejection rate (now around 80%) is steadily increasing. ‘Our aim was to reduce decision time to 30 days,’ said Evers. ‘It is important that authors know they will get a quick response from Human Reproduction.’
- Evers, who paid tribute to his fellow editors Chris Bavitt and Felice Petraglia, pointed out that the outside covers of all three ESHRE journals have been redesigned this year, and that the publisher is working on the inside pages.

6. Paramedical group
- Helen Kendrew, the Past Chair of the Paramedical Board, reported that paramedical members comprise nurses, midwives, lab technicians (the largest group), counsellors and psychologists, and clinical embryologists up to BSc level.
- Helen Kendrew, matron at Bath Fertility Centre in the UK, took over as Chair of the Paramedical Board in Munich. Cecilia Westin from Gothenburg took over as Chair of the Paramedical Board.
- Helle paid tribute to Inge Rose Jørgensen from Copenhagen, who has now stepped down from the Board. Ingel has been replaced by Annick Geril, a midwife at Ghent University Hospital, Belgium.
- The first exam in ESHRE’s nurse/midwife certification programme will take place in Lisbon in 2015. The reading list and examination questions are now being finalised. The log book is downloadable from the ESHRE website and must be completed by midwives, technologists, the largest group), counsellors and psychologists, and clinical embryologists up to BSc level.
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The next Annual Assembly will be on 16 June 2015 in Helsinki from 3-6 July.

7. Financial report
- The Chairman presented the balance sheet (income and expenditure) for 2013 and the budget for 2014. Income in 2013 (€6,455,607) was ahead of expenditure (€5,590,633), leaving a favourable balance of €864,974. Both income and expenditure were higher than forecast in the budget. A budget similarly constructed to 2013 - to provide a small positive balance - has been set for 2014.
- The annual meeting continues to provide the Society’s greatest source of income (72%) and expenditure (51%). Educational activities are the major source of SIG expenditure. The 2013 value of ESHRE’s assets, including stocks and cash balances, increased by more than €800,000 from 2012. The financial state of the Society was described by the Chairman as ‘in good shape’, with sufficient funds ‘to invest in education’.
- The financial report for the year ending 31 December 2012. The financial state of the Society was described by the Chairman as ‘in good shape’, with sufficient funds ‘to invest in education’.

8. Future meetings
- The Society’s 31st Annual Meeting in 2015 will be held in Lisbon from 14-17 June. The 32nd Annual Meeting in 2016 will be held in Helsinki from 3-6 July.

9. Election of honorary members for 2015
- The two nominees proposed by the Executive Committee for honorary membership in 2015 were Professor Paul Devroey and Professor Steve Hillier. Both nominations were ratified by the AAM.

10. Any other business
- The next ‘Best of ESHRE & ASRM’ meeting will take place in New York from 5-7 March 2015. The Chairman said that the format of the three previous events will be maintained for 2015.
- The Chairman paid tribute to Basil Tarlatzis for his ‘very active’ representation of ESHRE with EBCOG (European Board and College of Obstetrics and Gynaecology). Tarlatzis, said the Chairman, had represented ESHRE’s educational interests from 1999 to 2013, when Roy Farquharson took over, and his contribution had been important in developing ESHRE’s leading role in training and medical education.

- The next Annual Assembly will be on 16 June 2015 in Lisbon at 18:00.

There has been a huge response to the first announcement of ESHRE’s research grant scheme. Up to €150,000, with funding spread over one to three years, will be available from this year, with the scheme designed to support scientists and clinicians in basic and clinical research in reproductive medicine.

By the deadline for submissions in May, 259 grant applications had been received by ESHRE, with proposals set for evaluation over two rounds. The first evaluation - by the Executive Committee and SIG Co-ordinators - has now been completed, leaving a short-list of ten applications for further assessment by a committee of independent reviewers. The evaluation of proposals will give emphasis to originality, design, feasibility, quality of the consortium, and expected impact.

The grants will range from €50,000 to €150,000 and will be awarded to projects running between one and three years. All future applications can be submitted only in response to a ‘call for proposals’ published in February every second on the ESHRE website. This year, following the second round independent evaluation, the final decision will be made in December.

The European Commission reaffirms support for embryonic stem cell research

The European Commission has reaffirmed its commitment to stem cell research after rejecting claims from the millenium-signature pro-life campaign known as ‘One of Us’. The campaign had succeeded in gathering the one million signatures necessary for a European Citizens Initiative, a public citizen scheme inviting the European Commission to propose legislation on matters in which the EU has legislative power.

The campaign had sought an EU ban on the funding of activities which presuppose the destruction of human embryos, in research, development and public health. But the European Commission, following a public meeting on the Initiative in March, delivered its response on 28 May, by declaring that ‘the existing funding framework, which was recently debated and agreed by EU Member States and the European Parliament, is the appropriate one’.

In rejecting the ‘One of Us’ claims, the Commission reiterated its position on embryonic stem cell research, noting the ‘triple lock’ system for HESR, agreed by Member States and Parliament when they approved Horizon 2020 legislation in 2013. This triple lock system for HESR research funding, which the Commission considers in full accordance with EU Treaties and the Charter of Fundamental Rights, requires that:
- national legislation is respected – EU projects must follow the laws of the country in which the research is carried out
- all projects must be scientifically validated by peer review and must undergo rigorous ethical review
- EU funds may not be used for derivation of new stem cell lines, or for research that destroys embryos – including for the procurement of human embryonic stem cells.

Notice of the Commission’s rejection of the ‘One of Us’ proposals clearly stated that the Commission does not explicitly set out to fund research involving human embryonic stem cells. Rather, the Commission funds research into treatment for diseases or healthcare challenges, for instance therapies for Parkinson’s disease and Huntington’s disease, or diabetes. Research may involve human embryonic stem cells if these are part of the best project proposals.

ESHRE, along with other health organisations, had opposed the ‘One of Us’ campaign, arguing that a ban on the funding of embryonic stem cell research ‘would jeopardise progress in regenerative medicine, reproductive health and the treatment of genetic disease. ESHRE Chairman Juha Tapamainen said he welcomed the Commission’s decision as a reflection of common sense and public opinion.'
ESHRE's European IVF Monitoring (EIM) Consortium has now been active for over 15 years and has reached the remarkable data milestone of more than 1 million babies recorded. The Consortium is presently evaluating around 600,000 cycles a year in an ever escalating total of European ART activity. In 1997, the first year of EIM analysis, just 482 clinics in 15 countries were represented in 203,225 cycles of IVF and ICSI; in 2011, the year described provisionally by EIM Chairman Markus Kupka in Munich, 1034 clinics in 33 countries were represented.

The profile of the cycles, as well as their number, has also changed. Now, ICSI still dominates treatment, with almost 300,000 cycles, but frozen embryo transfers, egg donation and IUI all represent considerable activity. Frozen cycles in 2011 were almost as frequent as fresh IVF cycles (120,032 FER vs 140,999 FET), and the number of three embryo transfers remains two embryos (around 58%), but the proportion of single embryo transfers continues to rise, to almost 30% in 2011. The number of three embryo transfers is now considered and now at around 15%, with Greece, Lithuania, Serbia and Moldova the main contributors. Pregnancy rate per aspiration was 29.1% for IVF and 26.8% for ICSI, a divergence in success which has been apparent for the past two years - while average pregnancy rate per transfer has risen from 28% in 1997 to 32.1%. Pregnancy rates from frozen cycles continue to improve - from 14.1% in 1997 to 21.4% in 2011, an improvement reflected in the ever increasing use of FER. Results with IUI remain modest, and much dependent on patient age.

Stark differences in national availability persist, with many countries operating below the 1500 cycles per million population threshold defined as the global need for ART. Belgium, Denmark, Norway, Slovenia and Sweden continued their high rates of availability, each with more than 2000 cycles per million population - and each no doubt reflecting generous state reimbursement schemes. UK and the Netherlands each had low rates of around 1000 cycles per million. Such huge contributions of data present a considerable task to the Consortium and Kupka.
ESHRE JOURNALS

On top of the world in reproductive science

- Human Reproduction and Human Reproduction Update in two leading positions
- ESHRE titles maintain their mark of quality in Reproductive Biology and Ob/Gyn

For the first time ever ESHRE journals occupy the top two places in the categories of both Reproductive Biology and Obstetrics and Gynaecology according to the latest impact factor report.

Human Reproduction Update has held its long established place as the most influential journal in both categories with an impact factor of 8.657, while ESHRE's flagship journal, Human Reproduction, with an impact factor of 4.385, has climbed above the green journal Obstetrics and Gynaecology and now sits in second place in the O&G category.

"I am very proud of the continuing rise in quality of Human Reproduction," said Editor-in-Chief Hans Evers. "According to this new impact assessment we have now passed all other OB/GYN journals and are second only to our sister journal Human Reproduction Update, which as a review journal, of course, is in a league of its own."

The release of impact factors this year - for citations during 2013 - was delayed for more than a month. Release of the much anticipated Journal Citation Reports by Thomson Reuters usually comes just before ESHRE's Annual Meeting in June, but this year did not occur until the end of July (because of changes and additions to the analytics system).

In the category of Reproductive Biology ESHRE's third title, Molecular Human Reproduction, figured fourth in the listing, with an impact factor of 3.483. ESHRE's review journal Human Reproduction Update continues to lead both categories by a very long way. It's great news that Update is still at the top in Reproductive Biology and O&G, said Editor-in-Chief Felice Petraglia. "We increased our total cites/immency index from a base of slightly fewer articles published, and I now have the general impression that our impact factor is stable following a recent trend of small fluctuations shown by all journals in our categories. All three editors have committed their journals to quality manuscripts and a rigorous peer review and acceptance process.

According to Thomson Reuters, owners of the Journal Citation Reports, the impact factor is a reliable measure of journal quality. Published in 2011-12. Impact factors remain the most recent trend of small fluctuations shown by all journals in our categories. 'All three editors have committed their journals to quality manuscripts and a rigorous peer review and acceptance process.

Reproductive biology

Title | Total cites | 5-yr Imp Factor | Impact Factor
---|---|---|---
Human Reproduction Update | 5799 | 9,464 | 8.657
Human Reproduction | 27398 | 4,619 | 4.585
Fertil Steril | 28747 | 3,982 | 4.295
Molecular Human Reprod | 4900 | 3,959 | 3.483
Biol Reprod | 21696 | 3,945 | 3.451
Placenta | 6579 | 3,351 | 3.295
Reproduction | 6923 | 3,616 | 3.262
Semin Reprod Med | 1505 | 3,203 | 3.0
Reprod Biomed Online | 5168 | 2,682 | 2.98
Reprod Toxicol | 4247 | 3,024 | 2.771

Obstetrics and gynaecology

Title | Total cites | 5-yr Imp Factor | Impact Factor
---|---|---|---
Human Reproduction Update | 5799 | 9,464 | 8.657
Human Reproduction | 27398 | 4,619 | 4.585
Obstet Gynecol | 25283 | 4,755 | 4.368
Fertil Steril | 28747 | 3,982 | 4.295
Am J Obstet Gynecol | 32056 | 3,778 | 3.915
BJOG - Int J Obstet Gynecol | 12822 | 3,935 | 3.862
Gynecol Oncol | 18375 | 3,915 | 3.687
Placenta | 6579 | 3,351 | 3.295
Ultrasound Obstet Gynecol | 8105 | 3,246 | 3.14
Best Pract Res Cl Ob | 1824 | 2,653 | 3.0

Are we still talking about £200 a cycle? For the lab phase, yes. There will still be costs for personnel and maybe £100 for ovarian stimulation, because we will promote mild stimulation protocols. Don't forget that the clinics must follow the Walking Egg philosophy - they have to transfer a maximum of one or two embryos, there must be family planning and mother care service available, and endoscopy nearby. If they agree to this, we can deliver everything, and monitor their progress day-by-day. There's no doubt that the system works, but we now need confirmation from the London and South Africa trials. If the results are positive, we'll need to see how the system copes with a warmer climate and different environment.

And you have plans for that? Yes. We've plans for Ghana and Kenya, but many more countries have shown interest.

How did you personally get to this point? How did your interest develop?

I worked in South Africa for three years from 1982 to 85 and we had to go out from Pretoria to provide family planning services. And every time we went there were people who came asking for help for childlessness. I spoke about it to others and they told me it was a very serious problem, with severe socio-cultural and economical

On the long dusty road to affordable IVF in Africa

The politicians didn't want to talk about infertility because IVF was too expensive.

For: You're best known for your work with developing countries and a £200 per cycle IVF concept. Where are you right now with this project?

WO: We are almost ready to introduce the Walking Egg kit. It's a tool box in which we provide everything you need for IVF - aspiration needle, transfer catheter, culture system. Everything is there, because we've found in the past few years that if you change anything - a vacuum, medium content - problems will occur.

So it is a kit? Yes, we've included everything. A temperature box, vac containers, citric acid, bicarbonate.

Willem Ombelet: 'If you listen to the people in developing countries, you soon discover that being childless is a real disaster.'

Willem Ombelet

Human Reproduction and Human Reproduction Update in two leading positions

- ESHRE titles maintain their mark of quality in Reproductive Biology and Ob/Gyn

Editors Felice Petraglia (Update) and Chris Barratt (MHR), both committed to quality in acceptance of manuscripts.
all the money for that? But the room problem when HIV is prevalent and we need epidemiologists or sociologists - never from developed countries. Is it just a question of priorities?

But there’s still a lack of enthusiasm in developing countries. Is it just priorities, it’s ignorance. I don’t think it’s just priorities, it’s ignorance. I have to admit that we have a twin rate of about 11%, and in my view that’s too high. It would be better at 5 or 6%. If you have a very low multiple rate, I don’t see how any government can deny such a policy.

And today, how does the Walking Egg project fit into your work?

We came together as people from different origins. There’s no place for infighting here, we can only progress in discussion with different people. We thought the concept of a walking egg was appropriate - it just walks where it wants to go, no boos, no interest in colour or religion, the egg wants to be fertilised or is searching for contraception. It’s a unique metaphor for universal access to family planning, infertility care and adequate mother care. The artist Koën Vanmeechelen, created the walking egg statue in 1998. ESIRE also remains very important in bringing different groups together: paramedics, andrologists, biologists. We hope to get them all involved in the global project. We also need different societies and organisations to support us, but we also look forward to discussion and criticism of what we’re doing. Sometimes we make mistakes and have to change strategies.

How do you combine your work in a Belgian IVF clinic with your work in developing countries?

I get up at 5 o’clock every day, so I’ve done more than two hours work before I get to the hospital, and this is usually work on the Walking Egg. I’ve also found that running a good IVF centre actually made it easier for me to get financial support from other organisations, especially to support the project in its early phase.

And travelling?

This year I haven’t travelled too often. But I think my travelling will increase again as the kit becomes better known. Next year will be much busier. Now I’d go to Africa three or four times a year, but it will be next year - but in most cases only for two or three days.

So how do you see the future for this project in developing countries? Do you really believe it will become a reality?

I think in those countries where there is a budget for wider healthcare - Ghana, Kenya, Tanzania, Uganda, India - there will be great demand. We still have to convince those centres performing regular IVF that we’re not in competition with them, we’re only trying to reach those for whom regular IVF is far beyond their budget. I think these kinds of projects are the future for resource-poor countries. There are many people who can afford €200, and they’ll go for it because it’s so important to them culturally. And for those who can’t afford it, provided the programme is ethically correct and it works, I am almost sure we will get support from local governments, Western governments and the banks. If they know there is no corruption involved, they’ll be happy to pay €200 for an IVF cycle if the success rate is acceptable.

The Belgian regulations allowed a very generous reimbursement system dependent on a single embryo transfer. It’s still one of the most progressive systems in the world.

Would you agree that Belgium leads the world here?

Belgium had a good record of deliveries and perinatal outcome in Belgium for many years, but there was always criticism about too many multiples. So we thought, let’s give them what they want - with the assumption that fewer multiples would provide the funding to reimburse infertility couples. We had a good health minister at the time, with a long-term view. I also happened to be the President of the Belgian Society of ORGI at the time - so we were able to make a strong case for IVF. That’s what we proposed, and I still believe it’s the best reimbursement policy in the world.

But other countries haven’t taken it up to the same extent?

I don’t know why. I have to admit that we made a breakthrough in allowing us to be put back in women under 35 if the embryos were not top quality. Of course, ‘top quality’ is subjective, but I still believe we have too many multiples in the second cycle.

The real breakthrough came with the Arusha meeting in 2007, when we were able to bring attention to what I knew was a huge problem in these countries. The meeting in Arusha, Tanzania, had the support of ESIRE and its newly formed Task Force for Developing Countries and Infertility, of which Ombelet, pictured fifth from right, was Co-ordinator. Second from the right is the artist Koën Vanmeechelen, whose concept meeting with ambassadors of African countries a few months ago and all of them got the same answer - we are very interested, but there’s no budget available.

Even though we now have a twin rate of about 11%, and in my view that’s too high. It would be better at 5 or 6%. If you have a very low multiple rate, I don’t see how any government can deny such a policy.
Scientific misconduct in academic publishing

Hans Evers, the Editor-in-Chief of Human Reproduction, describes the many shades of scientific misconduct in our medical and scientific journals, and how software can now spot plagiarism at the click of a mouse. To the best of our knowledge, no major transgressions have appeared in ESHRE’s flagship journal.

If you look for truthfulness, you might just as well be blind! Not many of our readers will recognize the words, but they’re from a 1979 Billy Joel song called Honesty - and honesty, as Joel presumed, seems an increasingly rare commodity in performing and publishing scientific research.

As I recounted in one of my editorials in Human Reproduction, several German (and other) politicians have been given a hard time in recent years after political adversaries applied software for the detection of plagiarism to their PhD theses and other prior publications only to discover considerable amounts of unattributed ‘text borrowing’.1 The most notorious examples were Baron Karl-Theodor zu Guttenberg, who saw his doctorate revoked by the University of Bayreuth in 2011 and was subsequently forced to resign as German defence minister, and Hungary’s President Pal Schmitt, who also had to resign after losing his doctorate in 2012, again as a result of plagiarism.

That was mere plagiarism, defined as the misappropriation of another person’s words or ideas and presenting them as one’s own. But plagiarism is not limited to words or ideas. George Harrison, of Beatles fame, lost a lawsuit for unattributed appropriation of the melody line of He’s So Fine (by Ronald Mack) in Harrison’s chart-busting hit song It’s Sweet Lord.2 Or, if you’ve after paintings by old or new masters, there are villages in China whose entire population is devoted to the reproduction of famous works of art. Young artists will work on several identical pieces of decorative paintings at the same time to produce dozens of ‘original’ Van Gogh or Warhol paintings for sale in China and abroad.

Within the broad limits of scientific misconduct, however, plagiarism of text ranks at the lower end of the seriousness scale - although no doubt high on the frequency scale. At the top of the seriousness scale are data fabrication, the making up of results, and data falsification, the manipulation, alteration or suppression of results such that the outcome no longer truthfully represents what has actually been found. Deviating from the approved study protocol, adapting or altering the primary research question after the start of the study, performing unplanned sub-group analyses and unintended multiple comparisons (‘data dredging’, ‘fishing expeditions’), and omitting outliers that ‘distort the picture’ also belong to this latter category of data fabrication.

Among the top names in our field – with a frantic claim to shame – are the Japanese biologist Haruko Obokata, whose star quickly rose after she published two papers in Nature on retroprogramming mature mouse cells back into an embryonic state by the application of acid stress.3 But leading the field are the South Korean veterinarian Hwang Woo Suk, notorious for fabricating a series of human cloning experiments in 2004, and the UK gynaecologist Malcolm Peacock, who fraudulently described and reported the ‘successful’ relocation of an intact ectopic pregnancy from a woman’s Fallopian tube back into her uterus.4 Other types of research and publishing misconduct include failure to obtain appropriate ethical approval for animal or clinical studies, and failure to obtain informed consent. I should also mention here two other dubious practices: ghost authorship, in which someone makes an important contribution to a paper but is not listed as an author, such as a drug company-employed medical writer who puts a multicentre trial report on paper and submits it for publication under the names of clinicians who may or may not have actually participated in the trial; and gift authorship, the granting of authorship (often under pressure) to a person who has not contributed significantly to the study, such as the Head of Department who insists on being named as the last author, or a prominent scientist in a bid to secure acceptance for publication by a high-impact journal.

Scientific misconduct in the medical field can, if unexposed, be ultimately damaging to patients. And it certainly becomes damaging, if exposed, to the guilty party who produced the fabricated research findings. Indeed, one wonders why ostensibly reputable academics would run such a risk? Why did Andrew Wakefield, a British surgeon, publish fraudulent data claiming a causal association between the administration of the triple measles-mumps-rubella (MMR) vaccine to young children and the signs of bowel disease and autism? As a result parents in the UK stopped having their children vaccinated against measles, and a disease almost eradicated in the UK became endemic once again.

But, while publishing a fabricated paper in Nature is one thing, making the front page of the New York Times is quite another (‘Diederik Stapel perpetrated an audacious academic fraud by making up studies that told the world what it wanted to hear about human nature’). Culprits who made the headlines have been stripped of their positions and licences; others have even been brought to court. Eric Poeschla, an obesity, ageing, and menopause researcher from Baltimore and Burlington, USA, concocted patient records to back up his scientific claims and forged data in federal grant applications. He was the first investigator in the USA to be sentenced to prison (one year) for scientific misconduct. He admitted having falsified 15 applications for funding by the National Institutes of Health, and pleaded guilty to the accusations of having fabricated data in all of his original scientific articles. As far as we know (knock, knock on wood) no...
major fraud papers have been submitted to Human Reproduction so far, but we have had papers whose results seemed almost too good to be true. ‘Funny enough to come up with that’, said one student, our future scientist.

A reaction had to come, and it came in the form of plagiarism detection software. Human Reproduction uses CrossCheck by Turnitin, a member of the Turnitin product family. Checking for the plagiarism of text can be automated, but cannot for the plagiarism of ideas, even though the two are not always inextricably linked together. We check every manuscript accepted for publication and have at least one but for every issue of the journal, usually a paper with much too borrowed text without appropriate credit to the original authors. The occurrence rate is about one per 20–25 manuscripts, or 4–5%.

In science, paying tribute and giving credit to the authors of the original work is essential, it is a form of honesty. But plagiarism comes in colours, and it is not always easy to draw the right conclusions. For that reason, we let the CrossCheck software perform the first round of screening and then the suspect manuscripts will be examined by hand in our editorial office. Stealing whole paragraphs without attribution is different from ‘borrowing’ a few nicely crafted, linguistically and grammatically impeccable single lines by non-native English speaking authors.

Constrained paraphrasing of the description of a technical procedure in the Material & Methods section will not always lead to a better understanding. Composing a Discussion section from borrowed lines only is a misdemeanour (even with proper citation).

Turnitin has published a White Paper on the Plagiarism Spectrum that is worth reading. It notes the two basic questions that define plagiarism: ‘Is the work the author’s own creation and written in the author’s own words?’, and if not, ‘Does the writing provide appropriate credit to previous work?’ Because plagiarism is never that black and white, the White Paper introduces a new concept of a ‘plagiarism spectrum’, and discerns gradations of severity in cool e-generation terminology, from the highly problematic CLONE and CTRL-C plagiarism (submitting another’s work, word-for-word, as one’s own) to AGGREGATOR and RE-TWEET (‘includes proper citation, but the paper contains almost no original work’).

The latter case rates only a very low score on the user’s ‘problematic scale’, perhaps reflecting how easy it is to reuse the same text in a slightly different fashion. In between these two extremes are FIND–REPLACE (changing key words and phrases but retaining the essential content of the element in a paper), REMIX (paraphrasing from other sources and making the content fit together seamlessly), and RECYCLE (borrowing generously from one’s own previous work without citation).

The last is sometimes (misleadingly) referred to as self-plagiarism, but one cannot commit fraud by ‘misappropriating someone’s own words or ideas and presenting them as one’s own’. It’s not the re-using of the same words, but the lack of proper reference to it. Who wants to read the same review by an authority in the field under a slightly modified title in two or more different scientific journals without being informed about this duplicate publication and without cross-referencing? Who wants to find the same group of people included in a subsequent article by the same authors, without being informed of their re-emergence in this extended series?

Then there is the FIREFIGHTER (the combination of perfectly cited sources with copied passages – without citation – in one paper), MASHUP (a paper that represents a mix of content from several different sources without proper citation), and finally the 404 ERROR# (a written piece that includes citations to non-existent or inaccurate information about sources).

I recommend the Turnitin White Paper to all the young researchers in my department, and in my view it is mandatory reading for every student and aspiring scientist. Plagiarism is thief – of words, of ideas. If we want to stop it we have to stop it at high school. But will we still be able to change the attitude of a whole generation? Will they care? Or, to quote @EmilyAsk94 on Twitter: ‘Seriously, how many times am I going to have to listen to a lecture about what #plagiarism is? Or @JakeActis, tweeting to another member of the e-generation: ‘You should have to put your tweets through http://turnitin.com. We all know you’re not cool enough to come up with that’.

This paper is based, with permission from the author, on an Editorial I wrote for Human Reproduction: JHL (Han) Evers is Professor of Obstetrics and Gynaecology at the University of Maastricht and head of the Centre for Reproductive Medicine. He was Editor-in-Chief of ESHRE from 2001 to 2003 and has been Editor-in-Chief of Human Reproduction since 2013.

2. @JakeActis. The My Sweet Lord/He’s So Fine Plagiarism Suit, Abbeyd’s Beatles Page, 1993 (accessed 8 May 2014).
Aneuploidy screening still dominates members’ activity

• Provisional data collection results for 2012 presented in Munich

• IT system now under review for more efficient long-term database

With provisional results for 2012 (Data Collection XV) reported in Munich, the PGD Consortium is now into its 15th round of annual data collection. Publication of results from Data XII (for 2009) were published earlier this year in Human Reproduction, while reports for Data XIII, XIV and XV are ‘on course’.

The data collections are extremely valuable for monitoring accuracy, reliability, effectiveness and safety of PGD and PGS, said the Consortium’s outgoing Chair Joanne Traeger-Synodinos in Munich, ‘but they are a massive undertaking.’ A Consortium Working Group is currently evaluating a database revision to make the collection process more efficient. The aim is to select a partner company which can develop a user-friendly and efficient. The aim is to select a partner company which can develop a user-friendly and efficient. The aim is to select a partner company which can develop a user-friendly and efficient. The aim is to select a partner company which can develop a user-friendly and efficient.

As ever, PGS remains the greatest indication, but with the latest collection as reported in Human Reproduction, the company which can develop a user-friendly and efficient. The aim is to select a partner company which can develop a user-friendly and efficient. The aim is to select a partner company which can develop a user-friendly and efficient.

Despite the challenge, however, data continue to accumulate, and the latest collection as reported in Munich was derived from more than 60 centres (from a Consortium total of 124) and almost 7000 cycles. As ever, PGS remains the greatest indication, but with the latest collection as reported in Human Reproduction, the company which can develop a user-friendly and efficient. The aim is to select a partner company which can develop a user-friendly and efficient.

There were some further qualifications of these trends in a short report from the Consortium’s Working Group on new technologies in PGD, chaired by Martine de Rycke. Forty-six centres responded to the Working Group’s survey, which showed that time-lapse imaging for embryonic assessment is used by 11% of the 46 centres (22%). The survey also found that, for PGS, 89% of all cycles were performed with cleavage-stage biopsy at days 1, 3, with polar body, and 10% with trophectoderm.

The survey reflects a shift towards trophectoderm biopsy; when compared with Data XI, for example, trophectoderm biopsy has increased from below 1% to 15% in 2012. Similarly, in PGS 32% of centres (accounting for 24% of all cycles) currently rely on trophectoderm biopsy. However, the frowned technology for PGS is array CGH (76% of all cycles surveyed), though FISH still accounted for 17% of cycles.

Commenting on the survey results, the Consortium’s new Chair Edith Coonen, warned that the centres who replied to the survey are not necessarily the same as those who took part in the data collections and some caution is needed when comparing the data sets.

Cumulative analysis of Data Collections 1-XV showed that 58% of all cycles reported were for aneuploidy screening, while 22% were for monogenic diseases. Social screening, incidentally, remained as a minority indication at just 1%. Among the specific monogenic disease indications, cystic fibrosis, Huntington’s disease, beta thalassaemia, myotonic dystrophy and fragile X syndrome were by far the most common.

PGD CONSORTIUM

Activity report. Working groups monitor technology trends, service provision in IVF centres, and HLA tissue matching among Consortium members

Before reviewing our latest activities in what has been a very busy time, I would like to thank Jan Traeger-Synodinos, who stepped down as Chair at our annual PGD Consortium meeting in Munich, and Joep Geraedts, who ended his advisory role in the Steering Committee earlier this year. The efforts they have each put into the Consortium are considerable and very much appreciated. For the next two-year term, the Steering Committee will comprise Edith Coonen (Chair), Sibhban SenGupta (Chair-elect), Martine De Rycke, Celine Mouotou and Georgia Kokkali, who was elected as a new Committee member by Consortium members last June. I should also add that the Steering Committee could not function without the support of ESHRE’s Scientific Manager Veerle Goossens and welcomes the input of the non-voting members Ursula Eichenlaub (Coordinator of the SIG Reproductive Genetics), Ian (as Past Chair) and Cristina Magli (ESHRE Executive Liaison Officer).

Data collection

The collection of data XV continues as usual. Data XIII will hopefully be published later this year and data XIV is in the process of cleaning. For future data collections we hope to have an on-line data submission platform ready for the end of 2015. We are currently looking into the format of this new database. The aim is to generate data that meet the needs of Consortium members: that is, to provide information on the use and success of PGD and PGS in general, but, maybe more importantly, to signal trends and provide detailed information on the use and success of PGD and PGS using new technologies and strategies. All this needs to be accomplished without asking too much from participating Consortium members.

This is a complex project which Celine Mouotou is co-ordinating with help of Martine De Rycke.

Working groups

However, data collections do not represent real-time trends in PGD. For this reason the Steering Committee started a Working Group in 2013, chaired by Martine de Rycke, to monitor new technologies in PGD. Results from the first questionnaire were published last year and the second one, titled ‘Transplant following selection and birth of an HLA-compatible child’, will soon be contacted and asked to fill in a questionnaire. A manuscript will be prepared based on the results of the survey and centres contributing data will be included for authorship.

Education

With respect to the educational aims of the PGD Consortium, the Steering Committee intends to facilitate exchange of experience between Consortium members and we are pleased to inform you that a first interactive webinar on PGD for HLA took place last Spring (hosted by Jan Traeger-Synodinos), with a second one, titled ‘FISH or Chips’, scheduled for October this year (hosted by Edith Coonen).

The Steering Committee hopes that the Consortium continues its important role as a forum for all PGD practitioners to exchange data, experiences and valuable expertise. However, we cannot accomplish this without the help of you, our colleagues. Thus, we want to encourage participation of member centres, not only in the data collections but also in other (WG) activities. Your input will be very much appreciated.

Outgoing Consortium Chair Joanne Traeger-Synodinos reported data from 7000 cycles from 2012.
Two new ESHRE guidelines - in psychosocial care and premature ovarian insufficiency - now set for publication

The ESHRE guideline is now running at full speed and following the development manual established by the SIG SIGQ in 2009 and updated last year. After publication of the ESHRE guideline on The management of women with endometriosis, the next two guidelines are now being prepared for publication.

The development group from the SIG Psychology & Counselling guideline is now working on the final touches for the ESHRE guideline on Routine psychosocial care in infertility and medically assisted reproduction – A guide for fertility staff. The guideline provides information on the psychosocial needs which patients experience throughout their treatment and guides fertility staff in detecting and addressing these needs. The treatment pathway is subdivided into the pre-treatment period, including assessment and diagnosis, during treatment, and after (successful or unsuccessful) treatment. Additionally, evidence is summarised on patients’ preferences in the psychosocial care they receive at clinics and how that care contributes to their well-being. The ultimate aim of the guideline is to raise staff awareness about patient preferences for psychosocial care and to enable them to lead patients with the challenges they encounter during their journey in the fertility clinic.

A second guideline now in its final stages before publication is the ESHRE guideline on The management of premature ovarian insufficiency. The etiology of POI is wide ranging, as are the sequelae of a POI diagnosis. Women with POI do not only suffer from vasomotor and genito-urinary symptoms, POI also affects their life expectancy, quality of life, bone health, cardiovascular health, neurological function, and sexual function. This guideline provides a description of the clinical evidence for diagnosis, assessment of causation, and all sequelae of POI with their suggested management.

Finally, a chapter on treatment options is provided. The guideline provides all the necessary information clinicians need to diagnose and treat women with POI, with the aim of improving care for women with POI across Europe.

A guideline development group for early pregnancy has now been composed. This group will work on the fourth ESHRE guideline on Recurrent miscarriage, including assessment and treatment options. The aim is to publish this guideline in 2015.

Ideas for new topics are always welcome. If you think there is a need for an ESHRE guideline on a specific topic, please contact nathalie@eshre.eu, or the appropriate SIG Co-ordinator.

Deputies Claudia Spits (left) and Tanja Milachich with SIG Co-ordinator Uruela Eichenlaub-Ritter at the business meeting in Munich.

The three phases of psychosocial need during fertility treatment, as described in Munich by the Chair of the guideline development group Sophie Ganeiro.
Our precongress course – Targeting and managing special patient groups - was a huge success in Munich and very well attended. The afternoon session, which included hands-on opportunities for trophectoderm biopsy specifically for lab technicians, were very well received (with pictures below). Nurses in the group were able to participate in interactive counselling sessions, which are always challenging and thought provoking. The Board would like to thank all the contributors for their hard work in preparing for and participating in our successful course. We sadly said goodbye to Inge Rose Jørgensen in Munich when she attended her last board meeting. Inge has been a hard working board member for the past eight years and has been instrumental to meetings and to precongress and Campus courses will be missed. We are fortunate to maintain a connection with Inge, who has been instrumental in the development of the nurse and midwife certification course, as she will remain a member of the Steering Committee.

The next meeting of the nurse and midwives certification committee will be held on 9 October in Brussels, where we hope to complete our preparations for the examination to be held for the first time in Lisbon in June next year. Board members received many positive comments from nurses present at the Annual Meeting in Munich and are looking forward to completing their log books. While they are not exactly looking forward to an exam, they are very pleased to be able to access this educational resource.

The next Paramedical Board meeting will be held in Brussels on 8 October, when we will be planning the precongress course for Helsinki 2016 and will formally welcome our newest Board member, Annick Geril a midwife from Ghent.

Future activities

We are co-ordinating two Campus courses over the next few months. The first is a jointly run course with the SIG Early Pregnancy on Bringing evidence based early pregnancy care to your clinic. This will be held in Copenhagen on the 11-12 December. We are also very excited to be running a Basic training course for paramedics working in reproductive medicine in Lisbon from the 19-21 March 2015. This is the first time the course has been run in Portugal and is in response to popular demand. It is an ideal course for nurses, midwives and lab technicians who might be new to the field and also for those who might feel the need to update their skills and knowledge. We are looking forward to meeting colleagues at both these Campus courses.

We would be delighted to hear from ESHRE Paramedical Group members if there are any burning issues or topics which you would like us to address or courses that you feel would be valuable. Please feel free to contact me directly.

Helen Kendrew
Chair Paramedical Board
helen.kendrew@bathfertility.com

SIG EARLY PREGNANCY

Early pregnancy care in the clinic

A new steering committee of the SIG EP was confirmed in Munich, with Siobhan Quenby as the new Co-ordinator, supported by Emma Kirk as Deputy and Astrid Marie Kolte as the new Junior Deputy. Mariette Goddijn will be Past Co-ordinator for the next two years. Currently there is a call from ESHRE’s Central Office for a new Deputy. A joint Campus meeting arranged with the Paramedical Group, Bringing evidence-based early pregnancy care to your clinic, will take place in Copenhagen on 11-12 December. The meeting has been designed with gynaecologists, midwives, nurses, psychologists and lab technicians in mind. Early pregnancy complications, such as (recurrent) miscarriage and ectopic pregnancy are prevalent and can have a major impact in women’s lives. The course will provide high quality, evidence-based information for clinicians treating patients with these conditions. We hope for much interaction from debates and round-table sessions. Topics will include the management of ectopic pregnancy, developing an early pregnancy and recurrent miscarriage unit, and psychological support. Hot off the press in a closing lecture will be the first results of the Promise trial from Raj Rai, on progesterone in recurrent miscarriage. Meeting venue is the Tivoli Hotel and Congress Center, an attractive location in the heart of Copenhagen.

Astrid Marie Kolte (DE), Junior Deputy
Mariette Goddijn (NL), Past Co-ordinator
Emma Kirk (GB), Deputy
Siobhan Quenby (GB), Co-ordinator

SIG SOCI-CULTURAL ASPECTS OF (IN)FERTILITY

Socio-cultural aspects of (in)fertility

The Annual Meeting in Munich was a test for the willingness of other SIGs and Task Forces to collaborate on socio-cultural issues which transcend borders, both the actual European boundaries, and the semantic borders of scientific subjects. Our initial concern choices the matter of oocyte cryopreservation and the larger social and cultural issues of ‘insurance’ against age-related fertility decline. We asked all members of the Committee of National Representatives to send us some basic information on oocyte cryopreservation in their country. Most have answered, for which we are very grateful, and confirms that the subject is of interest throughout ESHRE. Indeed, now that the efficiency of the technique has been dramatically transformed by vitrification, there has been increased media and women’s interest in this field for non-medical reasons, as well as its practice for medical indications. It is felt that the use of such oocytes is likely to grow, but without data we cannot confirm this, nor help those interested make an informed decision about efficiency and safety. So we hope to encourage colleagues to collaborate on European data of what is now in storage and later in use.

Some countries have started already collecting data, and we know from ESHRE figures that Italy and Spain perform 85% of the small number of IVF cycles using cryopreserved oocytes in Europe. Our objective is to stimulate an ESHRE register in this specific field, and we are also discussing this with EMD.

To start with, we are collating preliminary background information on European practice as a necessary step towards a possible study, which we hope to propose to the Executive Committee before the end of the year.

Other plans include a collaboration with the SIG Ethics & Law for a precongress course in Lisbon and with the SIGs Early Pregnancy and Ethics & Law for Helsinki, where our contribution would include such public health issues as the global rise in obesity.

Françoise Shenfield (GB), Co-ordinator
Virginie Rozée (FR), Junior Deputy

STEERING COMMITTEE

STEERING COMMITTEE

Françoise Shenfield (GB), Co-ordinator
Paul Devroey (BE), Deputy
Anna Pia Ferrari (IT), Deputy
Virginie Rozée (FR), Junior Deputy

SIG EP’s new Steering Committee pictured in Munich, from left, Siobhan Quenby, Astrid Marie Kolte, Mariette Goddijn and Emma Kirk.

STEERING COMMITTEE

Siobhan Quenby (GB), Co-ordinator
Emma Kirk (GB), Deputy
Astrid Marie Kolte (DE), Junior Deputy
Mariette Goddijn (NL), Past Co-ordinator

The SIG EP’s new Steering Committee pictured in Munich, from left, Siobhan Quenby, Astrid Marie Kolte, Mariette Goddijn and Emma Kirk.

The SIG Early Pregnancy in Prague, pictured in Munich, from left, Siobhan Quenby, Astrid Marie Kolte, Mariette Goddijn and Emma Kirk.
**GnRH triggering for the elimination of OHSS**

During our business meeting in Munich a call for proposals for a SIG RE Campus meeting in 2016 and for our preconference course in 2016 in Helsinki was made, with a deadline at the end of September 2014. Some proposals were put forward and discussed briefly by the SIG RE members attending. A final decision on these two events will be made in October during the agonist triggering Campus in Thessaloniki. (Please e-mail any comments or ideas to me at stratis.kolibianakis@gmail.com).

**Annual Meeting Munich**

Our preconference course in Munich, The contribution of endocrinology and early pregnancy management to the success of an ART centre, was organised with the SIG Early Pregnancy and proved very successful. The course provided an update of clinically important research areas in reproductive endocrinology at the intersection with routine fertility treatment, with a special focus on reproductive success/failure and recurrent pregnancy loss.

**Forthcoming events**

The next event on our agenda is focused on OHSS complications. This will take place at a Campus workshop in Thessaloniki, Greece, from 31 October to 1 November and is titled Making OHSS a complication of the past: State-of-the-art use of GnRH agonist triggering. We encourage you to register for this exciting course. It will provide a critical review of the use of GnRH agonist triggering for the elimination of OHSS, with specialists in the field providing an update and addressing controversial areas on its safety and effectiveness. Focus will be on the problem of OHSS as assessed by incidence, prevalence, morbidity and mortality, as well as by its pathophysiology and predictability. Additional discussion will cover the preovulatory LH peak (as affected by GnRH agonist triggering), effect upon corpus luteum formation, and endometrial gene expression. The central debate of the course will consider GnRH agonist triggering as an optimal strategy for OHSS prevention in IVF, as well as the difficulties and advantages of other approaches, such as a freeze-all embryos approach with transfer in subsequent cycles, lutal phase rescue with small doses of HCG, and steroid supplementation.

Our Campus workshop for 2015 will be held in Helsinki and organised by our Junior Deputy Tehtä Piironen. The title of the workshop is Old and new in reproductive endocrinology. The course comprises a series of lectures on basic reproductive endocrinology and the latest updates in the field. The programme will cover the hormonal environment during pregnancy and early stages of reproductive development from the fetal period to adulthood, with a focus on developmental disturbances of reproductive organs during early and late reproductive life. Repeated implantation failure is the subject of our preconference course in Lisbon 2015. The course will provide a critical appraisal of RIF management strategies.

**The relevance of data collection systems to ART research and practice**

The annual reports of ESHRE’s European IVF Monitoring (EIM) Consortium are among the most cited references of Human Reproduction. They provide a snapshot of ART activity each year, and, now in their 15th edition, a cumulative trend picture over time. Now, the EIM Consortium has joined forces with the Co-ordinator and Deputy Co-ordinator from the respective data monitoring systems.

Three topics for which data collection can provide a sure basis for research will be covered in detail: trends in the application and success of PGD programmes in different countries and how local circumstances affect uptake and outcome; and cross-border reproductive care - only with a reliable data collection system can the extent of this recent phenomenon be assessed. The programme will also examine the core values behind ESHRE’s own data monitoring - safety, quality of treatment and accessibility - and ask if ‘success rates’ are related to the validity of ART. The programme will also consider the impact of ESHRE’s own data monitoring on the design and outcome of research and is expected to stimulate discussion about the importance of data collection in research.

**Future activities**

Following the SIGS business meeting, we are happy to confirm some very exciting courses in the coming months.

The Annual Meeting in Munich got off to a great start with our preconference course on ‘Fetal sparing surgery in malignant and benign conditions’. There was great debate amongst the audience on how to manage such problems as severe endometriosis, large ovarian cysts and massive uterine fibroids. Newly found interest arose from the lecture by Grigoris Grimbizis on fertility-sparing treatment of adenomyosis. It became apparent that, despite its use as a common condition, there has been a lack of consensus on the correct diagnosis, classification and treatment, further developments of which are eagerly anticipated. Finally, it was most stimulating to discuss the difficult topic of fertility preservation in young women with cervical, endometrial and ovarian cancers. The biological perspective, shared by Drs Nouri, Maneo and End, was invaluable, as was the discussion by Professor Metwor on effects of chemotherapy on the ovary and tissue cryopreservation.

Live surgery

As ever, this year’s live surgery session drew much attention. The surgery was performed in Thessaloniki, Greece, and broadcasted live via real-time videolink. There were three concurrent theatre sessions available to the panel for observation and interactive discussion. Rudi Campo led the hysteroscopic cases involving septal resection and an endometrial polyp with the SIG Endometriosis and Endometrium on the panel for observation and interactive discussion. Rudi Campo led the hysteroscopic cases involving septal resection and an endometrial polyp with the SIG Endometriosis and Endometrium on the panel for observation and interactive discussion.

Field in the coming months.

**First certifications in endoscopic reproductive surgery - at both levels - awarded in Munich**

The biannual endoscopy course organised by Stefan Gordts will take place in Leuven on 15-17 October, when candidates will have the opportunity to follow several hours of live surgery and participate in hands-on laparoscopic skills training.

In December the SIG will also co-host a joint Campus symposium in Liege, with the SIG Endometriosis and Endometrium on the topic of ‘Contraversies in endometriosis and adenomyosis’. This will be a unique interdisciplinary course covering areas from genetics and epigenetics to the surgical treatment of these disorders. Finally, we are happy to confirm that there will be a workshop held in Lyon, organised by Antoine Waterlot, on 17-18 April next year on ‘Complications in endoscopic surgery’. Practical sessions relevant to all reproductive surgeons will be covered, focusing on preventing and managing common surgical complications.

**Training and education**

The ESHRE Certification for Reproductive Endoscopic Surgery (ECRES) continues to run smoothly, with the latest exams successfully completed in Munich. Despite the certification programme being only recently introduced, it has seen a steady increase in interest. In Munich we had the first live certification for the Bachelor in Endoscopy (Level 1) and 11 certifications for the ECRES Reproductive Surgeon accreditation (Level 2).

Antoine Watrelot (FR), Deputy Co-ordinator Tin-Chiu Li (GB), Co-ordinator Grigoris Grimbizis (GR), Deputy Co-ordinator Antoine Waterlot (FR), Deputy Co-ordinator Sotirios Saravelos (GR), Junior Deputy Vassilios Tamos (GR), Past Co-ordinator Deputy Co-ordinator Grigoris Grimbizis described the fertility-sparing treatment of adenomyosis at this year’s preconference course.
The ‘collateral damage’ of privacy regulation in the USA. How the New York Times described the vanishing baby boards in US fertility clinics.

They’re the emblems of a clinic’s success, a coo-coo reminder of the real-life testimonies of IVF and real-life testimony to the value of persistent treatment. Yet not everyone goes weak at the knees before these cute collages of baby pictures displayed in the waiting-rooms of our fertility clinics. The baby pictures, apparently, are all over the public areas of fertility clinics in Europe, but for how long can they remain?

‘We have many patients who send us pictures of their babies,’ says Filippo Ubaldi, clinical director of the GENERA Centres in Italy. ‘But there are just as many who have no wish to share their pictures - and if I were a patient I’d be one of them. Even worse, patients still having treatment but not yet pregnant can easily be disturbed by all those smiling babies. I don’t like too many of these photos in the clinic.’

Ubaldi’s reservations are human and understandable, but they’re not the reason why IVF clinics in the USA are now removing the baby collages from their reception area. The reason is privacy - and the possibility that a baby’s image in a public place is actually identifiable information. ‘I guess patients send in their baby photos prominently, but he too recognises that the ‘data protection laws make it difficult’ and that ‘consent’ might solve the problem. Many of his patients don’t mind sharing their baby pictures but don’t want any identifying details. ‘I guess patients send their pictures as a mark of gratitude,’ says Velasco, ‘a happy ending to a difficult story. And the clinics are happy to display them as testimony to their treatments.’

Indeed, the VUB even welcomes the photos. ‘It encourages those still having treatment,’ explains Tournaye. ‘It’s the same whenever we organise a get-together for the children: there are always loads turning up.’

In the USA the Hipaas legislation was introduced a decade ago to protect the privacy of individually identifiable health information. ‘The intent of the law is well understood,’ says Simon Brown Focus on Reproduction