NEWSLETTER
INTERNATIONAL FEDERATION OF FERTILITY SOCIETIES

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Reproductive health reflects the holistic approach to human reproduction, which involves safe sex as well as preconception care and intervention, leading to planned pregnancies and healthy children.

As nicely described by Professor Robert Norman in this issue of the Newsletter, this approach is far more important and relevant to the vast majority of the population, who reproduce naturally and often under suboptimal conditions, especially in the developing countries. It is also more cost-effective to develop efficient counseling services that would inform people about the different aspects of reproductive health than developing successful ART programs, although obviously one is not exclusive of the other.

Hence, the use of contraception to prevent unwanted pregnancies and abortions, the prevention of sexually transmitted diseases (particularly HIV), HPV vaccination, the maintenance of an appropriate body weight, as well as the avoidance of smoking and/or drug and alcohol abuse prevent frequent causes of infertility and decrease the need for ART treatment. Moreover, the addition of folic acid, the regulation of blood glucose levels and a healthy diet can significantly decrease the incidence of several severe pregnancy complications and fetal abnormalities.

Undoubtedly, Reproductive Medicine has made remarkable progress and is now offering couples many options that would allow them to have a happy and healthy reproductive life. Nevertheless, it is our responsibility, as health professionals, to disseminate the available knowledge and, ultimately, up to our patients to make the right choices.
The Workshop in Iran was held in conjunction with the Iranian Society for Reproductive Medicine (Secretary Dr. B. Foruhan as the principal organiser) and the Isfahan Fertility and Infertility Centre in Isfahan from 8-10 May. The IFFS speakers were Dr. A. Paffoni, andrologist from Milan, Dr. R. Mehta, embryologist, from Mumbai, India and Dr. H. Fatemi from Brussels, endoscopist discussing endometriosis. Unfortunately Prof. J-N. Hugues from France was unable to come but allowed his slides on ovarian stimulation regimes to be presented. There were also lectures on implantation and recurrent abortion as well as scientific contributions from the Royan Institute in Tehran and from its local branch to an audience of 300. The discussions centred on evidence based medicine. Although most of the senior gynaecologists were male, almost all the younger ones were female, no males any longer being allowed to train in obstetrics and gynaecology, denying opportunities to enthusiastic young people.

Hammammet, Tunisia was the venue for a joint Workshop with the Mediterranean Society for Reproductive Medicine on 18 May organised by Dr. Juan Garcia Velasco from Valencia. Other speakers were Dr. L. Nardo and Dr. M. Afnan from the U.K. Participants also came from Morocco and Lebanon in this one day meeting as part of a parallel session in the general programme, the audience varying from 60 to 400 during the day. This was an opportunity to develop contacts with North Africa and extend our educational programme.

From June 20-22 a workshop was held in Nanjing, China, a former capital during the dynastic era, organised by Profs. Z-J. Chen and J. Liu. The IFFS speakers were Prof. J.L. Simpson of Miami, USA, Prof. R. Homburg of Amsterdam/Tel Aviv and myself, speaking about the genetics of ovarian failure, ovulation induction and dysfunctional uterine bleeding respectively. The audience was greater than 400 and all young assistants were medical students dressed in orange T-shirts emblazoned with the IFFS logo.

In each location our hosts were generous in their hospitality and in sharing their cultural treasures, so that all speakers left with a wish to return and culturally enriched.

Negotiations are proceeding with Jordan, Malaysia, Ivory Coast, Chile and a number of other venues to set up workshops on subjects appropriate for their local societies. IFFS feels privileged to be able to share the expertise of its speakers and grateful for their enthusiastic support of this project.
Reproductive medicine has made remarkable progress over the past 50 years with the introduction of new drugs, diagnostic tools, techniques for monitoring, simple and advanced reproductive technology and emerging science technology and medicine. It is easy to be dazzled by high pregnancy rates on IVF programs by pre-implantation genetic diagnosis, donor gamete program and the myriad complexities of social interaction during the application of reproductive technology. Many millions of dollars have been spent on optimising assisted reproductive technology programs and developing new methods of treating infertile couples. Our programs are governed by regulatory bodies, total quality management programs now demand IVF laboratories follow techniques previously used in manufacturing. Every group of doctors seeks that extra one to two percent increase in pregnancy rates to confirm their excellence in reproductive medicine.

It is very easy to forget that a very small percentage of people across the world reproduce through high technology programs such as is found in Western countries. The vast majority of people conceive naturally under very uncontrolled circumstances where they smoke cigarettes, are exposed to environmental pollutants, may be under or over weight, may be heavy smokers, not be on folic acid and are exposed to drugs and chemicals in the environment over which they have no control. Throughout pregnancy they may be exposed to under or over nutrition, have uncontrolled blood sugar or diabetes and many have no antenatal care. These are areas in which we can make a difference, a much greater difference than we can by seeking to optimise our IVF programs. And yet, even in an IVF program we are dealing with women and men who are severely overweight, who smoke or have other poor environmental lifestyles that may well program the developing embryo away from achieving its optimal potential.

We have abundant evidence in later pregnancy of the effect of the environment and nutrition on the outcome of an individual born to a compromised pregnancy and increasingly we are understanding the influence of a compromised conception on long term outcomes. The science of epigenetics is also teaching us that the environment can interact with our genes in a way that can program us for health or disease throughout life. There are now abundant experiments showing the influence of vitamins, folic acid and other factors on epigenetic control of gene expression. There have been reports in the literature that make us somewhat afraid that we may be replicating some of the epigenetic effects in tissue culture or in the way that we look after embryos in an IVF program. Although these are far from proven, we should at least be aware of the impact of lifestyle on patients seeking to become pregnant.

The areas in which we have compelling evidence for the effects of the environment on fertility and pregnancy outcome are in weight and smoking. Over and over again published studies teach us that extremes of weight are associated with infertility and where pregnancy is achieved, much higher risks of miscarriage and of abnormal fetal growth. The increasing amount of obesity in many parts of the world is strongly associated with sub fertility, congenital abnormalities, gestational diabetes, increased hypertension in pregnancy, increased operative delivery, deep vein thrombosis and many other conditions. We are also well aware that babies that are under weight or overweight at birth have a compromised outcome later in life. The evidence for the adverse effect of smoking is also compelling.

The development of programs to deal with adverse lifestyles in men and women seeking treatment for fertility is extremely urgent and in the modern day, many patients are looking for a quick
fix rather than going through a systemic approach to improving their lifestyle and eliminating factors that compromise their fertility and subsequent health of their baby. Powerful technology, such as IVF, allows patients to take a detour around the lifestyle issues and get a positive pregnancy test but this is only the start of the journey and many pot holes exist in the pregnancy road into which patients who have taken a detour can fall rather than to sort out the main route.

The above is equally valid to the vast number of people in the population who have no occasion to seek medical advice regarding their fertility before they become spontaneously pregnant. The great challenges for us are to encourage doctors and patients to take appropriate action before couples seek to become pregnant. I believe that we need three main action plans.

1. Every individual should have her reproductive life plan. For example, for a teenager a reproductive life plan might incorporate the use of oral contraceptives, vaccination with anti HPV and rubella, attention to any signs and symptoms of polycystic ovary syndrome and maintenance of an appropriate weight. When they form a relationship in which they seek a pregnancy, their reproductive life plan should also include pregnancy at a relatively early age compared with the current practice, attention to adverse lifestyle factors such as overweight, smoking and lack of folic acid in the diet. Once they have finished their pregnancies, a reproductive life plan would incorporate appropriate contraception or sterilisation, attention to menstrual dysfunction and appropriate prophylactic and diagnostic measures to avoid gynaecological cancer.

2. Preconception planning. We should make it easy for couples who are deciding to have a child to get informed advice before they cease contraception. This would incorporate advice about the value of using folic acid for women, seeking to optimise weight, cessation of smoking and other drug use, information about reproductive physiology to enable optimal timing of intercourse and where appropriate, addressing blood sugar, irregular menstrual cycles and any inherited or acquired diseases in one or both of the partners.

3. Intervention program. Advice is not sufficient for most couples – there also needs to be appropriate programs set up. There are a number of programs addressing issues to do with smoking and patients should be allowed to get information to access these. Increasingly we recognise that just losing 5% of the total body weight and becoming fit will allow an obese insulin resistant patient to start to cycle regularly and to improve fertility. Easy and inexpensive programs should be devised to allow couples to take part in maximising their reproductive fitness.

We have optimised our control over reproductive technology but we have not addressed the most important messages. These are of individuals having appropriate information so that they can make decisions regarding their reproductive health to minimise or maximise fertility as they plan and also to carry through good habits in pregnancy to optimise the chance of having a healthy baby. Many members of IFFS do not have access to the remarkable technology seen in many Western countries but they are able to give appropriate advice, reproductive health planning and preconception interviews that can change the lives of many babies who are born and improve the health and general well being of the community conceived during pregnancy. The returns on the investment on giving people information about their reproductive health and allowing them to address this is a far better investment than ART.
As was mentioned in the previous issue of the IFFS Newsletter, the decision of founding the association was made during a casual dinner conversation on October 16, 1951.

The following day 21 physicians met, ratified the document of needs and purposes and elected a slate of officers. The Founding Board of Directors of the IFA was made up of 4 officers and numerous Honorary Vice-Presidents, Active Vice-Presidents and National Secretaries. Many of those listed were important figures in the field but were not in attendance at the congress.

Officers elected were President: B. Bernard Weinstein, New Orleans, LA. USA - Vice-President: Arthur Campos de Paz, Rio de Janeiro, Brazil - Secretary General: Carlos D. Guerrero, Mexico D.F., Mexico - Associate Secretary: Abner I. Weisman, New York City, USA

Among the decisions taken at this inaugural meeting were to offer all 54 registrants at the congress full membership in IFA and to explore the possibility of holding the 1st World Congress of Fertility and Sterility as a joint meeting with the American Society for the Study of Sterility (ASSS), later to become the American Society for Reproductive Medicine (ASRM), which at that time had a membership of approximately 300. The congress would be held in 3 years time in New York City. Interestingly, the logo of IFFS today is only slightly modified from the one designed and used on the certificates of attendance at that meeting in 1951.

Congressess of IFA

The First World Congress of the IFA was held in the Henry Hudson Hotel, New York City, May 25-31, 1953 as a joint meeting with the ASSS. Bernard Weinstein was the President of IFA and Irving F. Stein was President of ASSS. Walter W. Williams who had been the first President of ASSS and was at that time their Secretary, was made an Honorary President of IFA. An andrologist, he held degrees in veterinary medicine and medicine.

Abner I. Weisman was the local organizer and W.I. Pomereneke was the official liaison between the two societies. The meeting was a great success outwardly with a registration of 1300 delegates from 53 countries. It is recorded that in the course of the meeting friction arose between the two organizations. The ASSS leadership was irritated because the IFA insisted on publishing the transactions of the congress themselves and because of their lack of help in generating funding of the congress. The ASSS decided that since they had raised most of the funds they would not provide financial assistance for a future joint congresses. Difficulties continued after the congress because the ASSS membership criteria were very selective and would not grant membership to some of the members of IFA. Interestingly, 24 years would pass before they met jointly again.
Switzerland – In the Heart of Europe

Bruno Imthurn, MD
President
Swiss Society for Reproductive Medicine

Switzerland is a multicultural and multilingual country. It is not only the country of delicious chocolate and tasty Emmental cheese, but also of a successful industry on the highest international level. The origin of this success – maybe surprising for some of our friends abroad – is an open minded population and a liberal legislation.

However, in reproductive medicine everything seems to be different. Since 2001 Switzerland has a federal act, which regulates reproductive medicine in a very restrictive way, the law for reproductive medicine. This law regulates mainly by the ban of a couple of techniques. Of course some of them are widely prohibited and not only in Switzerland, such as reproductive cloning. However, other methods, which are accepted without any discussion in most countries of the world, are illegal. This includes embryo freezing, preimplantation diagnosis and egg donation. In addition, the selection of the most viable embryo is not possible, as the law limits the number of zygotes to three, which can be cultivated to cleaved embryos.

The reason for this restrictive law was a federal initiative started in the mid nineties of the former century. This initiative had the aim to ban any kind of assisted reproductive technology (ART) in Switzerland. It was a fundamentalist religious group, which started this initiative. Within a few months this group found more than 100,000 Swiss citizens, who were ready to support this plan by signing the proposal. Following the rules of the direct democratic system in Switzerland, where the people has the sovereign power and not the parliament, this initiative had to pass a plebiscite. In the case of a “yes” by the majority of the voters, in fact, ART would have no more been possible within the borders of Switzerland. That is why the two chambers of the Swiss parliament created a bill that in general met the conditions of the initiative group, but still would it make possible to help childless couples with ART procedures. After weeks of intensive discussion in the public and fighting of many affected couples, the initiative was rejected with more than 70% of the votes in early 2000. As result, however, the restrictive law came into force on January 1, 2001.

In the first years there was much fear about the pregnancy rates and consecutively about the loss of patients to the neighbouring countries. Yet, irrespective of the restrictions nowadays the best ART centres in Switzerland reach clinical pregnancy rates of close to and even above 40% per initiated cycle, hence, pregnancy rates, which are comparable to the best centres in European countries with a much more liberal legislation.

Nevertheless, the prohibition of embryo freezing, preimplantation diagnosis and egg donation remains a heavy burden for reproductive medicine in Switzerland. Whereas the Swiss centres have to follow the law and are inspected unannounced and biannually by the authorities, the couples within Switzerland are free to go to countries where the needed therapies are available.

But there is light on the horizon. In 2005 the federal parliament decided to delete the prohibition of preimplantation diagnosis out of the law and therefore to revise the Swiss law for reproductive medicine. At the moment the bill is in the rewriting process. Whether additional features such as the ban of embryo freezing and egg donation are modified, as well, is not clear, yet. The Swiss way of legislation is slow. After the making of the new law it has not only to pass the two chambers of the parliament, but probably a new plebiscite, as well. Although another two to three years will be necessary for this procedure, finally, we can be sure that Switzerland stands behind the new law.
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