



## Letters to the Editor

### Spinal cord injured men and infertility

In *Spinal Cord* 2, 1999, Sønksen *et al* gives a very up to date review of the treatment of male infertility in SCI.<sup>1</sup> The comment given by Dr Ohl contains a statement that deserves some opposition: 'we would generally transfer four embryos per cycle. With this philosophy, we have enjoyed a significant IVF pregnancy rate (37%), while maintaining a multiple birth rate of only 18% including only one triplet pregnancy'.

When we started to do IVF with sperm from SCI men some 7-8 years ago, we used the standard procedure in our IVF clinic: Three embryos were transferred per cycle. After the first five couples had been treated, we were left with one failure, one singleton pregnancy, one pair of twins and two triplet pregnancies. This was not quite what we had intended, particularly when the two fathers of the triplets both were tetraplegic.

Our procedure is now to offer two embryos per cycle if the couple wants to risk a twin pregnancy, otherwise we transfer one. We never transfer more than two embryos. We have to remember that the spouses of SCI men usually are completely normal, young nullipara with no history of abortions or other gynecological problems. These women are different from the usual female clients of an IVF clinic.

With one (or two) embryos transferred per cycle our pregnancy rate for SCI couples are still better than the average (25-30%) for the remaining couples in our IVF clinic. In our opinion the transferring of more than two embryos is contraindicated in SCI couples, considering the extra burden triplets (and perhaps twins) will represent in a family with a father that can not take part fully in the daily work with multiple small children of the same age.

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### References

1. Sønksen J *et al*. Clinical case of the Month. Treatment of infertility. *Spinal Cord* 1999; 37: 89-95.

### In reply to Dr Stien

We appreciate the comments of Dr Stien regarding the number of embryos to transfer during in-vitro fertilization cycles. He should be congratulated that his clinic is able to achieve pregnancy rates of '25-30%' when transferring only one or two embryos per cycle. Unfortunately, most centers cannot boast such a rate when transferring so few embryos.

The quandary in the decision of how many embryos should be transferred can be reduced to a very simple issue: the balance between pregnancy rates and multiple birth rates. These two numbers are inextricably related. In other words, when the number of embryos is increased, the pregnancy rate and the multiple gestation both increase. Clinics transferring six embryos may have pregnancy rates >50% with multiple rates also >50%.

Striking the proper balance between maximizing the pregnancy rate and minimizing the multiple birth rate is the challenge. There is an emotional price from entering multiple unsuccessful cycles of inseminations or IVF. In the US, unlike Scandinavia, there is also a financial price, since IVF is uniformly paid for from the patients' private funds. Most of the patients in the US are willing to accept a modest risk of twins (an extremely low risk of >twins) for a higher pregnancy rate.

While we agree that there may be added difficulty in rearing twin and triplet sets when the father is disabled, we think it is rather paternalistic to assume that such a burden cannot be carried. The triplet pregnancy alluded to in the article was to a man who is C7 quadriplegic who takes a very active role in raising his children (when he is not at work) and he and his wife are extremely happy of the outcome. They are particularly happy since they had previously gone through 12 cycles of unsuccessful electro-ejaculation/insemination cycles and paid the emotional price of failure for some time.

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