Current Medical Research

Hanna Klaus, M.D.

Natural Family Planning

Diocesan Activity Report

SUPPLEMENT

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A Randomized Clinical Trial of Mifepristone (RU486) for Induction of Delayed Menses: Efficacy and Acceptability. D.A. Grimes et al. *Contraception* 46:1-10, 1992.

A double blinded protocol of RU486 was offered to 16 women as a menstrual regulator to women whose menses were delayed up to 10 days. Eight women received a placebo. Four of eight women in each treatment group proved to be pregnant. Seven of the eight women who received RU486 were not pregnant at a two week follow up. Those women who had been pregnant expressed initial relief. This continued at 2-4 weeks after the procedure. Longer follow up is not available.

Fetal Intracardiac Potassium Chloride Injection to Avoid the Hopeless Resuscitation of an Abnormal Abortus: I. Clinical Issues. NB Isada et al. *Obstetrics & Gynecology* 80:296-299, August 1992.

When a fetal birth defect leads to elective abortion, and the fetus is born alive, the neonatologist tries to resuscitate the immature newborn. This is embarassing to the genetics/obstetrical group at Wayne State University, Detroit, who now inject the fetal heart with potassium chloride through an ultrasound guided needle to prevent such live births. The new procedure was prompted by a $19 million damage award to a handicapped child who weighed 490 g and was not resuscitated until four minutes after birth, and survived. The group reports the results of 21 women whose fetuses were killed by intracardiac potassium chloride injection prior to initiating intraamniotic infusion of urea and placement of 1-4 hygroscopic cervical dilators, followed by intramuscular injection of 15 methylprosta glandin F_{2a}. The women who were more than 20 weeks pregnant had been referred urgently in order to obtain the procedure before the legal cut off point of 24 weeks *[at Wayne State.]*

Fetal Intracardiac Potassium Chloride Injection to Avoid the Hopeless Resuscitation of an Abnormal Abortus: II. Ethical Issues. JC Fletcher et al. *Obstetrics & Gynecology* 80:310-313, August 1992.

Ethicist John Fletcher joins Isada et al. in laying out the ethical issues to prevent the "rare but catastrophic occurrence of live births [after an abortion of 20 weeks or later] which can lead to fractious controversy over neonatal management." On the side of allowing the procedure, they note that the woman's decision to abort is protected, the psychological harm(?) of a live birth are avoided, and the *potential for coercive intervention by other health care personnel is eliminated.* Opposing this conclusion are those who say that all abortions are unjust, that newborns and second trimester fetuses at similar weights with identical defects should be handled similarly and that the patient is not entitled to death of the fetus, only to the evacuation of uterine contents. Unsurprisingly, they conclude that their procedure is justified.

Conditions for Choosing Between Drug Induced and Surgical Abortions. A Bachelot et al. *Contraception* 45:547-599, July 1992.

A comparison of choice for drug induced or surgical abortion was performed among French women. In France, women who are pregnant no more than 49 days from their last menstrual period have the option of choosing between surgical abortion or RU486. Data from 488 women were studied for their initial choice and compared with the method actually used. Sixty two percent chose RU486. Most had already made the decision before seeking

medical advice. They were slightly less satisfied with the abortion experience than they had expected: 12.4% dissatisfied with RU486 compared to 3.6% of the vacuum aspiration group. RU486 women needed more rest and quiet afterwards. *[50% and 63% wanted to verify the expulsion, suggesting that the need to deny the pregnancy is not as great as some in this country have supposed. When RU486 is marketed as a way of bringing on a period without knowing one was in fact pregnant or not, acceptability may be lower than expected by the marketers. Ed.]*

Psychiatric Sequelae of Abortion: The Many Faces of Post Abortion Grief. EJ Angelo. *The Linacre Quarterly* 59:69-80, May 1992.

Since induced abortion is a physician caused death (iatrogenic) every post abortion woman has undergone a real death experience-the death of the child. Grief is the natural consequence of death. While the current obstetric and psychiatric literature is filled with articles about grief following perinatal death, whether due to spontaneous abortion, premature birth, still birth, or sudden infant death syndrome, the woman who elects to abort her child is not given recognition that she has suffered a loss because the "abortion counselor" persuades her that there is no loss, that she has just gotten rid of "a blob," etc. As a result of this, the woman cannot share her grief in order to come to terms with it. In normal grief, there are four stages of "grief work." Dr. Angelo quotes Horowitz (Stages): **I. Outcry**. The immediate response to death which may include intense expression of emotion and a turning to others for support; **II. Denial**. The bereaved person may wish to avoid reminders of the deceased and focus attention on other things, i.e., arrangements for a funeral, at which time emotional numbness or blunting may occur; **III. Intrusion**. The negative recollections of the deceased become frequent, including bad dreams and daytime preoccupation which may interfere with concentration on other tasks; **IV. Working Through**. The bereaved person begins to experience both positive and negative memories of the deceased, but without the intrusive or disturbing quality previously noted. The process is completed when the person once again has the emotional energy to invest in new relations, work, etc.

Pathological grief occurs when the normal stages of grief are intensified, prolonged, or delayed, or when the bereaved person cannot resume functioning because of other psychiatric or other psycho-physiological symptoms. This may occur immediately after the death when the outcry stage may intensify into panic or withdrawal or when the denial phase is magnified into overuse of alcohol or drugs or escape into frantic, sexual, athletic, work, thrillseeking, or risk activity. Depression usually follows pathological or unresolved grief and may easily follow when the cause of the grief may not be spoken about. It is characterized by morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment, or psychomotor retardation. Often, the depression is disguised because the patient may not volunteer her abortion history because of intense shame or guilt, or because she has not yet developed a trusting relationship with her therapist, or the abortion was a long time ago and thought not to matter. Some post abortion depressions do not surface until 8-10 years later the woman can no longer function and her life is in danger. This has been a common finding in outreach programs to post abortion women. There may be other negative factors in the history which might account for the depression: alcohol and drug abuse, failed marriage, job stress, and/or intrusive obsessive thoughts. Dr. Angelo cites the example of a 75 year old woman in the nursing home who was heard to mutter repeatedly: "I killed my baby." In fact, the abortion had occurred 60 years before! Society also has a blind spot about the significance of perinatal loss and grief following induced abortion. This is shared by many psychiatrists and other mental health professionals. *[Unfortunately, this is far from uncommon. Ed]*

Peterson, in a study of post abortion women in Germany, believes that when deep feelings of guilt which have been suppressed for a long time are followed by a "breakthrough of destructive deep awareness with chaos, panic, revulsion, and hate," these feelings must be acknowledged and the woman helped to come to accept existing reality and assume responsibility and feeling of guilt toward the dead child. The therapist must be able to endure the flood of primitive feelings which a patient needs to pour out over a number of sessions without either rejecting the patient or asking her to diminish their intensity. Otherwise, the process of mourning cannot begin.

Unlike the woman who had a spontaneous miscarriage or stillbirth, the woman who has had an abortion has no visual memories of her child, no pictures, no shared experiences to help her work through the grief process. Yet she has frequently formed a mental image of her child. It is that mental image which has been haunting her, intruding itself into her thoughts day and night. It may be a child being torn to pieces or crying out in pain, or reaching out to her for help. She has often named her child and may have regularly occurring conversations with her or him in her mind. The therapist must accept all of this and help the woman to work through it. The depression must be treated with proper medical means, including safeguards against attempted suicide and medical treatment of depression as indicated.

In Japan, women who have aborted often request memorial services for their children. At Buddhist temples parents rent stone statues of children for a year and offer prayers for the babies. They visit the statues and leave flowers and messages, and are thus enabled to acknowledge the reality of the child.

While suicide risk is very low during pregnancy and the first year after childbirth, after stillbirth suicides are six times higher than after live birth. There are no published studies of the rates of suicide after abortion. Youthful suicides are increasing rapidly, the majority are at 15-24 years of age, the age at which most induced abortions occur. Among "normal" adolescents sexuality and loss are two of four risk factors associated with a nearly fivefold increase in the risk of suicidality. The relationship between teen sexual activity, pregnancy, and loss is apparent in this age group. Not only women but men whose children are aborted sometimes go into a serious depression whose cause may not be understood if the history is not sought sensitively.

Post traumatic stress disorder is an anxiety disorder which has been accepted as a diagnostic category. Anniversary reactions on the expected date of the delivery of the aborted child, or subsequent anniversaries of that date or the date of the abortion often take the shape of suicide attempts. Other manifestations of anniversary reactions are physical symptoms, most commonly involving the reproductive system like abdominal pain or painful intercourse. However, headaches, chest pain, eating irregularities and increased drug and alcohol abuse are often seen. There is intense and persistent emotional pain after the abortion, especially at the time of the anniversary. Many times these women are subjected to extensive and unnecessary medical workups. Self punishing behavior is not restricted to a time of the anniversary, and may be triggered by any experience which reminds the woman of a baby, for instance, an Asian student who came to study Early Childhood Education responded very strongly to the class in Prenatal Development. Dr. Angelo cites examples of men whose chronic post abortion grief was somatized as gastric symptoms. Unresolved post abortion grief may also be responsible for marital conflicts, problems with sexual intimacy, and parent child relationship difficulty. While Dr. Angelo makes a plea for urgent compassionate treatment of women who have had abortions, she rightly suggests that not only alternatives to abortion, but proper teaching about the true meaning of and reverence for human sexuality constitute the ultimate in abortion prevention.

Transvaginal Embryo Aspiration — A Safe Method for Selective Reduction in Multiple Pregnancies. J. Itskovitz, Eldor et al. *Fertility & Sterility* 58:351-355.

Nineteen women who were treated for infertility with ovulation induction or IVF/gift had multiple pregnancies in excess of 3 to 7 embryos. Using an ultrasound guided needle through the vagina into the uterus, at no more than 7 weeks of gestational age, all pregnancies were reduced to 2 except one woman who wished to retain 3 of her 4 embryos. The embryos were sucked out through the needle. Those embryos which were retained continued to develop normally, and all but one woman delivered at 32-40 weeks of age. One woman delivered twins at 25 weeks; only the larger fetus survived. Since this was 17 weeks after the aspiration, it is unlikely that the immature delivery resulted from the procedure. Even so, the undesired pregnancy loss was only 5.3% in this series, only one third as high as when fetal reduction is carried out through the abdominal route after 9 weeks of age. The authors considered that maternal attachment had not had a chance to develop as strongly; hence earlier fetal reduction was better tolerated emotionally. Women consented to these procedures because

of the higher risk of perinatal morbidity when more than two fetuses are gestated. Among triplets, 16% of neonates die during the perinatal period. Another 15% do not survive infancy, while 20% of survivors suffer significant long term morbidity. Maternal morbidity is increased by the prolonged bed rest which is often prescribed for multiple pregnancy. The women also have a higher rate of anemia, post partum hemorrhage, pregnancy induced hypertension, and Caesarian deliveries. This study was carried out in Haifa, Israel. In Judaism, it is permissible to perform a medically indicated therapeutic abortion up to 40 days from conception (almost 8 weeks of menstrual age). *[One can only observe with enormous sadness that better controlled ovulation induction would not have led to multiple pregnancy and the wisdom of* ***Donum Vitae*** *is once again demonstrated. Ed.]*

Three Years' Experience With Levonorgestrel Releasing Intrauterine Device and Norplant 2 Implants: a Randomized Comparative Study. S.L. Wang et al. *Advances in Contraception* 8:105-114, 1992.

A three year experience with a levonorgestrel releasing intrauterine device was compared with Norplant 2 implants. These are two vehicles for delivering levonorgestrel. Two hundred women were followed for 36 months. They were randomly assigned to one method or the other. Only one pregnancy occurred in the IUD users at 12 months. Change in bleeding pattern was the most frequent reason for discontinuation. The discontinuations for irregular bleeding with Norplant 2 were 17.3% at 24 months; 26.8% at 36 months, compared to 3.3% with the IUD at both 24 and 36 months. Lack of menses and pain were encountered only in the IUD group. From 20-40% of women using Norplant 2 reported prolonged bleeding throughout the 36 months. More than 97% of subjects reported satisfaction with the methods. *[Norplant 2 contains the same amount of levonorgestrel as the Norplant system, but uses two wider and longer rods instead of six shorter narrower ones. This makes for greater ease of both insertion and removal. Ed.]*

Clinical Evaluation of Quinacrine Pellets for Chemical Female Sterilization. T. Agoestina and I. Kusuma. *Advances in Contraception,* 8:141-151 June 1992.

The Indonesians packed quinacrine pellets into the uterus near the tubal openings for non surgical female sterilization. One hundred women received three monthly insertions of 250 mg of quinacrine each and were followed at 1, 3, 6, and 12 months after the third insertion, a total of 15 months in all. The Life Table failure rate was 3.1% and the continuation was 96% at one year. More than 20% of the women had amenorrhea by the third insertion, but most had returned to normal by one year. The researchers suggest larger trials. *[Indonesia has a very strong and coercive family planning policy. Women do not complain much and are expected to be compliant. Methods used in such settings may not be acceptable in others. Ed.]*

The Progestin Only Oral Contraceptive - Its Place in Postpartum Contraception. I.C. Chi et al. *Advances in Contraception,* 8:95-103 1992.

The progestin only oral contraceptive has not been widely used; hence a study was undertaken. It can be used when there are contra indications to estrogen and has been advocated during breastfeeding, because if anything, it increases the amount of milk and has not been found to be harmful to the baby. It is less effective in preventing unplanned pregnancy than Norplant, Depoprovera, or Progesterone, releasing IUDs. The World Health Organization study on the vaginal ring releasing 20 mg of levonorgestrel per day reported 3.7 unplanned pregnancies per 100 women years. The one year discontinuation rate, including loss to follow up, was 50%. Progesterone oral contraceptive users appear to have a higher risk than combined oral contraceptive users for ectopic pregnancies, if there is unplanned pregnancy. In the United States, the overall percentage of ectopic pregnancies is estimated to be 0.3-3% while the rate among progesterone oral contraceptive users is 2.8-4.1%, a proportion nearly as high as that for the 4.3% reported by IUD users. *[Clearly the IUD is not totally effective as a contraceptive! Ed.]*

The higher incidence of ectopic pregnancies with progesterone is thought to be due to changes in tubal motility, secretions, and ciliary activity which may decrease the rate of transport of the blastocyst in the fallopian tube. *[In evaluating other risks, the article fails to consider that progesterone is the hormone which causes cell mitosis in the breast; whereas estrogen causes mitosis in the uterus.*

There may well be a fall out of increased breast cancer under these circumstances. Undoubtedly, this will form the basis of another study. Ed.]

Survivors of Extreme Prematurity—Outcome at 8 Years of Age. W.H. Kitche et al. Aust N Z J *Obstet Gynaecol* 31:337-339, 1991 cited in ACOG Current Journal Review 5:37, 1992.

Survivors of premature birth between 24 and 29 completed weeks of gestation were studied at 8 years of age. Sixty one percent survived; 27% of these were available for study: 70% of the children were not disabled; 13% had mild disability; 2% moderate; and 4% severe. Although survival decreased with decreasing gestation, the disability among the survivors did not increase. Earlier assessment of the same children at approximately 2 years of age had been unduly pessimistic especially for those born earlier than 26 weeks of gestation. *[In view of these studies, assessment at birth should not be overly concerned with long term neurologic outcome when making clinical decisions. Ed.]*

Authoritative Parenting and Adolescent Adjustment Across Varied Ecological Niches. L. Steinberg et al. *Journal of Research on Adolescence* 1:1:19-36, 1991.

The authors examined the widely reported positive correlation between "Authoritative Parenting" and teenagers' adjustment to see whether it was moderated by the ecological context in which the adolescents live. They studied an ethnically and socio economically diverse sample of 1,000 high school students in respect to their family background, parents' behavior, and 4 indicators of adjustment: school performance, self-reliance, psychological distress, and delinquency. Subjects were divided into 16 sub-groups defined by race, socio-economic status, and family structure. Analysis of adjustment scores of students from authoritative vs. non-authoritative homes found that positive correlations of authoritative parenting transcended race, socio-economic status, and family structure. "Virtually regardless of their ethnicity, class, or parents' marital status, adolescents whose parents are accepting, firm, and democratic earn higher grades in school, are more self reliant, report less anxiety and depression, and are less likely to engage in delinquent behavior." *[Authoritative parenting is defined as high indemandingness but also high in responsiveness, while permissive parenting is high in demandingness but low in responsiveness, and authoritarian parenting is high in demandingness and low in responsiveness. Ed.]*

Treating the Distorted Body Experience of Anorexia Nervosa Patients. W. Vandereycken et al. *Journal of Adolescent Health* 13:403-405, July 1992.

Patients with anorexia nervosa have a distorted image of their bodies. "They feel fat" irrespective of their weight loss. The real nature of this "body image disturbance" is unclear, but an inpatient treatment program at the University of Leuven (Louvain) uses body experience therapy which includes a highly structured behavioral contract regarding weight and eating, intensive and confrontational group therapy, active participation of the patient's family, and an emphasis upon altering the distorted body experience. Techniques which alter the body experience begin by asking the patient to describe herself while looking in a mirror. She is dressed in a bikini and videotaped. Admission tapes are compared with discharge tapes used in therapy sessions. Self awareness is needed to get in touch with one's body image, and to reexperience and rediscover the body as part of one's identity. To help patients become aware of the feeling and impulses arising within themselves, exercises such as breathing, relaxing, massage, sensory awareness, and dance are used. Pleasurable experiences can be derived from playing in the swimming pool, wrestling for fun, and free expression in dance, among others. This is an important aspect of helping people become "at home" in their bodies again and is an important tool in the treatment of anorexia nervosa. *[Those of us who believe and teach not only the theology of the body, but the pedagogy of the body, as we do in Natural Family Planning find this distortion of the normal self perception interesting. Ed]*

Triphasic Combination of Ethinyl Estradiol and Gestodene: Long Term Clinical Trial. F. Weber Diehl et al. *Contraception* 46:19-27, July 1992.

The monophasic combination of Ethinyl Estradiol and Gestodene

has been used in Germany, Sweden, and England for some time. Gestodene is a more stable steroid, does not have the same noxious effects on carbohydrate and lipid metabolism as levonorgestrel. A new triphasic formulation was tried in 1933 women for up to 36 cycles. Two user related pregnancies were encountered. Initially there was spotting and breakthrough bleeding, but this did not persist for more than three months. Other complaints were minor breast tenderness and headaches. Blood pressure and body weight remained essentially unchanged. This drug provided reliable contraception with good tolerance and cycle control for up to three years. *[Because two drug companies are litigating ownership of gestodene, it is not expected that we will see gestodene on the US market any time soon. Ed.]*

Underdiagnosis of Genital Herpes by Current Clinical and Viral Isolation Procedures. L.A. Koutsky et al. *The New England Journal of Medicine* 326:1533-1539, June 4, 1992.

Generally, diagnosis of clinical herpes simplex virus (HSV) infection in women relies on clinical findings and sometimes the use of viral culture. To assess the effectiveness of this approach, the authors performed physical examinations, colposcopy, pap smears, viral cultures, and HSV serologic typing on 779 randomly selected women from an STD clinic. Altogether 48% of women turned out to have positive cultures, yet only 2/3 of these presented clinical signs. Many asymptomatic cases of HSV infection are missed if one relies on symptomatology as an indicator for cultures.

Risk of Leukemia after Chemotherapy and Radiation Treatment for Breast Cancer. R.E. Curtis et al. *The New England Journal of Medicine* 326:1745-1751, June 25, 1992.

There have not been many studies to evaluate the late effects of chemotherapy for breast cancer. Of 82,700 women who had a breast cancer diagnosis between 1973 and 1985, 90 patients later developed leukemia. The risk of acute non lymphocytic leukemia was significantly increased after regional radiotherapy (relative risk 2.4); Alkylating agents only (relative risk 10); and combined radiation and drug therapy (relative risk 17.4). The drug Melthalan was ten times more likely to induce leukemia than cyclophosphamide (RR 13.4 vs. 3.1). Cyclophosphamide is in common use today and is associated with low risk. When systemic drug therapy is combined with radiation therapy which delivers high doses to the marrow, the risk of later development of leukemia appears to be increased.

Use of Injectable Progestin (medroxyprogesterone acetate) in Adolescent Health Care. F. Isart et al. *Contraception* 46:41-48, July 1992.

A questionnaire about the use of medroxyprogesterone acetate (DMPA) use by adolescent health care providers was circulated at the 1991 Meeting of the Society for Adolescent Medicine. Thirty three percent of 160 American and Canadian physicians responded. Two thirds of these had prescribed depoprovera as a form of birth control. Nearly half had prescribed it to more than 10 young women. Female physicians were more likely than males to have prescribed the drug, and pediatricians more likely than gynecologists. The strongest indication was mental retardation. *[The FDA is now considering permitting the drug to be used for birth control in the United States. Note that since the majority of recipients were mentally retarded, prevention of pregnancy was considered of higher priority than protecting them from rape. Ed.]*

Carbohydrate Metabolism Before and After Norplant[R] Removal. J.C. Konje et al. *Contraception* 46:61-69, July 1992.

Norplant users' carbohydrate metabolism was measured with an oral glucose tolerance test before and after removal of the device. While the glucose tolerance curve increased slightly during the use of the device, (35.1 min mmol vs. 26.1 min mmol) this was not statistically different. However, the areas of insulin under the curve, while not great, were significant. The mechanisms which delay return of insulin metabolism to normal after removal of Norplant are still under discussion, but change in liver structure and function and increase in insulin antagonistic hormones, such as growth hormone, cortisol, and glucagon, and increase in peripheral resistance to insulin have been postulated. The authors postulate that slower return of insulin level

after Norplant removal may be due to persistence of the stimulus to the pancreas from previously elevated glucose levels even after the discontinuation of Norplant. While these changes are mild in normal women, offering of the device to women at risk for diabetes mellitus could be problematic. Currently women are not screened for diabetes before insertion.

Evaluation of a 1 Year Levonorgestrel Releasing Contraceptive Implant: Side Effects, Release Rates, and Biodegradability. P.D. Darney et al. *Fertility and Sterility* 58:137-143, July 1992.

A volunteer trial of a 1 year levonorgestrel releasing contraceptive implant was conducted in California. Forty eight women who had borne children and were ovulating were randomly assigned to a 2.5 or 4 cm contraceptive capsule which was worn under the upper arm skin for one year, if not removed earlier for other reasons. The 4 cm implant provided serum levonorgestrel levels from 0.65 ng per mL shortly after insertion to 0.2 ng per mL at 12 months while the 2.5 cm implant's levels were too low for contraception. The 4.0 cm implants suppressed ovulation in approximately 80% of cycles. The capsules remained in tact. Three fourths of the women bled abnormally and showed a slight decrease in LDL lipoproteins.

GNRH Antagonists in Men: Development of a Male Contraceptive. S.N. Pavlou. *Contraception* 46:197, August 1992.

Gonadotropin releasing hormone (GnRH) is necessary to induce the pituitary to produce follicle stimulating (FSH) and luteinizing hormone (LH). Antagonists to GnRH were developed to prevent spermatogenesis. GnRH antagonists compete with the normal binding sites for GnRH and therefore prevent its elaboration. There have been many technical difficulties in arriving at a useful substance, but Nal-Glu is an antagonist which was given in single doses to normal men and found to decrease FSH, LH, and testosterone. When 5 mg Nal-Glu was given daily to normal men for three weeks, FSH, LH, and testosterone progressively decreased and were totally suppressed from day 18 until the end of the study at 26 weeks. Higher doses of Nal-Glu (10 mg) inhibited the brief escape (paradoxical rise seen in the first week of the study). Because testosterone secretion is necessary for the libido, exogenous testosterone by injection was added to the regime. The study shows that prolonged administration of Nal-Glu antagonists can effectively suppress pituitary and gonadal function, and that the addition of testosterone can result in sustained and reversable azoospermia in men without loss of libido. *[It remains to be seen what other untoward metabolic effects will turn up if they are looked for. Ed.]*

Prevalence of Human Papillomavirus Infection in Men: Comparison of the Partners of Infected and Uninfected Women. A. Bergman and R. Nalick. *Journal of Reproductive Medicine* 37:710-712, August 1992.

The "male reservoir" of human papillomavirus (HPV infections) carries the major responsibility for womens' reinfection. Two hundred seven (207) males were examined for HPV associated lesions. Their average age was 27 years; 113 were sexual partners of women with known genital HPV lesions, while 94 were sexual partners of women with no known HPV infections. The men agreed to visual inspection of the genitalia, application of 5% acetic acid in gauze followed by a colposcopic inspection with a green light filter. Any lesions that appeared positive were biopsied under local anesthesia. Seriologic typing was not done. Sixty nine percent in the risk group (those who were sexual partners with infected women) were found to be positive compared to 2% of the low risk group. *[Since serologic typing and in situ hybridization were not performed this study cannot show the true incidence of asymptomatic HPV infection in males. Ed.]*

QUESTIONS?

*Do you need further information regarding research reported in this Supplement? Have you a specific question which you'd like to ask the Editor? Please direct your letter to the Editor, **Current Medical Research,** DDP/NFP, 3211 Fourth St., N.E., Washington, D.C. 20017. We look forward to hearing from you.*

The Prognosis and Management of Cervical Cancer Associated With Pregnancy. M.P. Hopkins and G.W. Morley. *Obstetrics & Gynecology* 80:9-13, July 1992.

The influence of pregnancy on survival of women with invasive cervical cancer was studied in 53 women who had invasive cancer, and who were less than 46 years old. They were compared with a matched group of non pregnant female cancer patients. The mean age was 30. The cumulative 5 year survival was 83%. Survival was not effected by the trimester in which the cancer was diagnosed. Eighteen of twenty one patients who received radical hysterectomy survived: three of four also were treated at term; all five were treated in the second trimester, and ten of twelve treated postpartum. Of the 12 who were treated with radiation therapy, 7 survived: 1 was treated at term, 5 of 6 in the second trimester, and 1 of 5 treated postpartum. When compared with non pregnant patients who were less than 46 years old when invasive squemous cell cancer of the cervix (Stage 1B) was diagnosed, there was no difference in their cure rates or survivals.

When radical hysterectomy is performed in the second trimester, it is performed with the fetus in utero and then followed by lymphnode dissection. If the pregnancy has progressed more than 20 weeks at the time of diagnosis, the patient is advised to wait until she is 35 weeks unless there is rapidly enlarging tumor. Caesarian delivery is then performed, followed by radical hysterectomy. One woman who delivered vaginally developed metastatic disease in the episiotomy site three months after the delivery. In view of this rare but lethal complication, abdominal delivery is advisable.

Insemination Data on Men with Varicoceles. J.L. Marmar et al. *Fertility and Sterility* 57:1084-1090, May 1992.

A group of men with a diagnosis of varicocele who had not achieved pregnancy by natural coitus were examined. Fourteen were untreated, five had received medical treatment, thirty four had varicocelectomies, and eighteen a combination of surgery plus medical treatment. Sperm processing and intrauterine insemination was performed. Six pregnancies occurred with 66 cycles of sperm processing and IUI (intrauterine insemination) among 28 men with normal sperm penetration assays. There were no pregnancies in 121 cycles among 43 varicocele patients with abnormal SPAs. It appears that IUI is of no benefit in achieving pregnancy if the man's sperm are not at normal level of sperm penetration.

Culdoscopic Gamete Tubal Transfer: a New Approach to Gamete Intrafallopian Tubal Transfer. E. Diamond et al. *Fertility & Sterility* 57: 1114-1116.

A variation of achieving successful pregnancy by using the culdoscopic approach to gamete intrafallopian tube transfer is reported. Under epidural anesthesia, ova are obtained from the follicle through a needle introduced through an incision in the vagina. Ova and a semen sample are then transferred into the tube with a Marrs gamete transfer catheter after suitable preparation. Of six clinical pregnancies, five are ongoing while one woman miscarried. Culpotomy is less invasive than the usually performed laparoscopy.

Current Medical Research, a supplement of the **NFP Diocesan Activity Report**, is published quarterly. Hanna Klaus, M.D. is the editor. The purpose of the supplement is to serve the Roman Catholic diocesan NFP programs of the United States through providing them with up-to-date information on research within the field of fertility, family planning, and related issues. The Diocesan NFP teacher should be equipped to understand the various methods of contraception and be able to explain their incompatibility with the practice of the natural methods of family planning.