

The success rate of IVF remains disappointingly low: only about 1000 babies have been born in Britain so far, and of those over 500 started life at the Bourn Hall centre, in Cambridge. Many of the centres have not yet succeeded in getting a pregnancy to term.

In the wake of the Warnock report, which, among other things, recommended that a statutory body should be set up to oversee IVF centres, and public fears that unsupervised scientists might conduct unethical research on spare embryos, the Voluntary Licensing Authority for Human In Vitro Fertilisation and Embryology was set up in March 1985 to fill the void. Its brief was to monitor the activities of the IVF centres until a statutory body was established—something that still appears to be at least a year or 18 months off.

The authority, set up and financed by the Medical Research Council and the Royal College of Obstetricians and Gynaecologists, published its first report last week.¹ On the face of it the findings are reassuring: all 25 of the IVF centres were quick to invite the authority to inspect them, and 24 were subsequently approved. The remaining one is expected to obtain approval shortly. No evidence of unacceptable or unethical practice was found, and proposals for further research work were sound. Of the 10 centres that are undertaking research, most are concentrating on ways to improve the technique of IVF. Only one centre is looking at genetic abnormalities in the pre-embryo (the approved term for the product of the fertilised egg up to day 15 or 16). Another is concerned with research on a new contraceptive pill and a third with studies of male infertility.

The chances of achieving pregnancy, which is not, of course, synonymous with going to term and producing a normal baby, depend on the selection of patients and the technical skill of the unit, but results from 200 IVF centres world wide with a cumulative experience of 11 000 pregnancies yield some hard information. If one pre-embryo is replaced the chances of a pregnancy are about 9.5%; replacing two increases this to 15%, three to 19%, and four or more to 25%. Replacing more than four embryos puts the mother at high risk of multiple pregnancy and there is also an increased risk of miscarriage, so at present it is widely recommended that three to four embryos should be replaced. This gives the best chance of success, and the multiple pregnancy rate, 14-24%, is acceptable.

Precise rates of pregnancy, pregnancies going to term, selection criteria, and so on for each centre are not known, and the voluntary licensing body, members of which were speaking at a recent press conference at the Royal College of Obstetricians and Gynaecologists, said that they were not about to publish a league table ranking the centres in order of success. They did suggest, however, that prospective patients should ask the centre they approach to give them an idea of its success rate so that they did not embark on treatment with a false sense of optimism.

The licensing authority has not yet delved into the delicate business of recommending who should be offered IVF. Should it be only childless couples? What about those with only one child desperate for a second, or a pair of lesbians, or a committed "one parent" mother? It has, however, tackled the more tangible issues: its recommendations include the suggestion that every centre should have a written policy for the disposal of spare embryos (many centres had no disposal policy at all). Couples must give consent whether their spare embryos should be destroyed, stored, or used for research. It also recommends that the centres should use a standard consent form.

Despite its self confessed lack of statutory power, the

voluntary licensing body seems convinced that it has succeeded in its policing role and that no unethical experiments are being carried about behind closed doors. "Our visits are not whitewash expeditions," said the authority's chairman, Dame Mary Donaldson. She did, however, admit that it would be "nice to be made official," although she had no suggestions on how the government could be persuaded to introduce legislation in the near future.

As the demand for IVF continues to grow—and the private sector responds with enthusiasm—is it likely that the National Health Service will be spurred into action to provide a service that is so obviously wanted? Sadly the answer is almost certainly no. No one dies of infertility—except by suicide.

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¹ Voluntary Licensing Authority for Human In Vitro Fertilisation and Embryology. *First report*. London: Medical Research Council/Royal College of Obstetricians and Gynaecologists, 1986.

Pseudo-obstruction

Murphy and others spoke about "spastic ileus" towards the end of the last century and in the first 40 odd years of the present one.¹⁻⁴ Not, however, until 1948 did Ogilvie identify a cause of this functional obstruction, when he described it in patients with malignant retroperitoneal infiltration.⁴ Shortly thereafter, in company with his Edinburgh surgical colleagues, one of us drew attention to a group of patients who may present in medical, surgical, or orthopaedic wards with appearances which resemble acute mechanical obstruction, usually but not always of the large bowel, but in whom a mechanical cause is not found.⁵ We introduced the term "pseudo-obstruction" for the clinical entity which embraces Ogilvie's syndrome, other causes of retroperitoneal effusion (such as that which occurs after a lumbar spine fracture,^{6,7} and the intestinal dysfunction in hypoxia,^{5,7,8} electrolyte imbalance,^{6,9-11} and uraemia.^{7,11}

The term pseudo-obstruction is a misnomer, because the patients are acutely obstructed but they do not need an operation and may do badly after laparotomy for at least two reasons. Firstly, they are often ill from the underlying cause and, secondly, with the abdomen opened the surgeon may make the wrong move and so precipitate disaster.

With the syndrome well delineated it should, perhaps, now be easily recognised and wrong moves should be rare. Unfortunately this is not so. This year we have in our unit taken over the management of two patients operated on elsewhere: both had classical pseudo-obstruction; neither should in retrospect have been treated as if they had mechanical obstruction; one died and the other had a long and difficult convalescence. Sadly the message has yet to strike home.

The context is helpful in making the diagnosis. The patient—often elderly—may be in hospital or in bed at home with some other illness or after an injury such as a fractured hip or pelvis.^{6,7,12} Not infrequently he or she has become dehydrated and mildly uraemic,¹¹ a process favoured by renal or cardiac disease, for which the patient may already be

receiving treatment.^{7 12-14} The abdomen distends gradually and is tympanic; bowel sounds continue to be heard and may become high pitched as the small bowel works normally to expel its contents into an increasingly distended caecum. Bowel actions stop, or only a small amount of liquid faeces is passed. X ray films of the abdomen are called for and show diffuse gaseous distension compatible with a large bowel obstruction though not usually typical of it.^{5 6 10} The worried emergency surgeon called to see such a patient fears that he is missing a mechanical cause and wants to operate just to make sure. At laparotomy he finds a diffusely distended large bowel without a cause.¹⁵ Particularly if the small bowel is also dilated he may be tempted to undertake some form of operative decompression by inserting a sucker, and in consequence the risk of peritoneal contamination is added. Finally, a caecostomy or colostomy may be made in the hope—usually in our view vain—that this will decompress the bowel. The outcome of this inappropriate surgery is at best a difficult convalescence and at worst death from either a surgical complication or intercurrent disease.

All this should no longer happen. Large bowel obstruction is rarely a true surgical emergency. The clinical problem should be considered with great care before a surgeon undertakes a laparotomy. There are exceptions to this rule: these include signs of peritoneal irritation and progressive rapid distension of the colon. Yet in nearly every case there will be time to confirm or reject the diagnosis of mechanical large bowel obstruction by one of two methods—a water soluble contrast enema or colonoscopy. The value of the first has recently been reported from Aberdeen.¹⁶ Ninety one patients with suspected large bowel obstruction underwent a contrast examination. The mechanical nature of the problem was confirmed in 50 of the 79 in whom the clinical diagnosis was thought to indicate such a cause but refuted in the remaining 29—figures which confirm the investigation as worth while in the general context of large bowel obstruction. Eleven of the 29 had other non-obstructing organic causes, but the other 18 were considered, after radiological examination, to have pseudo-obstruction. Of particular interest were the 12 patients initially thought to have the latter condition. The diagnosis was confirmed in 10 but the other two were shown to have carcinoma of the colon. The lesson seems clear: if there is any doubt whatever—and not many clinicians can be free of doubt in the often puzzling circumstances of clinical large bowel obstruction—a contrast enema will save a substantial number of patients from unnecessary and dangerous surgery while disclosing a mechanical cause in a smaller number of unsuspected cases.

Sigmoidoscopy has long been a method of establishing the diagnosis and carrying out treatment for sigmoid volvulus.¹⁷⁻²¹ The advent of colonoscopy has opened the possibility of applying the same principle in the suspected case of pseudo-obstruction. Considerable success has recently been reported.^{6 22-24} This is an obvious alternative tool, and it has the additional advantage that the colon may be decompressed either by the instrument itself or through a long tube hauled up on a thread passed down the operating lumen of the colonoscope before it is inserted.²⁵ Not every patient will respond at once to such management; the underlying cause, if it can be found, must also be treated. In

Britain colonoscopy is currently less likely to be available than contrast radiology, but ever increasing numbers of surgeons are acquiring familiarity with the technique.

The management of confirmed pseudo-obstruction is essentially non-operative.^{6-8 11 12} Correction of fluid and electrolyte abnormalities, restoration of adequate oxygenation, and intravenous nutritional support for patients who are slow to resolve are the main techniques. Nevertheless, surgeons need to remember that the functionally obstructed colon may dilate to the point of caecal rupture.²⁶⁻²⁸ Such a possibility, though rare, should be in the mind of all those who look after patients with the condition. Caecal tenderness should be tested for at frequent intervals; a failure of remission of the distension and a colon that continues to dilate up to and beyond 8-9 cm in the ascending or transverse sections despite treatment are indications for considering laparotomy.^{6 7 11 12} A pinhole perforation may also leak air to give a large pneumoperitoneum as the first and relatively benign sign that something has to be done.¹² Simple caecal exteriorisation is the correct procedure when a gangrenous or ruptured caecum is found.^{8-12 23 27 29} In our opinion tube caecostomy is unsatisfactory and dangerous.

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