

## Ten Things Physicians and Patients Should Question

1

### Don't perform routine diagnostic laparoscopy for the evaluation of unexplained infertility.

In patients undergoing evaluation for infertility, routine diagnostic laparoscopy should not be performed unless there is a suspicion of pelvic pathology based on clinical history, an abnormal pelvic exam or abnormalities identified with less invasive testing. In patients with a normal hysterosalpingogram or the presence of a unilaterally patent tube, diagnostic laparoscopy typically will not change the initial recommendation for treatment.

2

### Don't perform sperm DNA fragmentation analysis in the initial evaluation of the infertile couple.

Studies document that extreme variability exists among these tests, with very little correlation between results and outcomes. They have also been shown not to be cost-effective and often lead to more expensive treatments.

3

### Don't perform a postcoital test (PCT) for the evaluation of infertility.

The PCT suffers from poor reproducibility and its predictive value for pregnancy is no better than chance. Utilizing the PCT leads to more tests and treatments but yields no improvement in cumulative pregnancy rates.

4

### Don't routinely order thrombophilia testing on patients undergoing a routine infertility evaluation.

There is no indication to order these tests, and there is no benefit to be derived in obtaining them in someone that does not have any history of bleeding or abnormal clotting and in the absence of any family history. This testing is not a part of the infertility workup. Furthermore, the testing is costly, and there are risks associated with the proposed treatments, which would also not be indicated in this routine population.

5

### Don't perform immunological testing as part of the routine infertility evaluation.

Diagnostic testing of infertility requires evaluation of factors involving ovulation, fallopian tube patency and spermatogenesis based upon clinical history. Although immunological factors may influence early embryo implantation, routine immunological testing of couples with infertility is expensive and does not predict pregnancy outcome.

6

### Don't obtain a karyotype as part of the initial evaluation for amenorrhea.

Amenorrhea is the absence of menstruation and can be attributed to many causes. A karyotype (chromosomal analysis) is not indicated as an initial test for amenorrhea as it is not a screening test. However, it is indicated to further evaluate the etiology of an elevated follicle-stimulating hormone (FSH) in a woman under 40 years of age or in the presence of physical findings suggestive of disorders of sexual development.

7

### Don't prescribe testosterone or testosterone products to men contemplating/attempting to initiate pregnancy.

Testosterone therapy is widely used as treatment for hypoandrogenemia and associated symptoms such as sexual dysfunction. However, it is well established that exogenous testosterone and other androgens can lead to decreased or absent sperm production, low sperm count, and infertility. Furthermore, this is not always reversible, even after removing the exogenous androgens.

8

## Don't obtain follicle-stimulating hormone (FSH) levels in women in their 40s to identify the menopausal transition as a cause of irregular or abnormal menstrual bleeding.

Menstrual bleeding patterns for women after age 40 are less predictable than in the younger years due to the normal menopausal transition. Menopause is defined as the absence of menstrual periods for one year when no other cause can be identified (it is often accompanied by symptoms such as hot flashes and night sweats). During this time, blood levels of FSH vary both from woman to woman and from day to day in the same woman. An FSH level does not predict when the transition to menopause will occur, diagnose that it has begun or provide reassurance that contraception is no longer necessary. If there are no other causes of irregular or abnormal bleeding, the treatment for these women will not change based on the FSH level.

9

*This recommendation has been withdrawn.*

10

## Don't perform prolactin testing as part of the routine infertility evaluation in women with regular menses.

It has become common practice to obtain prolactin levels in the routine infertility evaluation. However, there is no reason to expect that a woman would exhibit clinically significant, elevated prolactin levels in the presence of normal menstrual cycles and without galactorrhea (milk discharge from breast). Therefore, serum testing of prolactin levels in a normally menstruating woman without galactorrhea provides no benefit and would not impact clinical management.

11

## Don't use tests of ovarian reserve (oocyte quantity measures such as AMH or FSH levels) to judge a woman's reproductive potential (whether someone is likely or unlikely to become pregnant).

Markers of ovarian reserve, such as early follicular phase FSH or antimüllerian hormone (AMH) levels, have been shown to be poor independent predictors of reproductive potential. Therefore, they should not be used as a "fertility test" for women who are not infertile or who have untested fertility.

## How This List Was Created

The Practice Committee of the American Society for Reproductive Medicine (ASRM) reviewed evidence from ASRM's practice documents to identify possible topics along with suggestions for possible topics from the ASRM Board of Directors. By consensus, the Practice Committee narrowed the list to the top Ten most overused tests within specified parameters. Additional input was sought from the ASRM Board of Directors and members and incorporated. The final list was reviewed and approved by the ASRM Board of Directors. The ASRM Board of Directors and Practice Committee are comprised of representatives from every aspect of reproductive medicine through our five affiliated societies including the Society for Assisted Reproductive Technologies, the Society of Reproductive Surgeons, the Society for Reproductive Endocrinology and Infertility, the Society for Male Reproduction and Urology and the Society of Reproductive Biologists & Technologists.

ASRM's disclosure and conflict of interest policy can be found at [www.asrm.org](http://www.asrm.org).

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