

# Techniques used for IUI: is it time for a change?

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Submitted on December 22, 2016; resubmitted on May 11, 2017; accepted on June 4, 2017

**STUDY QUESTION:** Are the guidelines for the technical aspects of IUI (WHO, 2010) still in accordance with the current literature?

**SUMMARY ANSWER:** In general, the laboratory guidelines of the World Health Organization (WHO) are a suitable protocol, although the evidence is not always conclusive and some changes are advisable.

**WHAT IS KNOWN ALREADY:** Lack of standardization of the technical procedures required for IUI might result in inter-laboratory variation in pregnancy rates. Most centers still use their own materials and methods even though some guidelines are available.

**STUDY DESIGN, SIZE, DURATION:** A structural review focusing on the association between pregnancy rates and the procedures of semen collection (e.g. ejaculatory abstinence, collection place), semen processing (e.g. preparation method, temperature during centrifugation/storage), insemination (e.g. timing of IUI, bed rest after IUI) and the equipment used.

**PARTICIPANTS/MATERIALS, SETTING, METHODS:** A literature search was performed in Medline and the Cochrane library. When no adequate studies of the impact of a parameter on pregnancy results were found, its association with sperm parameters was reviewed.

**MAIN RESULTS AND THE ROLE OF CHANCE:** For most variables, the literature review revealed a low level of evidence, a limited number of studies and/or an inadequate outcome measure. Moreover, the comparison of procedures (i.e. semen preparation technique, time interval between semen, collection, processing and IUI) revealed no consensus about their results. It was not possible to develop an evidence-based, optimal IUI treatment protocol.

**LIMITATIONS, REASONS FOR CAUTION:** The included studies exhibited a lack of standardization in inclusion criteria and methods used.

**WIDER IMPLICATIONS OF THE FINDINGS:** This review emphasizes the need for more knowledge about and standardization of assisted reproduction technologies. Our literature search indicates that some of the recommendations in the laboratory guidelines could be adapted to improve standardization, comfort, quality control and to cut costs.

**STUDY FUNDING/COMPETING INTEREST(S):** The Dutch Foundation for Quality Assessment in Medical Laboratories (SKML), Nijmegen, The Netherlands. S.K. and W.N. have no conflicts of interest to disclose. C.B. and A.W. are members of the board of the SKML. With a grant from SKML, L.L. was paid for her time to perform the research and write the publication. D.B. received grants from Merck Serono, Ferring and MSD, outside the submitted work.

**REGISTRATION NUMBER:** N/A.

**Key words:** IUI / technical aspects / semen preparation / pregnancy outcomes / laboratory guideline / review

## Introduction

At the moment, there is an ongoing discussion about the value of IUI. Recent Dutch studies showed a positive performance of the treatment especially in cases of mild andrological and unexplained infertility (Bensdorp et al., 2015; Moolenaar et al., 2015; Tjon-Kon-Fat et al., 2015). On the other hand, the British guideline for infertility treatment strongly reduced the indications for IUI to sexual dysfunction, same sex relationship and special conditions (NICE, 2013). In this guideline, clinics are directed to apply in IVF or ICSI as a first line treatment in the majority of cases. However, the evidence cited to support this guideline was, not robust (Woodward et al., 2016). Not only clinical, but also economical and financial evidence favors IUI over IVF in many cases (Bahadur et al., 2016c). A lot of discussion is ongoing on this subject (Heneghan et al., 2016; Spencer et al., 2016; Bahadur et al., 2017). Probably, for this reason, until now only a small proportion of clinics have made significant changes to their IUI practice (Kim et al., 2015) and IUI is still performed on a large scale worldwide and it remains worthwhile to try to improve the outcome.

The IUI procedure can roughly be separated in three steps: diagnosis and indication, cycle preparation and the technical stage. The third step, including the whole process between semen collection and insemination, is barely included in guidelines. Only the World Health Organization (WHO) laboratory manual (WHO, 2010) attempts to describe the process. This description is incomplete, because parts of the pre- and post-laboratory stages are missing.

This structural review focuses on the technical phase of IUI and we check whether the present guidelines are in concordance with available literature. As the WHO manual (WHO, 2010) is the only international guideline that describes a protocol for semen collection, analysis and preparation, we used this guideline as the main reference point for our study.

## Methods

The available literature on the following procedures or variables of IUI was reviewed: ejaculatory abstinence (EA), semen collection place, time intervals (i.e. between semen collection and semen processing, between semen processing and insemination, and between semen collection and insemination), semen preparation methods, centrifugation medium, centrifugation and storage temperature, timing of IUI, use of different disposables (e.g. catheters) and duration of bed rest after IUI.

A computerized search was carried out in Medline and in the Cochrane library. Key words for the search were 'intrauterine insemination', 'IUI' or 'artificial insemination'. Specific key words used for the individual variables included: 'ejaculatory abstinence', 'ejaculatory frequency', 'time interval', 'collection to processing', 'collection to IUI', 'processing to IUI', 'semen purification', 'semen preparation', 'semen separation', 'density gradient', 'swim up', 'wash', 'buffer', 'zwitterion', 'bicarbonate', 'HEPES', 'MOPS', 'TEST', 'medium', 'temperature', 'centrifugation', 'incubation', 'storage', 'timing', 'insemination timing', 'disposable', 'devices', 'tube', 'glove', 'pipette', 'catheter', 'collection container', 'bed rest', 'supine positioning', 'immobilization' and 'mobilization'. The titles and abstracts were screened to exclude citations considered as irrelevant, thereafter full texts of potentially eligible studies were reviewed. Articles published before 1 November 2016 in peer reviewed journals in the English language were included. The references and related citations of these articles were used to identify extra potential articles of interest. Studies reporting the impact

of used laboratory procedures on sperm parameters or IUI pregnancy rates (PRs) were included.

The recommendations on technical aspects of IUI stated in the WHO guideline (WHO, 2010) were used as reference and compared with the results of the literature search. The results were arranged in an evidence-level structure as described by NICE (2013). Finally, a summary is given of the recommendations, limitations of the available literature and knowledge gaps.

## Ejaculatory abstinence

The WHO recommends an EA period of 2–7 days before semen collection (WHO, 2010), both for diagnostics and semen preparation. Although no explanatory literature is provided, studies on sperm parameters support this recommendation since an EA of 2–7 days resulted in a significantly higher semen volume (Carlsen et al., 2004; De Jonge et al., 2004; Marshburn et al., 2014) and total motile sperm count (TMSC) (Jurema et al., 2005; Levitas et al., 2005; Marshburn et al., 2010). On the contrary, a recent study reported a significant higher sperm motility for ejaculates of infertile men if they were produced within 40 min after an initial sample with <5 million motile spermatozoa (Bahadur et al., 2016b). Moreover, an EA period of 0–2 days also resulted in higher percentages of morphologically normal spermatozoa (Levitas et al., 2005, 2006; Bahadur et al., 2016b).

The explanation of these observations can be found in the effect of reactive oxygen species (ROS). A certain level of ROS is required for the maturation of epididymal spermatozoa (Noblanc et al., 2011). Excessive ROS, however, can induce oxidative damage which negatively affects the fertilization potential of spermatozoa (Marshburn et al., 2014). The exposure time of spermatozoa to ROS is influenced in an EA time-dependent manner, thereby influencing the incidence of sperm DNA fragmentation, especially in infertile men (Sharma and Agarwal, 1996; Alkan et al., 1997). As a consequence, a shorter period of EA will result in higher PRs both in natural and IUI cycles, especially in sub-fertile men (Gosalvez et al., 2011; Sanchez-Martin et al., 2013).

So far, the relationship between duration of EA and IUI PRs has been investigated in only two retrospective studies. These studies showed a negative impact of longer EA periods on PRs in cohorts of 372 (Marshburn et al., 2010) and 417 couples (Jurema et al., 2005). These studies reported highest PRs in the group with an EA up to 2 days and up to 3 days, respectively. In a retrospective pilot study, it was also found that in cases of oligozoospermia, the aggregation of consecutive ejaculates resulted in a higher PR (Bahadur et al., 2016a). So, irrespective of a higher TMSC, the WHO recommendation of 2–7 days is debatable. A possible bias in the plea for a shorter EA is that these couples had intercourse shortly before insemination, thereby increasing the probability of a natural conception. More studies are needed to confirm these findings, both in normozoospermic and oligozoospermic men. For now, it can be advised to change the WHO recommendation into an EA period of maximum 3 days.

## Time intervals

The time intervals between semen collection to processing, processing to insemination and semen collection to insemination have impact on IUI PRs (Table I). However, the WHO provided only a recommendation for the time interval between collection and processing (WHO, 2010). They stated that semen sample collection for IUI should

**Table 1** Summary of findings reported by literature when comparing the impacts of time intervals on the IUI pregnancy rate.

Time interval	Time intervals studied (min)	Study	Included couples (n)	Cause of infertility	Time interval with statistically significant highest pregnancy rates (min)
Semen production → processing	15–30, 31–60, >60	Yavas and Selub (2004)	62 (132 cycles)	Female, male, unexplained and combination	15–30*
	<30, 30–60, >60	Song et al. (2007)	335 (633 cycles)	Female cervical factor, male	No difference
Semen processing → IUI <sup>#</sup>	≤30, 31–60, >60	Yavas and Selub (2004)	62 (132 cycles)	Female, male, unexplained and combination	≤30 and 31–60*
	Not defined	Song et al. (2007)	335 (633 cycles)	Female cervical factor, male	No difference
	<30, 30–59, 60–89, 90–119, 120–180	Kilicdag et al. (2005)	– (1125 cycles)	Mild male, unexplained	≥30
	<40, 40–80, >80	Fauque et al. (2014)	709 (862 cycles)	Female, male, unexplained	40–80
	<60, about 24 h	Jansen et al. (2016)	1135 (2154 cycles)	Female, male, unexplained	No difference
Semen production → IUI	≤90, 91–120, >120	Yavas and Selub (2004)	62 (132 cycles)	Female, male, unexplained and combination	≤90*
	Not defined	Song et al. (2007)	335 (633 cycles)	Female cervical factor, male	No difference

\*Results reported in couples with human menopausal gonadotropin (hMG)-treated women, no differences in couples with clomiphene citrate (CC)-treated women, <sup>#</sup> samples were stored at body temperature.

– = not available in study.

preferably take place in a private room near the clinical laboratory, but when collection at home is preferred the semen should be delivered to the laboratory within 1 h after collection (while protected from extremes of temperature) (WHO, 2010).

When comparing PRs, a higher PR was reported when semen was collected in the clinic (Yavas and Selub, 2004). Another study found no difference in PRs between collection at home and in the clinic (Song et al., 2007). Furthermore, semen collection in the clinic led to a time interval that was on average 26 min shorter than collection at home (Yavas and Selub, 2004). Nevertheless, no impact of time interval duration was found in a large study population ( $n = 633$  cycles) (Song et al., 2007). This was also shown in women treated with clomiphene citrate ( $n = 95$  cycles) in another study (Yavas and Selub, 2004). On the contrary, a shorter time interval (i.e. 15–30 min) resulted in a higher PR in a small group of women treated with human menopausal hormone (hMG;  $n = 37$  cycles) (Yavas and Selub, 2004). Lower PRs caused by longer time intervals, might be explained by decapacitating factors in the seminal plasma (Kanwar et al., 1979; Rogers et al., 1983; Mortimer et al., 1998) or ROS-induced DNA damage (Marshburn et al., 2014; Yavas and Selub, 2004).

Regarding storage time after processing (i.e. time interval between processing and insemination), a shorter time interval was related to a lower proportion of premature sperm chromatin decondensation (Hammadeh et al., 2001a), to less sperm DNA fragmentation (Fauque et al., 2014) and to a higher PR due to the storage time-dependent spontaneous acrosome reaction (Mansour et al., 2008; Fauque et al., 2014). In practice, however, no consensus was shown in reported ideal time intervals. PRs were comparable when IUI was performed within 30 min or after 31–60 min of storage, but decreased after >60 min, only in couples with hMG-treated women (Yavas and Selub, 2004). Others

reported highest clinical PRs in the groups with a storage time of 40–80 min (Fauque et al., 2014) and >30 min (Kilicdag et al., 2005). With another approach, another study (Song et al., 2007), found no differences in storage time intervals between a group of pregnant and non pregnant couples. Moreover, a recent study reported no difference in ongoing PRs between immediate insemination and insemination one day after semen processing (Jansen et al., 2016).

Two retrospective studies evaluated the impact of the total time interval between semen collection and insemination. In one study, higher PRs were found when insemination took place within 90 min after semen collection (i.e. compared to 91–120 min and >120 min) (Yavas and Selub, 2004), the other study found no differences (Song et al., 2007).

In conclusion, literature on this subject is scarce and presented contradictory results. More information can be obtained in RCTs, but also in retrospective, well-designed multicenter studies, where standardized time intervals should be compared. For now, it is not possible to recommend one time interval over the other, nevertheless, the majority of the results propose to avoid long time intervals. Especially the time interval between semen collection and processing should not exceed 60 min, since no pregnancies were reported in this group (Yavas and Selub, 2004; Song et al., 2007).

## Semen preparation methods

After semen production and liquefaction, it is necessary to separate sperm from the seminal plasma, thereby preventing uterine cramps, extended ROS formation and inhibition of fertilization (Kanwar et al., 1979; Agarwal et al., 1992). Many separation techniques have been described. Compared to the initial semen sample, the use of all these techniques resulted in significantly better semen parameters

(Joshi *et al.*, 1998; Chen and Bongso, 1999; Hammadeh *et al.*, 2001b) and higher IUI PRs (Goldenberg *et al.*, 1992).

According to the WHO, the choice of semen preparation technique should be based on the nature of the semen sample (WHO, 2010). It is recommended to use swim-up in cases of normozoospermia, while density gradients should be the method of choice in other cases.

Density gradient centrifugation started with the use of Percoll<sup>®</sup>. In 1996, however, Percoll<sup>®</sup> was withdrawn from the clinical market, since it was stated that the polyvinylpyrrolidone (PVP)-coated silica in Percoll<sup>®</sup> contained endotoxins (Svalander *et al.*, 1995). Since then, several endotoxin-free products with silane-coated silica particles were introduced. In first instance, research concentrated on comparing these new products to Percoll<sup>®</sup> and conflicting results were found with respect to sperm motility and recovery rate (Centola *et al.*, 1998; Claassens *et al.*, 1998; Chen and Bongso, 1999; Sharma *et al.*, 1999; McCann and Chantler, 2000; Ren *et al.*, 2004; Tsai *et al.*, 2004). Despite these disagreements, silane-coated products are now widely used (Henkel and Schill, 2003).

There is consensus that the swim-up technique resulted in lower recovery rates compared to density gradient centrifugation, making it suitable only in cases of normozoospermia (Van Voorhis *et al.*, 2001; Henkel and Schill, 2003). As swim-up selects spermatozoa based on their motility, one would expect that it would result in a high fraction of motile spermatozoa. Some studies, however, reported a comparable or even lower motility if swim-up was compared to gradients (Le Lannou and Blanchard, 1988; Almagor *et al.*, 1993; Dodson *et al.*, 1998). The same is true for the percentage morphologically normal spermatozoa (Le Lannou and Blanchard, 1988; Chan *et al.*, 1991; Chen *et al.*, 1995; Erel *et al.*, 2000).

In practice, the clinical outcome of IUI is of more importance than the value of semen parameters. In 2007, a systematic Cochrane review (Boomsma *et al.*, 2007) included six RCTs in their meta-analysis, comparing the effectiveness of density gradient techniques versus swim-up techniques and versus wash-only. They concluded that there is no evidence to choose for one technique over the other. The included studies, however, were characterized by low numbers of patients, diversity in the cause of infertility and diversity in the techniques that were compared. Only one study (Carrell *et al.*, 1998) included a larger study population ( $n = 363$ ). Still, this study is of limited value, since five different techniques were studied in a population with all causes of infertility. Since Boomsma's review, only one suitable RCT has been performed. A significantly higher PR (both per cycle and per couple) was found using density gradient centrifugation (SpermGrad<sup>®</sup>) compared to the swim-up technique, in couples with unexplained infertility (Karamahmutoglu *et al.*, 2014). An overview of all studies is given in Table II (Zavos and Centola, 1992; Carrell *et al.*, 1998; Dodson *et al.*, 1998; Ragni *et al.*, 1998; Xu *et al.*, 2000; Tsai *et al.*, 2004; Grigoriou *et al.*, 2005; Posada *et al.*, 2005; Soliman and Goyal, 2005; Karamahmutoglu *et al.*, 2014). Additional studies with standardized patient inclusion criteria and study designs are necessary to confirm the results obtained from these studies.

## pH buffer of washing and storage medium

To maintain an optimal pH level, the WHO recommends to select a buffer medium based on the used incubator: a zwitterion-buffered medium (e.g. HEPES, TEST, MOPS) if the incubator contains

atmospheric air and a bicarbonate-based medium if the incubator contains an atmosphere of 5% CO<sub>2</sub> (and if gas exchange is allowed) (WHO, 2010). Meanwhile, most commercially available sperm wash media contain zwitterions for pH buffering, although a certain level of bicarbonate is present as key capacitating agent for spermatozoa (Gadella and van Gestel, 2004). Although these media are effective, there are concerns that zwitterion buffers may interfere with some important processes in different cell types and, consequently, have negative effects on gametes and embryos (Swain, 2010).

As far as we know, only one RCT (Byrd *et al.*, 1991) compared the PRs of sperm prepared with bicarbonate buffer and with HEPES buffer, in IUI with cryopreserved donor sperm ( $n = 324$  cycles). This study reported significantly higher PRs when sperm was prepared using HEPES buffer. It has to be stated, however, that the effect might not be attributed to HEPES alone as two different culture media were used (HTF and HAM's F10). More RCTs are necessary on this subject, with stratification for normozoospermic and oligozoospermic men, and with temperature as important factor as the pH of buffers is temperature-dependent.

## Temperature during centrifugation

It was suggested that the impact of the centrifugation temperature on sperm capacitation might mimic the impact of the storage temperature (Marin-Briggiler *et al.*, 2002), as reported later in this review. In a group of 50 normozoospermic men, however, no significant difference was found in the level of DNA damage between samples centrifuged at controlled (testis or body temperature: 35 or 37°C, respectively) and non-controlled temperature (room temperature: ~25°C) (Repalle *et al.*, 2013). In another small group of normozoospermic men ( $n = 10$ ), the percentage of motile sperm cells was higher after centrifugation at 34°C compared to centrifugation at room temperature (Franken *et al.*, 2011). The samples centrifuged at 34°C were reported with a higher sperm yield, but only when they were also stored at this temperature before semen processing. Both studies provided no explanations for the temperature-dependent influences of semen centrifugation.

Only one RCT ( $n = 671$ ) evaluated the impact of centrifugation temperature on IUI PRs. Included were couples with unexplained infertility and no differences were found in sperm parameters and IUI PRs between controlled and non-controlled centrifugation temperature (Selvaraj *et al.*, 2013). Based on this RCT and since non-controlled centrifugation is commonly used for reasons of ease, we conclude that further evaluation is not needed at this moment.

## Temperature during storage

Usually, the storage of semen samples after preparation takes place at body temperature. Long-term storage ( $\geq 24$  h) of spermatozoa at body or testis temperature, however, resulted in reduced motility and sperm quality (Calamera *et al.*, 2001; Thijssen *et al.*, 2014). In general, reduced motility is observed both at room and body temperature in a time-dependent manner, but to a greater extent and more rapid at 37°C (Matsuura *et al.*, 2010). Moreover, long-term storage at 37°C resulted in an increased incidence of large vacuoles in sperm nuclei (Peer *et al.*, 2007). The positive impact of lower storage temperatures is explained by the switch of spermatozoa to a resting state, where better energy

**Table II** Main results of the randomized controlled trials comparing the IUI pregnancy rates between semen preparation techniques.

Study	Included couples (n)	Cause of infertility	Mean post-wash TMSC (million)	Compared preparation techniques (PR per cycle)	Main results according to pregnancy rates
Grigoriou <i>et al.</i> (2005)*	52	Unexplained	20	-Sperm wash with PAF in medium (23%)	Sperm treated with PAF significant higher clinical pregnancy rate than direct swim-up technique
			20	-Swim-up (8%)	
Posada <i>et al.</i> (2005)*	82 (121 cycles)	Not available	10.9	-Density gradient centrifugation (8%)	Significant increased clinical pregnancy rates in swim-up technique compared with density gradient centrifugation
			16.2	-Swim-up (26%)	
Soliman and Goyal (2005)*	63	Not available	Not available	-Density gradient centrifugation (11%) -Wash-only (14%)	No superior technique
Xu <i>et al.</i> (2000)*	60	Male factor	41.4	-Wang tube sperm separation (45%)	Wang tube sperm separation methods significantly higher pregnancy rate than other two methods in oligoasthenoteratozoospermic men
			24.3	-Swim-up (15%)	
			32.3	-Percoll <sup>R</sup> density gradient centrifugation (20%)	
Carrell <i>et al.</i> (1998)*	363 (898 cycles)	Female, male, unexplained	≥20	-Sperm washing (7%)	Swim-up and Percoll <sup>R</sup> density gradient higher chance (not statistically significant) of pregnancy than other techniques. Swim-down significantly lower pregnancy rate than swim-up and Percoll <sup>R</sup> technique
			≥20	-Swim-up (13%)	
			≥20	-Swim-down (6%)	
			≥20	-Percoll <sup>R</sup> density gradient centrifugation (13%)	
Dodson <i>et al.</i> (1998)*	80 (153 cycles)	Female, male, unexplained	29	-Double centrifugation (15%)	No superior technique
			6	-Multiple-tube swim-up (14%)	
			27	-Percoll <sup>R</sup> density gradient centrifugation (20%)	
Karamahmutoglu <i>et al.</i> (2014)	223 (338 cycles)	Unexplained, mild male	Not available	-SpermGrad <sup>R</sup> density gradient centrifugation (17%) -Swim-up (7%)	Higher pregnancy rates in density gradient centrifugation compared to swim-up in couples with unexplained infertility
Tsai <i>et al.</i> (2004)	121	Female ovulation dysfunction	Not available	-PureSperm <sup>R</sup> density gradient centrifugation (13%) -Percoll <sup>R</sup> density gradient centrifugation (14%)	No significant differences in pregnancy rate
Ragni <i>et al.</i> (1998)	121 (194 cycles)	Male, unexplained	8.5	-Swim-up (14%)	Test yolk buffer significantly increased pregnancy rate compared with standard swim-up
			7.6	-Swim-up with test yolk buffer (26%)	
Zavos and Centola (1992)	148 (307 cycles)	Female, unexplained	29.4	-Double wash (10%)	SpermPrep <sup>R</sup> filtration significantly higher clinical pregnancy rate per cycle than sperm wash
			26.7	-SpermPrep <sup>R</sup> filtration (21%)	

\*Randomized controlled trials (RCTs) reported by Boomsma *et al.* (2007) comparing the effectiveness of gradient technique versus swim-up technique versus wash technique. TMSC = total motile sperm count, PR = pregnancy rate, PAF = platelet-activating factor.

preservation might result in longer survival (Thijssen *et al.*, 2014). This hypothesis is supported by the reported influence of storage temperature on some cellular mechanisms involved in sperm capacitation: a temporary blockage of capacitation-related events was present during storage at 20°C, but not at 37°C (Marin-Briggiler *et al.*, 2002).

Clinical studies about the impact of storage temperature on PRs are missing. Furthermore, the above studies included small groups of men ( $n = 12-41$ ) and did not specify the impact separately for fertile and infertile men. Further research is needed to evaluate the impact of

storage temperature on IUI PRs. As literature is scarce, we can only recommend to avoid long-term storage at body temperature.

## Timing of insemination

The timing of insemination comprises two variables: the detection/induction of ovulation and the time interval from this point to insemination. The WHO guideline provides no recommendations for one timing method over the other. According to the NICE, however, the use

of basal body temperature charts does not reliably predict ovulation (NICE, 2013). In 2014, a review (Cantineau et al., 2014) included 18 RCTs about the effectiveness of different timing methods in natural and stimulated IUI cycles. When comparing hCG administration and LH surge as timing method for IUI, no differences in PRs were found, albeit the quality of evidence was low or very low. Additionally, double inseminations (e.g. at 24 and 48 h after ovulation induction) and the use of different types and dosages of hCG and GnRH-a resulted in no differences in IUI PRs (Polyzos et al., 2010; Cantineau et al., 2014).

Next to ovulation timing method, the timing of insemination can be discussed. The NICE guideline stated that insemination should be performed around ovulation (NICE, 2013). In literature, the comparison of different time intervals between ovulation induction and insemination showed no statistically significant differences in PRs (Huang et al., 2000; Claman et al., 2004; Wang et al., 2006; AboulGheit, 2010; Rahman et al., 2011; Aydin et al., 2013; Weiss et al., 2015). The majority of these studies compared time intervals between 24 and 48 h after ovulation induction. From a biological view, however, the insemination of sperm before ovulation might be favorable, i.e. at the time of ovulation induction (Pacey et al., 1995; Suarez and Pacey, 2006). After intercourse, spermatozoa attach to the isthmus epithelium, where this binding keeps them viable and prevents capacitation (Suarez and Pacey, 2006). Moreover, this interaction results in de novo protein synthesis (Holt and Fazeli, 2010). Once ovulation occurs, a cascade of signals results in a hyperactivated sperm movement towards the oocyte (Aitken and Nixon, 2013). This ovulation-related timing mechanism is important, since an early start of capacitation resulted in apoptosis of the spermatozoa (Aitken, 2011), while a late start of capacitation resulted in spermatozoa that were not equipped to recognize oocytes (Aitken and Nixon, 2013). Although the majority of these processes was found in animal studies with healthy subjects, it would be worthwhile to set up clinical studies to test this theory in humans. Only one study compared PRs between injection simultaneously with administration and 34–36 h after hCG administration, but found no statistically significant differences (Aydin et al., 2013).

Other treatment related factors might affect the correct moment of insemination. For example, embryos might be affected by premature luteinization, due to an early rise in progesterone at the end of the follicular phase in controlled ovarian hyperstimulated IUI cycles. This early rise of progesterone was observed in 22% of the cycles and led to reduced PRs from 23 to 8% (Requena et al., 2015). Also, human papillomavirus positivity was found to have a negative impact on IUI PRs (Depuydt et al., 2016).

Additional (multicenter) RCTs are recommended on all of these aspects.

## IUI devices

The most important devices of influence on IUI results are laboratory and clinical disposables and media, like semen containers, wash media and catheters. Two possible impacts of these products can be distinguished: function and toxicity. With respect to function, the type of catheter and ultrasound guidance can be of influence. A soft tip catheter was found to cause less trauma to the endometrium compared to a hard tip catheter (Lavie et al., 1997), but was not superior in PRs in a Cochrane review (van der Poel et al., 2010). Ultrasound guidance during insemination makes it possible to visualize the movement of the

catheter inside the endometrial cavity and could so avoid endometrial trauma and uterine contractions (Oztekin et al., 2013). This ultrasound guidance did not result in higher PRs in comparative studies (Ramon et al., 2009; Oruc et al., 2014; Polat et al., 2015), it will only result in more complexity and higher costs.

For both laboratory and clinical equipment, cytotoxicity is a problem. Nijs and colleagues (Nijs et al., 2009) state that toxicity can be caused by the composition of materials, the production process, the handling and packaging or the sterilization and transport processes. Using a human sperm survival assay (HSSA), these authors demonstrated that one type of sterile Pasteur pipette was related to a delayed manifestation of toxicity and that the inside lid of one type of sperm container caused an immediate negative impact on sperm motility. Others reported toxicity of certain ART products by use of a mouse embryo assay (MEA). The set up and validation of both assays is however poorly described, both biologically (Ainsworth et al., 2017) and statistically (Punt-van der Zalm et al., 2009). Also, pre-release clinical safety and effectivity tests of devices is missing in many cases and European legislation is unclear on this point (Wetzels et al., 2010). We conclude that additional well-described tests are needed before introduction of IUI and ART devices on the market.

## Bed rest after IUI

The WHO guideline provides no recommendations for bed rest after IUI (WHO, 2010). The rationale for a positive impact of a short period of supine positioning after insemination is that the spermatozoa may reach the fallopian tube within only 10 min (Settlage et al., 1973). Immediate mobilization might counteract this movement due to gravity (Ledger, 2009).

Few RCTs evaluated the impact of 10–15 min of supine positioning on IUI PRs compared to direct mobilization. In two of these RCTs, with inclusion of 391 and 95 couples, supine positioning led to higher PRs (Saleh et al., 2000; Custers et al., 2009). In disagreement with these findings, a recent RCT found no significant positive effect of bed rest after IUI. This study was performed in 479 couples with idiopathic or mild male subfertility (van Rijswijk et al., 2016). Possible explanations for these differences might be found in the indications for IUI and the number of treatments. For this moment, it is not possible to advise one policy over the other.

## Levels of evidence

Table III gives a summary of the impact of different laboratory procedures on IUI success. Also, the corresponding levels of evidence (LOE) according to the NICE guideline (NICE, 2013) are shown. These LOEs are however more or less misleading, especially in the assignment of level Ia and Ib. In these cases, the included RCTs are most of the times characterized by the absence of standardized methods or small sample sizes, resulting in contradictive results. In general, it is remarkable that the procedures for IUI are characterized by a low level of evidence or insufficient literature even though IUI has been performed for decades. Even well-designed retrospective studies are missing, while these could be performed relatively simply and would lead to valuable information for efficiently setting up the more complex RCT's.

**Table III** Main conclusions of the included literature about the impact of different laboratory procedures on IUI pregnancy rates and summary of the recommendations and suggested next steps in research. Presented are the levels of evidence according to the NICE guideline (NICE, 2013) and the number of studies.

Variable	Level of evidence	Number of studies	Main conclusions in literature; reported procedure with highest PRs	Recommendations based on literature and WHO guideline	Next steps in research
Ejaculatory abstinence	3	2	EA up to 2 // 3 days	EA ≤ 3 days	Evaluation in RCTs, with stratification for oligo- and normozoospermic men
Collection place (clinic versus at home)	3#	2	Collection in the clinic // no difference	Either in the clinic or at home	Evaluation in RCTs, with stratification for oligo- and normozoospermic men
Time intervals	3#	4	Avoid short and long TIs // no impact	Sample delivered within 1 h after collection, avoid long TIs between semen collection-insemination and semen processing-insemination	In first instance in multi-center retrospective studies, separately for oligo- and normozoospermic men
Semen preparation technique	1a#	6 † <sup>@</sup>	No superior method	Method selection should be based on semen sample	Identification of methodologies with best IUI results in retrospective studies (e.g. number of layers, volume of medium)
Buffer of wash medium	1b	1	HEPES buffer better than bicarbonate buffer	Selection of the medium buffer should be based on used incubator	Additional evaluation in RCTs, with stratification for oligo- and normozoospermic men
Centrifugation temperature	1b	1	No difference between body // testis and room temperature	Non-controlled centrifugation temperature, for reasons of ease	None
Storage temperature	2*	4	Storage at room temperature better than body temperature*	Avoid body temperature, especially during long-term storage	Evaluation of impact on PRs in RCTs, with stratification for oligo- and normozoospermic men
Method of timing IUI	1a	18 †	No superior method	No recommendable method	Evaluation in RCTs with standardized methods
Time between ovulation and insemination	1b	7	No superior time interval	Insemination 24–48 h after ovulation induction	Evaluation in RCTs with standardized methods, including insemination <24 h after ovulation induction. With stratification for oligo- and normozoospermic men
IUI devices	–	–	Some devices were reported as cytotoxic	Avoid the use of IUI devices that cause reprotoxicity	Development of well-described tests to identify safe and effective devices
Bed rest after IUI	1b	3	Bed rest of 10 // 15 min // no difference between bed rest and immediate mobilization	Either bed rest of 10–15 min or direct mobilization	Additional evaluation in RCTs, with stratification for oligo- and normozoospermic men

\*Based on the impact on sperm parameters instead of pregnancy outcomes.

†Number of studies included in systematic review; # studies show contradictory results; @ number of studies in the meta analysis; // results of different studies.

EA = ejaculatory abstinence, TI = time interval, PR = pregnancy rate, RCT = randomized controlled trial.

## Discussion

The general conclusion of this review is that evidence is poor on most technical aspects of the IUI procedure. Different studies show contradictory results, mainly due to a low degree of standardization, low statistical power and inaccuracy in handling confounding factors. Nevertheless, some advice can be given to change the current guidelines.

We state that an EA period of up to 3 days is preferable to the 2–7 days described in the WHO manual. Furthermore, we advised avoiding long time intervals between semen production and processing. It is easier to perform centrifugation and storage at room temperature and this yields good results. Finally, zwitterion-buffered media might be

preferred over bicarbonate-buffered media and IUI devices should be validated using HSSA.

Although only a part of these recommendations are really evidence-based, we think that they could be introduced for reasons of standardization, comfort (ease), quality control and costs. This does not mean that further research on these items is expendable. As literature is scarce, every new study can influence the recommendations. This was also the case for two items in this review: the time between sperm preparation and insemination and bed rest after insemination. In these cases, a recent retrospective study and RCT, respectively, reported different study results than the former literature, which resulted in a last-minute change of the recommendations.

Although RCTs can be preferred, multicenter retrospective studies could be informative as well in some cases, because these studies can give us the possibility to include the many variables that are present in the IUI process over the different clinics. In these studies, it is important that the participating clinics share the same definitions on their data, e.g. for cycle number, pregnancy outcome and underlying diagnosis. Furthermore, a good registration of all technical variables is important. Next to clinical studies, for some variables, it could also be useful to perform biological experiments as alternative, like zona binding assays or measurement of DNA damage after different time intervals of incubation of prepared semen.

Based on the results of this review and in agreement with other IUI-related reviews (Keel et al., 2002; Boomsma et al., 2007), we emphasize the importance of standardization in IUI (study) protocols and guidelines. Here we meet another problem, since the readiness of clinics to follow existing guidelines is low (Riddell et al., 2005; Haagen et al., 2010), even when two different implementation strategies were used (Mourad et al., 2011). An overview of guideline adherence of the laboratory stage of IUI is missing. We assume that this will be low also, because (older) studies ascribe limited willingness to follow guideline recommendations for processes related to IUI, like semen analysis (Helmerhorst et al., 1995; Ombelet et al., 1997; Souter et al., 1997; Keel et al., 2002; Riddell et al., 2005) and to the vagueness and incompleteness of the recommendations, since supporting evidence is missing (Helmerhorst et al., 1995; Penn et al., 2011). We agree with earlier statements (Haagen et al., 2013) that efforts should be made to improve guideline development and implementation by means of clinical results and economic consequences of IUI care.

This review indicates that further research on many IUI-related factors is necessary. We suggest to start with evaluating the current adherence to laboratory guidelines, e.g. by sending a questionnaire to fertility laboratories. This is also relevant with respect to semen analysis, as highlighted before (Bahadur et al., 2016c); only a fraction of the laboratories is ISO 15189 accredited to the WHO standards for semen analysis (WHO, 2010). This may lead to wrong classification of semen samples and therefore disproportionate use of IVF and ICSI treatments.

Next, further research to update the current recommendations should include RCTs focusing on the impact on IUI success of wash medium buffers, storage temperature, timing of insemination (<24 h after ovulation induction) and bed rest. A first multicenter RCT could focus on two aspects of the sperm preparation method: gradient centrifugation compared to swim-up and bicarbonate compared to HEPES buffer. This study can be performed with enough power within a limited period of time. Whether aspects like EA and collection place should be studied in RCTs is point of discussion. In these cases, multicenter retrospective studies including patient and treatment characteristics (e.g. female age, cycle number, ovarian stimulation protocol) can be helpful instead.

With the results of these studies, guidelines can be updated and implementation strategies (e.g. educational materials or standardized training visits) can be drawn up. Subsequently, the effectiveness of the implementation strategy can be evaluated, both in pregnancy results and in costs.

## Authors' roles

L.L., S.K., C.B. and A.W. searched the databases and wrote the first and final draft of this review. W.N. and D.B. contributed to the review

by helping with the interpretation of the data, revising the article critically and writing the final draft.

## Funding

Dutch Foundation for Quality Assessment in Medical Laboratories (SKML), Nijmegen, The Netherlands, a non-profit organization for external quality control for medical laboratories. Next to the authors, this foundation had no influences on the content of this study.

## Conflict of interest

S.K. and W.N. have nothing to disclose. C.B. and A.W. are member of the board of the SKML. With a grant from SKML, L.L. was paid for her time to perform the research and write the publication. D.B. received grants from Merck Serono, Ferring and MSD, outside the submitted work.

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