Time to pregnancy and sex of offspring: cohort study
Luc J M Smits, Rob A de Bie, Gerard G Essed and Piet A van den Brandt

BMJ 2005;331:1437-1438
doi:10.1136/bmj.331.7530.1437

Updated information and services can be found at:
http://bmj.com/cgi/content/full/331/7530/1437

These include:

References
1 online articles that cite this article can be accessed at:
http://bmj.com/cgi/content/full/331/7530/1437#otherarticles

Rapid responses
7 rapid responses have been posted to this article, which you can access for free at:
http://bmj.com/cgi/content/full/331/7530/1437#responses

You can respond to this article at:
http://bmj.com/cgi/eletter-submit/331/7530/1437

Email alerting service
Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Topic collections
Articles on similar topics can be found in the following collections
Pregnancy (884 articles)

Notes

To order reprints of this article go to:
http://www.bmjjournals.com/cgi/reprintform

To subscribe to BMJ go to:
http://bmj.bmjjournals.com/subscriptions/subscribe.shtml
Time to pregnancy and sex of offspring: cohort study
Luc J M Smits, Rob A de Bie, Gerard G Essed, Piet A van den Brandt

The proportions of X and Y chromosome bearing sperms in human semen are equal, but more boys than girls are born. Male embryos and fetuses have a greater risk of attrition in utero than their female counterparts, and therefore male excess is likely to be still larger at the time of conception. It remains unexplained, however, what is responsible, presumably at some point between insemination and conception, for the greater probability of Y bearing sperms fusing with the ovum. One hypothesis relates to experiments showing that Y bearing sperms swim faster than X bearing sperms in viscous fluids. For natural conception, human sperms have to penetrate cervical mucus, the viscosity of which varies among and within women. Since mucus viscosity also influences the probability of conception, we expected that natural conceptions that take longer to achieve are more likely to be male than quick conceptions. We tested our prediction by assessing the relation between time to pregnancy and sex of the offspring.

Participants, methods, and results
We analysed data of 5283 Dutch women who gave birth to singletons between July 2001 and July 2003. All of the women, at about 14 weeks of pregnancy, were recruited by midwives and gynaecologists (response rate 5283/7200, 73.4%). Mean age of the women at the time of conception was 30.5 years; 83% of their pregnancies were planned, and 47% were delivering their first baby.

Among the 498 (9.4%) women with times to pregnancy longer than 12 months, the probability of male offspring was 57.6% (297), whereas the proportion of male births among the 4785 women with shorter times to pregnancy was 51.1% (2445; $\chi^2 = 7.81, P = 0.0052$). The proportion of male offspring after different times to pregnancy in the 4982 couples with natural conceptions is shown in the figure.

We modelled the relation between sex ratio (probability of male offspring divided by probability of female offspring) and time to pregnancy with logistic regression:

$\ln(\text{sex ratio}) = (0.0131 \times \text{time to pregnancy}) + 0.0116$

($P = 0.0020$)

Using this function we computed that each additional year of trying to get pregnant is associated with a nearly 4% higher expected probability of delivering a male baby (see the line on the figure).

The association was robust to adjustment for maternal age, parity, body mass index, smoking status, alcohol use, season of conception, whether the pregnancy was planned or not, and variability of the menstrual cycle. Sex of the offspring of couples who had received medical help in getting pregnant (302) did not show any relation with time to pregnancy ($\beta = 0.0030, P = 0.59$).

Comment
The time taken to get pregnant is positively related to the chance of having a boy in couples conceiving naturally. The findings are consistent with the hypothesis that more viscous cervical mucus reduces the chance of conception and increases the chance of male offspring. Other explanations should nevertheless be considered. Firstly, while poor mucus quality may in itself be a cause of decreased fertility, it is often accompanied by hormonal problems and poor follicular development, conditions that may also give rise to lower birth rates by increasing the probability of early spontaneous abortion. Secondly, after multiple unsuccessful attempts at getting pregnant, couples may increase their coital rate and optimise the timing of their coital acts. Higher coital rates might increase the odds of male offspring; better timing, however, seems to have the opposite effect.

What is already known on this topic
The proportions of X and Y chromosome bearing sperms in human semen are equal, and male embryos and fetuses have a higher risk of dying in utero than their female counterparts. Nevertheless, throughout the world, more boys than girls are born.

Y bearing sperm may be able to swim faster than X bearing sperms through relatively viscous cervical mucus.

What this study adds
Taking longer to reach lasting pregnancy increases the chances of having male offspring, consistent with the hypothesis that poorly penetrable cervical mucus causes lower fecundity and higher likelihood of male offspring.
Family history of breast cancer and cost of life assurance: a test case comparison of current UK industry practice

A Hunter, S E Humphries

Under the currently extended moratorium, applicants for life assurance need not disclose the results of predictive genetic tests. The exception is for policies exceeding certain values, when insurers may seek results of tests approved by the government’s Genetics and Insurance Committee. The committee expects to receive applications for the use of adverse results from tests for the BRCA1 and BRCA2 genes. Currently, insurers may, and often do, seek family histories. Substantial epidemiological data describe the relative risks of developing breast cancer depending on family history and age. Preventive action for women at risk can include early enrolment on surveillance programmes and prophylactic surgery. Evidence is emerging for the benefits of the former, and evidence is strong for risk reduction by the latter.

Participants, methods, and results

We surveyed 21 companies representing 100% of the reinsurance market and 68% of the life and pensions market in the United Kingdom. We asked the companies to assess a fictional proposal for a 20 year policy (paying benefit only on death) by applying an excess mortality rating, defined as the percentage increase over the assumed rate of mortality. The applicant (scenario 1) was a 35 year old woman with unremarkable personal and family histories, except for breast cancer in the mother diagnosed at age 35. In line with standard insurance application forms, only first degree family history was given. In scenario 2, the same applicant had enrolled on a mammographic surveillance programme with no adverse results reported. In scenario 3, the same applicant had undergone prophylactic double mastectomy and oophorectomy (figure).

Sixteen companies responded. The responding and non-responding groups included a similar variety of company profiles (for example, global operations and size). Nine would not increase premiums under any of the scenarios. Six would increase premiums under scenario 1 (rating +50% or +75%), and of these, four would not load under scenario 3, and two would not load under either scenario 2 or 3. One small UK company would not raise premiums under scenario 1 or 2, but would apply an unspecified increase under scenario 3.

Comment

Most life insurance companies that responded to the survey would offer a standard premium in scenario 1 (unremarkable except breast cancer in the mother diagnosed at age 35). The lifetime relative risk of developing breast cancer for the applicant in scenario 1 is 5.7 (2.7 to 11.8). Using life tables developed at the Cambridge Genetics Knowledge Park (A Butterworth, personal communication, 2005) this translates into a 20 year breast cancer mortality risk (from age 35) of 1.95%, compared with 0.6% for the general population—that is, three times higher.

It is reassuring that not only did all companies that responded to the survey offer a standard premium in scenario 1 (unremarkable except breast cancer in the mother diagnosed at age 35), but also that they did not load the rating under scenario 2 or 3. Sixteen companies responded, and nine of these would not increase premiums under any of the scenarios. Six companies would increase premiums under scenario 1, but four of these would not load under scenario 3, and two would not load under either scenario 2 or 3.