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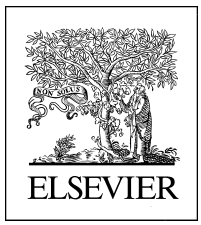

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M006
COMPARING MILD/MINIMAL STIMULATION PROTOCOL WITH GNRH ANTAGONIST TO STIMULATION WITH GNRH AGONIST LONG PROTOCOL FOR IVF IN PATIENTS AT HIGH RISK OF OVARIAN HYPERSTIMULATION SYNDROME

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Objectives: We undertook a prospective randomized study in a group of 433 patients at high risk of Ovarian Hyperstimulation Syndrome (OHSS) to compare minimal/mild controlled ovarian stimulation (COH) using GnRH antagonist (GnRHant) to COH who induce midluteal down regulation with GnRH agonist (GnRHa) followed by rFSH. and to determine which protocol reduce the risk of OHSS and optimize the procedure.
Materials: All patients had previously undergone a COH for IVF with 'long protocol': the ART cycle had been cancelled either for high risk of OHSS (>20 follicles seen at ultrasound and/or >3000 pg/mL of E2 on the day of HCG) or completed and followed by a clinical moderate/severe OHSS without pregnancy.
Methods: The patients were divided randomly into two groups: Group 1 (231 cycles) had minimal/mild COH with either clomiphene citrate+rFSH+GnRHant or rFSH+GnRHant; Group 2 (202 cycles) had COH with a "cautious" long protocol: pituitary down regulation was followed by the lowest possible dose of FSH as a starting point, on the basis of the experience from the previous stimulation. In both Groups ovulation was induced by 10.000 IU of HCG and the luteal phase was supplemented with progesterone 50 mg im daily In all patients the length of stimulation, the amount of gonadotrophins, E2 on the day of HCG, the number of eggs collected, the number of MII oocyte, the number of embryos obtained, the number of embryos transferred and pregnancy rate (PR) were evaluated.
Patients with E2 levels higher than 3000 pg/mL and a number of oocytes collected higher than 20 oocytes were considered at risk for OHSS. Incidence and severity of clinical OHSS were also evaluated.
Results: The total dosage of rFSH used was significantly less and the terminal E2 was significantly higher in Group1 than in Group2, whereas no statistical differences were noted in the length of stimulation. The number of eggs retrieved, the number of MII oocytes, the number of embryos obtained and the number of embryos transferred were significantly higher in Group1. PR was statistically significantly higher in Group1 than Group2. The rate of patients considered at risk of OHSS, incidence and severity of clinical OHSS did not differ among the two groups.
Conclusions: Our data show that in patients at high risk of OHSS a minimal/mild COH using GnRH antagonist provides a statistically significant higher PR without increasing the risk of OHSS when compared to standard long GnRH agonist protocol.

	Group 1 GnRH antagonist (n = 231)	Group 2 GnRh agonist (n = 202)	p
Total rFSH (UI)	1834±792	2318±1091	<0.05
E2 on HCG day (pg/mL)	1807±701	1677±749	<0.05
Length of stimulation (days)	13.7±2.2	14±3.2	n.s.
Oocytes retrieved	7.5±3.7	6.8±3.4	<0.05
MII oocytes	6.4±3.2	5.5±3.1	<0.05
Embryos	3.4±2.3	2.8±2.1	<0.05
Embryos transferred	2.2±0.8	1.9±1.0	<0.05
Pregnancy rate	32%	22.7%	<0.05

M007
LUTEAL PHASE SUPPORT IN FRESH IVF/ICSI CYCLES

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Objectives: The study was designed to compare the different duration for luteal phase support in patients undergoing fresh IVF cycles.
Materials: Propective Randomized Controlled study carried out from December 2007 till August 2009 at the international islamic center ART unit, Al Azhar university. It included 600 patients canditate for ICSI.
Methods: patients were randomized into 3 groups on the day of embryo transfer (ET) using dark sealed envelops. The patients were randomized into 3 groups: group1 (49 patients): recieved luteal phase support (LPS) in the form of progesterone oil IM injection once daily starting from the day of ET till day of positive BHCG result then stopped the day of pregnancy test. group 2 (50 patients): recieved luteal phase support (LPS) in the form of progesterone oil IM injection once daily starting from the day of ET till day of positive BHCG result, then recieved rectal progesterone 400 mg twice daily for 2 more weeks. group 3 (48 patients); as group 2 but rectal progesterone was continued till 12 wks of gestation.
Results: Mean clinical pregnancy rate was 24.5% in group1, 25% in group 2 and 24% in group 3 with no statistical difference between the three groups. First trimesteric miscarriage was 26.5% in group1, 26% in group2 and 25% in group 3 with statistical difference between the three groups.
Conclusions: we may conclude from this RCT that there is no advantage to continue LPS beyond the day of positive pregnancy test.

M008
HORMONAL MILIEU OF THE RESISTANT SIMPLE OVARIAN CYST

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Objectives: to compare levels of steroids and antimullerian hormone in follicular fluid and serum level of antimullerian in patients presented with persistent simple follicular cyst.
Materials: Prospective study done at the El-Minia infertility research and treatment unit (MIRU) Minia University Egypt.
Methods: 50 Patients included. Group I, included 40 patients with resistant simple cysts infertile and group II included 10 patients planned to be subjected to ICSI. Transvaginal cyst aspiration and ovum pick up (OPU), cyst fluid and follicular fluid (FF) were processed for hormonal measurement. Concentrations of serum FSH, serum AMH, cyst fluid or FF AMH; testosterones; estradiol were measured on the day of aspiration or day of oocyte pickup (OPU).
Results: The study demonstrated that concentrations of serum AMH were 14.6±3.3 ng/ml and 5.9±2.02 ng/ml in group1 and group II respectively. AMH aspirated from FF was 440.7±182.9 ng/ml in group 1 and 29.5±25.7 ng/ml in group II. This was of high statistical significant difference.
Conclusions: High serum levels of AMH in cases with ovarian cyst may be used to distinguish cases that will respond to hormonal treatment or cases that hormonal treatment will fail to achieve complete remission of that pathology.