displays the genetic lesion that characterizes fragile X-affected patients, having a full mutation (at least 285 CGG repeats). When injected into immunocompromised mice, various types of differentiated cells were found in the teratomas.

CONCLUSION: The successful derivation of HEF1X cell line opens a new avenue for the scientific study of the molecular basis of fragile X syndrome. This work represents the feasibility and importance of deriving human ES cell lines from genetically abnormal pre-embryos, especially in cases where no suitable cellular and/or animal models are available.

Supported by: None.

Wednesday, October 19, 2005
3:45 p.m.

O-259

G. Adamson, P. Lancaster, J. De Mouzon, K. Nygren, E. Sullivan, F. Zegers-Hochschild. Fertility Physicians of Northern California, Palo Alto, CA; School of Women’s and Children’s Health, University of New South Wales, Sydney, Australia; INSERM U569, Hopital de Bicetre, Le Kremlin Bicetre Cedex, Paris, France; IVF Unit, Sophiahemmet Hospital, Stockholm, Sweden; Unit of Reproductive Medicine, Clinicas las Condes, Santiago, Chile.

OBJECTIVE: To present the results of IVF from different countries and regions of the world for the year 2000.

DESIGN: Retrospective survey of regional, national and individual clinic registries of IVF cycles.

MATERIALS AND METHODS: Data forms were re-designed by the International Committee for Monitoring Assisted Reproductive Technology (ICMART) based on experience with previous surveys. Multiple communications were utilized to identify regional registers, national organizations and individuals who could provide data. Data forms with instructions were sent in English to those who responded. Returned surveys were collated, organized and analyzed using sums, percentages, means and regression analysis.

RESULTS: 1,429 clinics in 49 countries reported, representing approximately 2/3 of the 2,200 IVF clinics in the world, an increase of 20% since 1998. The mean center’s activity varied greatly, with many small centers with less than 100 cycles in Latin America (4%) and North America (35%) compared to Europe (15%), whereas centers with more than 500 cycles for those regions respectively were 7%, 12% and 37%. The clinics reported compared to Europe (15%), whereas centers with more than 500 cycles for individual patients. Pregnancy rates and delivery rates were calculated per organized and analyzed using sums, percentages, means and regression analysis.

RESULTS: There were no statistical differences, respectively, groups A and B, in terms of mean maternal age (29.9 ± 3.7 vs 31.0 ± 3.1; P = 0.132); BMI (23.7 ± 3.9 vs 22.2 ± 3.1; P = 0.073) and AhCG to OPU (35.0 ± 2.8 vs 35.7 ± 0.6; P = 0.125). Lower units of r-FSH were needed in group-A (1.659 ± 2.61) than in group-B (2.331 ± 518; P = 0.001) even though similar MII rate in both groups (79.4% ± 76.5%; respectively, Groups A and B, P = 0.221). No discrepancies were observed in terms of success rates. MII rates in both groups were 79.4% and 76.5%, respectively, in group-A and B (200 and 201, respectively).

OBJECTIVE: The addition of urinary hCG microdose in late follicular maturation phase seems to be enough to maintain steroidogenesis and promote final oocyte maturation. In this study we have interested in comparison of metaphase-II retrieved/oocyte (MII/rate) and clinical data in protocols with or without administration of recombinant (r-hCG) microdose.

Supported by: None.

Wednesday, October 19, 2005
4:00 p.m.

O-260

Better Outcomes Using Microdose of Recombinant Human Chorionic Gonadotropin (r-hCG Microdose) to Support Ovarian Folliculogenesis in Good Prognosis Patients.

OBJECTIVE: The addition of urinary hCG microdose in late follicular maturation phase seems to be enough to maintain steroidogenesis and promote final oocyte maturation. In this study we have interested in comparison of metaphase-II retrieved/oocyte (MII/rate) and clinical data in protocols with or without administration of recombinant (r-hCG) microdose. We also have evaluated MII/rate obtained according to patient body mass index (BMI); time interval between hCG trigger and oocyte collection (AhCG to OPU) and diameter of dominant follicle (DF) at the oocyte pick-up (OPU) moment.

MATERIALS AND METHODS: Seventy-four patients underwent 78 ICSI-cycles were included. As inclusion criteria we have considered women with age ≤ 35 years-old, BMI ≤ 29 kg/m², basal-FSH < 10 mIU/ml with regular menstrual cycles. Patients’ synchronization was done by using oral-contraceptive-pill. Pituitary blockage was achieved with analogue of GnRH (agonist and antagonist). Patients have received 225 IU of Gonad-F (r-FSH) started on day-3 of menstrual cycle. When the leading follicle reached 14 mm, patients were randomized using a 1:1 scheme to receive or not 7.7 μg of r-hCG diluted in 0.1 ml of a solution containing 250 μg of r-hCG, equivalent to 200 IU of LH activity per day (r-hCG microdose).

Forty-one patients in whom r-hCG microdose was administered (43 cycles) were included in Group-A. On days 9/10, r-hCG microdose associated with 75 IU of r-FSH was administered. From day-11 r-hCG microdose was used alone until the r-hCG trigger (Ovidrel-SC-250 μg). Thirty-three patients (35 cycles) who have not received r-hCG microdose were included in Group-B. OPU was performed approximately 36h after r-hCG trigger in both groups. The embryos produced after ICSI were transferred on day+3. Data were collected from individual country summaries and not by individual patients. Pregnancy rates and delivery rates were calculated per aspiration.

RESULTS: There were no statistical differences, respectively, groups A and B, in terms of mean maternal age (29.9 ± 3.7 vs 31.0 ± 3.1; P = 0.132); BMI (23.7 ± 3.9 vs 22.2 ± 3.1; P = 0.073) and AhCG to OPU (35.0 ± 2.8 vs 35.7 ± 0.6; P = 0.125). Lower units of r-FSH were needed in group-A (1.659 ± 2.61) than in group-B (2.331 ± 518; P = 0.001) even though similar MII rate in both groups (79.4% ± 76.5%; respectively, Groups A and B, P = 0.221). No discrepancies were observed in terms of success rates. MII rates in both groups were 79.4% and 76.5%, respectively, in group-A and B (200 and 201, respectively).

RESULTS: There were no statistical differences, respectively, groups A and B, in terms of mean maternal age (29.9 ± 3.7 vs 31.0 ± 3.1; P = 0.132); BMI (23.7 ± 3.9 vs 22.2 ± 3.1; P = 0.073) and AhCG to OPU (35.0 ± 2.8 vs 35.7 ± 0.6; P = 0.125). Lower units of r-FSH were needed in group-A (1.659 ± 2.61) than in group-B (2.331 ± 518; P = 0.001) even though similar MII rate in both groups (79.4% ± 76.5%; respectively, Groups A and B, P = 0.221). No discrepancies were observed in terms of success rates. MII rates in both groups were 79.4% and 76.5%, respectively, in group-A and B (200 and 201, respectively).

No discrepant results were noted in terms of MII/rate when AhCG to OPU was 36 h or > 36 h with or without r-hCG. However, in group A, MII/rate was significant lower when DF ≥ 20 mm (65.9%) compared with DF between 18 - 20 mm (72.8%; P = 0.001).

CONCLUSION: Higher implantation and pregnancy rates were gotten using fewer dose of r-FSH added by microdoses of rhCG as a source of LH. Both BMI and AhCG to OPU seems not impair the MI/rate. However, when these protocols using r-hCG are employed, the OPU should not occur when follicles were higher than 20 mm.

Supported by: None.