CONCLUSION: Although there are many similarities between Ob/Gyn NPs and MDs, NPs, on average, spent more time with patients, were more likely to discuss time to get pregnant and contraception/family planning with patients, more commonly reported lack of patient interest as a limitation for discussing fertility-related issues, and less commonly reported short visit time as a limitation for discussing fertility-related issues.

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A SURVEY OF THE EXPERIENCES AND ATTITUDES OF HEALTHY FERTILE DONORS OF OOCYTES USED FOR IN VITRO FERTILIZATION (IVF) TREATMENTS OF INFERTILE PATIENTS. M. J. Levy, D. L. Dagerman, K. S. Richter, M. Purcell, K. Bugge. Shady Grove Fertility Reproductive Science Center, Rockville, MD.

OBJECTIVE: To evaluate the experiences and attitudes of oocyte donors following their donation procedures.

DESIGN: Anonymous post-donation survey.

MATERIALS AND METHODS: 1045 women who had donated oocytes for use by a large infertility practice from 2000-2012 were sent an email invitation to respond to an anonymous web-based survey in 2012.

RESULTS: 235 oocyte donors completed the survey. Mean age at the time of first donation was 26.3 years, and the mean duration since their last donation was 2.8 years. Most (86%) indicated that financial compensation played at least a minor role in their decision to donate oocytes, but a clear majority (73%) indicated that the desire to help an infertile couple was a more important motivator than money while only 11% indicated that financial compensation was their primary motivation. Very few reported having any negative impacts on their social, romantic, or familial relationships during (9%) or after (2%) the donation process. Most (75%) indicated that they think about the outcome of their donation infrequently or not at all, and while a majority (63%) wished they could have known about the outcome of their donation, nearly all (95%) understood why they were not permitted to know the outcome. Most (85%) reported having no regrets about being oocyte donors, and most others reported only slight regrets. Majorities indicated that they would be very likely to recommend oocyte donation to a friend or family member (55%), or to donate again themselves if they were able (58%). Most (85%) reported that their donation experience was positive or very positive, while only 4% considered it a negative or very negative experience.

CONCLUSION: The results of this anonymous survey demonstrate that the primary motivation for most donors is the opportunity to help others rather than financial gain, and that the great majority of oocyte donors view their past donation as a positive experience that they would recommend to others.

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POTENTIAL REASONS FOR PATIENTS NOT PURSUING FERTILITY PRESERVATION AFTER REFERRAL FOR CONSULTATION AND COUNSELING. L. Pepin, J. Nulsen, C. Benadiva, M. Rescildo, L. Engmann. Center for Advanced Reproductive Services, Division of Reproductive Endocrinology and Infertility, Department of Obstetrics and Gynecology, Farmington, CT.

OBJECTIVE: It is recommended that fertility preservation should be addressed with every cancer patient of childbearing age and appropriate referral made to the fertility specialists. Most patients choose not to pursue any fertility preservation options even after extensive consultation and counseling with an REI. Our aim was to determine whether there were any obstacles or reasons for not pursuing fertility preservation before cancer therapy.

DESIGN: Prospective cohort survey.

MATERIALS AND METHODS: We mailed surveys to patients who were referred to our oncofertility program from 2009 to 2011 but did not pursue any form of fertility preservation. The survey was to determine the potential reasons for not proceeding with any of the fertility preservation options. The reasons offered in the survey included lack of time for treatment due to need to start treatment immediately, spouse or family members were opposed, oncologist was opposed, ethical/religious reasons regarding freezing embryos and financial reasons.

RESULTS: A total of 71 calls were received at the oncofertility hotline and 39 women (54.9%) were seen for consultation. Of the patients who were seen for consultation 11 patients (28.2%) opted for oocyte freezing and 10 patients (25.6%) opted for embryo freezing. Five patients (12.8%) opted for other treatments such as GnRHa treatment. Twenty-three women (58.9%) did not undergo any form of fertility preservation. We therefore sent the surveys to the 23 patients who did not proceed with any treatment. Preliminary results from some of the completed surveys show that financial reason is the major factor why most patients do not pursue treatment. However, a full analysis of all the completed returns will be presented at the meeting.

CONCLUSION: Financial reasons may be the driving force behind patient's decisions not to pursue treatment. Better awareness of insurance companies regarding fertility preservation may increase insurance coverage for patients and allow more patients to pursue fertility preservation.

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IS PARTNER CONSENT FOR A WOMAN'S PARTICIPATION IN FERTILITY CLINICAL TRIALS JUSTIFIED? THE REPRODUCTIVE MEDICINE NETWORK EXPERIENCE. R. G. Brzyski,[a] K. Barnhart,[b] N. Santoro,[c] E. Eisenberg.[d] [a]University of Texas HSC San Antonio, TX; [b]University of Pennsylvania Medical Center, Philadelphia, PA; [c]University of Colorado Anschutz Medical Campus, Aurora, CO; [d]National Institute of Child Health and Human Development, Bethesda, MD.

OBJECTIVE: Issues of justice and paternalism have been raised to address gender inequities in access to clinical trials. Reproductive research poses unique challenges in this regard. Our goal was to examine the salient issues of partner consent and women's access to fertility clinical trials in the context of a clinical trial (NCT01044862) of the Reproductive Medicine Network funded by the National Institute of Child Health and Human Development.

DESIGN: Critical review of literature.

MATERIALS AND METHODS: Search terms employed were: partner consent, informed consent, clinical trials, partner rights, clinical research and sexual partners. Databases searched were: Pubmed, Academic Search Complete, Web of Science, BioEthics Research Library, PsychInfo, Psycharticles, and Cumulative Index to Nursing and Allied Health Literature.

RESULTS: Content of publications identified was almost exclusively related to human immunodeficiency virus and other sexually transmitted infections, contraception, or partner abuse. Published statements from The American College of Obstetricians and Gynecologists (ACOG) and the World Health Organization (WHO) identified several relevant issues: 1) partner agreement or authorization for an individual to participate in research violates research subjects' autonomy and right to confidentiality (WHO); 2) Even if female participation involves a risk of pregnancy, partner consent is not necessary (ACOG); 3) When partners are both research subjects, consent efforts should minimize barriers to the woman's participation (ACOG).

CONCLUSION: It is common for partners to sign consent forms for fertility therapy, but informed consent for research involves unique issues. When partners are not research subjects, their consent for a woman's participation in research is not justified. When partners are research subjects, the process of informed consent must address the issues specifically relevant to the partner's participation.

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OUTCOME PREDICTORS-CLINICAL: ART

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MYO-INOSITOL: OVARIAN STIMULATION AND IVF OUTCOMES. G. Carlomagno,[a] M. Montanino Oliva,[b] S. J. Roseff,[c] V. Unfer.[a] [a]Agunco, Rome, Italy; [b]Villa Mafalda, Rome, Italy; [c]South Florida Institute for Reproductive Medicine, Jupiter, FL.

OBJECTIVE: More than 60% of in vitro fertilization (IVF) cycles do not result in pregnancy. Several studies have been carried out in order to identify factors affecting the IVF outcome. The main factors influencing IVF outcome are oocyte and embryo quality. Indeed, the only way to improve IVF success rate is to improve oocyte and embryo quality. Interestingly, while an inverse correlation was found between the FSH IU administered and the pregnancy outcome, a positive correlation was found between myo-inositol (MI) concentration in the follicular fluid and oocyte quality. In the present study we aimed to study whether MI treatment is able to improve oocyte, embryo quality and IVF outcome.

DESIGN: Double blind RCT.

MATERIALS AND METHODS: Patients undergoing ICSI procedure were considered eligible for the study. Patients were randomly assigned to

two groups; MI treated or placebo. Patients assigned to the MI treated group were treated with 4g of MI and 400μg of folic acid (Inofolic, Lo.Li. pharma, Rome or Pregnitude, Everett, West Orange, NJ) for 3 months before starting ovarian stimulation and throughout pregnancy. Patients assigned to placebo group were treated with 400μg of folic.

RESULTS: Total rFSH units (2214±793vs.2723.14±1466 IU, $P<0.05$) and number of stimulation days (11.5±1.8vs.12.4±2.3, $P<0.05$) were significantly reduced in the MI group. Fertilization and cleavage rate were higher in the MI group (73.1%vs.67%, $P<0.01$ and 72,4%vs.87.8%, $P<0.01$). Furthermore, Grade I embryo were higher in the MI group (72.4%vs.87.8%, $P<0.01$); this will likely reflect the increase in biochemical pregnancy rate observed (33.5%vs.23.5%, $P<0.01$). Clinical pregnancy showed a positive trend in the MI group (20.5%vs.18.4%, $P=0.06$).

CONCLUSION: MI treatment is able to reduce the number of FSH IU administrated and the stimulation days and to improve fertilization, cleave rate, embryo quality and pregnancy rate. Therefore we conclude that MI treatment should be routinely introduced in IVF protocols.

Supported by: This study was supported by institutional grant.

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IMPACT OF NUMBER OF OOCYTES THAWED AND THE DAY OF EMBRYO TRANSFER ON IVF SUCCESS RATES WITH VITRIFIED DONOR OOCYTES: AN INDIVIDUAL PATIENT DATA META-ANALYSIS FROM 508 THAW CYCLES.

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OBJECTIVE: To assess the efficiency of IVF with vitrified donor oocytes (VDO) in relation to the number of thawed oocytes (TO) and compare day 2-3 vs. day 5 transfer success rates.

DESIGN: Individual patient data of 4 studies reporting on VDO cycles with pregnancy outcome were pooled and meta-analysed.

MATERIALS AND METHODS: Of the 540 VDO thaw cycles, 508 met inclusion criteria. Binary multivariate logistic regression analysis was performed to identify the factors affecting live birth (LB) (ongoing pregnancies included) outcome. Thaw cycles were subdivided according to the TO number and day of transfer.

RESULTS: All cycles were from patients under 35 years of age. Neither age nor number of embryos transferred (ET) influenced LB outcome. However day-5 transfer resulted in higher likelihood of LB ($P=0.043$; OR 1.46, 95% CI 1.01-2.09). When adjusted for day of transfer, TO number influencing LB per TO was 6. When cycles with ≤ 6 or >6 TO were compared, thawing ≤ 6 oocytes was associated with higher per oocyte success rates for both day 2-3 and day 5 transfer [Table 1]. However, per ET success rates were higher with 6>TO cycles transferred on day 2-3. In contrast, if the transfer was on day-5, thawing more oocytes did not increase per ET success rates. Oocyte to usable embryo rate was significantly higher for cycles with ≤ 6 than >6 TO (44.6% vs 21.4%, $P<0.001$).

Table 1. Success rates in relation to TO and day transfer

	Day 2-3			Day 5		
	≤6 (n=93)	>6 (n=228)	*P*	≤6 (n=143)	>6 (n=44)	*P*
Imp./TO	12.2	7.9	0.003	21.8	10.6	<0.001
Imp./IO	13.2	8.7	0.004	24.0	14.9	0.002
Imp./ET	26.5	38.1	0.003	50	40.8	0.116
LB/TO	8.6	4.9	0.002	12.5	6.4	0.002
LB/IO	9.3	5.4	0.002	13.7	8.9	0.046
LB/ET	18.6	23.6	0.151	28.7	24.5	0.424

IO: injected oocyte, Imp.: Implantation (sacs).

CONCLUSION: Blastocyst transfer is associated with significantly higher success rates in VDO IVF cycles. Thawing more than 6 oocytes does not increase the chances of LB per thawed or injected oocyte in donor cycles supporting that only a few oocytes within a cohort are capable of producing a live birth.

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MORE IS NOT BETTER: DAILY SERUM FSH LEVELS DURING CONTROLLED OVARIAN HYPERSTIMULATION (COH) IN WOMEN WITH NORMAL (NOR) AND DIMINISHED OVARIAN RESERVE (DOR) ACROSS A SPECTRUM OF BODY MASS INDICES (BMI).

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OBJECTIVE: To determine serum FSH levels for optimal ovarian response during COH in lean (L) and overweight/obese (O) women with NOR and DOR.

DESIGN: Controlled study.

MATERIALS AND METHODS: Daily serum FSH levels were measured in women undergoing COH with agonist suppression (n=55). Women were first divided into 3 groups by age and ovarian reserve (OR): Group 1 NOR<35 (n=13), Group 2 NOR≥35 (n=33), Group 3 DOR (n=9) (NOR=maximum historical (MH) FSH≤10 IU/L, DOR=MH FSH>10IU/L). Women were then divided into 4 groups by BMI and OR: L NOR (n=19), O NOR (n=27), L DOR (n=4), O DOR (n=5) (L: BMI<25, O: BMI≥25). Daily serum FSH was measured by ELISA. Primary outcome measure: # of eggs retrieved. Student t-test and multiple regression analysis were used. $P<0.05$ was considered significant.

RESULTS: Group 1: an average daily serum FSH level of 11.9±2.7 IU/L was sufficient for retrieval of >6 eggs in all women. Group 2: despite similar amounts of gonadotropins and average daily serum FSH levels, 21% of women had ≤6 eggs. Group 3: used more FSH, had higher average daily serum FSH levels, but made less eggs (Table). When adjusted for age, L and O women received the same amount of FSH (NOR: 252±112 IU vs 304±72 IU and DOR: 499±68 IU vs 437±121 IU), had similar daily serum FSH levels (NOR: 14±6 IU/L vs 13±4 IU/L and DOR: 33±20 IU/L vs 18±7 IU/L) and # of eggs (NOR: 16±12 vs 16±9 and DOR: 6±4 vs 5±4) ($P>0.05$).

Daily Serum FSH levels and Cycle Outcomes in Women with NOR and DOR

	NOR<35	NOR≥35	DOR	*P*
Age (y)	30.8±3.3	38±2.4§	40.1±3.6*	0.001
FSH max (IU/L)	6.3±1.5	6.1±1.3	13.3±2.8*	0.001
Serum FSH (IU/L)	11.9±2.7	14±5.4	24.6±15*	0.013
Eggs	16.9±10.7	15.4±10.3	5.4±3.7*	0.0037

Data presented as Mean±SD *$P<0.05$ compared to Groups 1 and 2 §$P<0.05$ compared to Group 1.

CONCLUSION: Higher daily serum FSH levels do not guarantee more eggs following COH. Contrary to popular belief, O women do not need more gonadotropins than L women to produce similar number of eggs. An RCT is needed to fully evaluate whether lower doses of FSH would have an equivalent effect.

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WITHDRAWN