be transferred, resulting in less high order multiple pregnancies and increased implantation rates. The key to select potentially viable blastocysts for cryopreservation lies in a range of selection criteria that needs to be applied, in order to optimize the choice of the blastocysts with the best potential for successful cryopreservation.

**Material and Methods:** A total of 1754 frozen embryo transfers (FET) including day 5 (49%) and day 6 (51%) blastocysts were performed between 2004 and 2009. The patients ranged in age from 34.6 ± 5.1. Both natural and hormone replacement cycles were used to increase the receptivity of the endometrium. Laboratory protocols were followed, including vitrification and warming of the blastocysts and assisted hatching for all warmed blastocysts except those that were hatching on their own. Vitrification of blastocysts was undertaken utilizing an “open system” (Cryotop; Kitazato Bio Pharma Co. Ltd., Fuji-shi, Japan), and a “closed system” (HSV [High Security Vitrification Kit]; CryoBioSystem, L’Aigle, France) after a two-step loading with 15% (v/v) DMSO, 15% (v/v) EG, and 0.5M sucrose as vitrification solution at 24°C. To remove the cryo-protestats, blastocysts were warmed and diluted in 1.0M and 0.5M sucrose respectively.

**Results:** After warming 3465 blastocysts using both carriers, not one single blastocyst was lost during the vitrification steps of cooling and warming. We have seen a survival rate of 96.6% and clinical pregnancy rate of 43.1% (748 pregnancies/1737 FET), and an implantation rate of 30.1%. No differences were seen between the “open” and “closed” carriers system in terms of clinical outcome. After 6 years of vitrifying blastocysts the perinatal outcome is as follows: from 464 deliveries with vitrified blastocysts, 576 babies (277 boys and 299 girls) were born. 77% of the deliveries were singletons, whereas 22% resulted in twins and 1% in triplets. No abnormalities were recorded.

**Conclusions:** Vitrification of blastocysts is an effective, viable and feasible alternative to traditional slow-freezing methods while still being able to achieve high implantation and pregnancy rates. The key to this success lies in that vitrification can be undertaken on a more flexible basis by laboratory staff, reducing personnel time commitment, and may enable more optimal timing of embryo cryopreservation, thus allowing individual blastocysts to be cryopreserved at their optimal stage of development and expansion. Furthermore, a vitrification solution of 15% EG/DMSO is safe for clinical use. Contamination of embryos by bacteria or different strains of viruses from liquid nitrogen, can be avoided by moving forward to a closed system without it having a negative impact on the outcome.

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**SELECTED ORAL COMMUNICATION SESSION**

**SESSION 07: PSYCHOLOGY & COUNSELLING**

**Monday 28 June 2010 10:00 - 11:30**

**O-033 Group work with couples opting for donor insemination: predominant issues within a legislation requiring open-identity donors**

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**Introduction:** Third-party reproduction engages couples on a journey necessitating in-depth psychological adjustments, mainly the acceptance of sterility and of the donor’s role in the procreation of a child. In countries requiring open-identity donors, disclosure to the offspring includes the possibility of a future meeting with the donor, reinforcing the reality of this action. In most centres, pre-treatment couple counselling is mandatory and some couples seek the possibility to exchange experiences with others confronted with the same issues. Professionally-led group work may enable couples to better formulate their questions and may offer counsellors a new understanding of the predominant issues.

**Material and Methods:** Couples opting for donor insemination (DI) were encouraged during counselling to participate in a professionally-led group whose objectives were to share experiences and reflections. The group work was conceptualised in three phases. First, each couple told their own DI history and then the group viewed a witness-account of a couple with a DI child. Second, the group was divided into two: men and women were asked to formulate questions separately and these were later discussed in the re-united group. Finally, photos or sentences depicting emotions frequently described were displayed and each couple asked to choose and comment on one. At the end, each participant filled in an anonymous questionnaire evaluating the session.

**Results:** From 2004 to 2009, 145 couples were counselled for DI and 72 accepted an open invitation to group work. A total of 31 couples participated in six groups: 8 already had a DI child and 10 had an ongoing pregnancy, 2 were exploring the DI option and the 11 others were in treatment. All couples had the intention to tell their child about DI and most had already told close relatives. The predominant questions stemming from the women included at what age and with which words to disclose the DI to the child, how inseminations and pregnancy were generally experienced and how to deal with remarks on the resemblance to the father. The men’s issues included what helps to accept sterility, psychological implications of DI for the child, how DI fathers experience the encounter with their child, how to tell the child about DI, how to react if the child wishes to meet the donor. Other more practical questions included how the donor is chosen, books for parents and children, causes of sterility, same-donor siblings. The evaluations showed that the witness-account was appreciated for confronting ideas and opinions, as was separating men and women for in-depth discussion; the overall evaluations of the sessions were positive.

**Conclusions:** About one half of all DI couples were interested in receiving an open invitation to participate in a professionally-led group session. Couples’ decisions to take part came at different times; about one third of the participants joined once they had a child, one third when pregnant, and the last third before or during DI treatment. All participating couples intended to tell or had told their children. The group work demonstrated the value for DI couples of directly exchanging specific experiences, such as accepting sterility, undergoing treatment and pregnancy, getting to know one’s DI-conceived child, dealing with family and friends, reflecting on open-identity donors. The evaluations of the sessions showed that they provided a suitable framework for the highly appreciated opportunity to exchange experiences. In conclusion, participating in group work is enriching and helpful for couples open to sharing: those opting for secrecy should be encouraged to participate in individual counselling sessions in case of pregnancy and birth, which are clearly challenging moments for all DI couples.

**O-034 Profiles and motives of couples referred for preimplantation genetic diagnosis (PGD)**

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**Background:** PGD is nowadays a well-established alternative for prenatal diagnosis. However, information is lacking with respect to the motives of couples for choosing PGD.

**Methods:** In a prospective study of 280 couples referred for PGD, the profiles and the motives for PGD were studied by means of semi-structured interviews. The interviews were arranged following the PGD counselling procedure. Couples were referred for PGD for various genetic disorders. Couples were asked about their experience with their particular genetic disorder, urgency of child wish, which alternatives for PGD they had considered, their openness about the subject, and whether and how the genetic counselling session had influenced their decision. The choice moment was set at the time the couples reached their final decision. This could be immediately after intake or some months later. Multivariate regression analysis was used to analyse the data.

**Results:** So far, 190 interviews have been analyzed. These couples were referred for PGD for autosomal dominant (31%), autosomal recessive (21%), X-linked (21%) or chromosomal disorders (26%). Concerning the reproductive history 32% of couples had no previous pregnancy, 24% had a history of one or more uncomplicated pregnancies, and 45% had previous abortions, pregnancy terminations or both. A history of sub fertility or infertility was reported in 15% of these couples. Most couples (59%) had no living offspring, 16% had only healthy children, 18% only affected offspring and 6% had both healthy and affected children. The most frequently reported motives for having children were the wish to be a biological parent (67%) and the wish to be a part of a family with children (19%).
Half of these 190 couples decided eventually to opt for PGD. Based on four predictors for (dis)continuation of treatment, a correct prediction was possible for 72% of the couples (95% Confidence Interval 65-78%). One predictor for starting PGD was the absence of alternatives, due to either fertility problems or moral objections against terminating pregnancy. Furthermore the openness about the treatment to family and friends and the experience of miscarriages or a history of more than one pregnancy termination were predicting factors for choosing PGD. However, prenatal diagnosis is still the method of first choice for those couples without such experiences. So far, both the seriousness of the specific disease and the mode of inheritance didn’t significantly contribute to the choice for PGD.

For the majority of couples (58%, 95% CI 51-65%) the counselling was a confirmation of their initial ideas. The remaining couples wished to reconsider their options after counselling.

Conclusion: PGD is an acceptable reproductive and diagnostic option, particularly for couples with experience of pregnancy termination after prenatal diagnosis, and for couples having reduced chances of a spontaneous successful pregnancy. From our findings we conclude that genetic counselling is pivotal for allowing couples to make a well-motivated choice.

O-035 Knowledge and perceived risks in couples undergoing genetic testing after recurrent miscarriage and in men with poor semen quality

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Introduction: In reproductive medicine, couples with recurrent miscarriage (RM) and men with poor semen quality may undergo genetic testing as part of the diagnostic work-up.

We evaluated participants’ understanding of and perceptions about genetic testing before receiving their genetic test result. We also evaluated to what extent their knowledge, or the lack thereof, and perceived risks were associated with increased levels of anxiety and depression.

Material and Methods: This prospective questionnaire study was performed between January 2006 and June 2009 in seven clinical genetic centres and referring gynaecological departments. Couples with RM in whom parental karyotyping was performed in both partners, or couples with poor semen quality in whom karyotyping and DNA-analysis was performed in the male partner, were sent a questionnaire and both partners were asked to complete the questionnaire separately 1 to 3 weeks before receiving the results of genetic testing. The questionnaire consisted of questions about knowledge and awareness of the genetic test, the information received during the consultation, perceived risks of receiving an abnormal genetic test result or another miscarriage, a stillborn child, a child with major congenital abnormalities and conceiving at least one healthy child. Anxiety was measured using the validated Dutch version of the Spielberger State-Trait Anxiety Inventory (STAI) and depression was measured using the validated Dutch version of the second edition of the Beck Depression inventory (BDI-II). We included 439 participants (222 men and 217 women), 172 had a history of RM (39%) and 267 a history of poor semen quality (61%).

Results: 256 of 439 participants (58%) were not aware genetic testing was part of the diagnostic work-up of RM or poor semen quality. One third of participants stated that they did not receive any information about the genetic test from their referring doctor during the consultation (36% RM, 33% poor semen quality). Only 40% of the participants with RM (44% poor semen quality) knew the meaning of the genetic test, 38% stated they had no idea (42% poor semen quality). Almost half of all participants (46% RM, 45% poor semen quality) indicated they felt they had not been given the opportunity to ask questions. There were no significant statistical differences between participants with RM or poor semen quality in knowledge or awareness.

The average perceived risk of receiving an abnormal genetic test result was 15% in both groups. The participants with RM estimated their risk of another miscarriage around 50%. The RM group estimated their overall chance of conceiving at least one child (75%) much higher than the poor semen quality group (50%) (p < 0.01). The perceived risks for all risk scenarios were highly correlated (p < 0.01). Anxiety was highly correlated with perceived risk. Women with RM were more anxious than women in the poor semen quality group or men in both groups (p < 0.01). There were no higher levels of depression.

Conclusions: Most couples had a suboptimal understanding of the nature of testing and overestimated the risks of receiving an abnormal genetic test result before disclosure of the test result. Women with a history of RM had higher levels of anxiety compared to a reference population and compared to women with a partner with poor semen quality.

Improved knowledge of genetic testing in couples with RM and poor semen quality is needed before a genetic test is performed. This could lead to more realistic expectations of patients about the consequences of the genetic test and to less anxiety before disclosure of the genetic test result.

O-036 A preliminary profile of women opting for oocyte cryopreservation for non-medical reasons

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Introduction: As oocyte cryopreservation techniques are still considered experimental, the main professional bodies consider the non-medical use prenata
tural. However, fertility centres around the world have started to offer oocyte cryopreservation to healthy and fertile women. The major concerns are that women will deliberately postpone pregnancy, give priority to their careers and that it will offer a false sense of security that one is optimizing her chances of motherhood. With this study we try to construct the profile of the women opting for oocyte freezing for non-medical reasons.

Material and Methods: The Centre for Reproductive Medicine (UZBrussel) received 15 candidates who all underwent a semi-structured interview to assess their motivation to apply for this treatment and to evaluate whether they were aware of the risks and limitations of the treatment.

Results: The average age of the women at intake was 38.3 years (± 2.7, range 34-43). All women had a high educational level and stated they could financially afford the treatment. They all had had partner-relationships in the past and did not make their desire for a child concrete because they did not found the ‘right’ partner. 14 women were single and 1 had a recently ongoing relation. The majority discovered the possibility to freeze oocytes because the topic appeared in the media and/or by searching on the internet (73.4%).

Before they discovered this possibility; adoption or staying childless were considered as alternatives by 26.7% of the candidates and becoming a single mother with the use of donor sperm by 46.7% of the candidates. However, except for one woman who had just engaged in a relationship, actively keep on searching for ‘mister right’ was the only valuable option. The main reasons to opt for oocyte freezing were; ‘taking the pressure of the search for the right partner’ (53.3%), ‘giving a future relationship more time to blossoms before bringing up the subject of child-desire’ (26.7%) and for 33.3% it meant an ‘assurance against future infertility’. All 15 candidates had shared their intentions with their entourage and none of them felt discouraged by their entourage to undergo this treatment. The financial costs (53.3%) and the use of hormones (26.7%) were considered as the main disadvantages of the treatment. However, all of them accepted they had to undergo a fertilization treatment while being healthy/fertile and were even willing to repeat the treatment on average 2.14 (± 0.36) times. The average age women thought of using their frozen oocytes was 43.4 years (± 2.03). If they would find a suitable partner most of them want to try to become pregnant spontaneously, than perform IVF with fresh material and in last instance, use their frozen oocytes. The majority (50%) (p < 0.01) of all women had a suboptimal understanding of the nature of testing and overestimated the risks of receiving an abnormal genetic test result before disclosure of the test result. Women with a history of RM had higher levels of anxiety compared to a reference population and compared to women with a partner with poor semen quality.

Improved knowledge of genetic testing in couples with RM and poor semen quality is needed before a genetic test is performed. This could lead to more realistic expectations of patients about the consequences of the genetic test and to less anxiety before disclosure of the genetic test result.
event to opt for this treatment whereby women tried to buy a little biological time well aware that there is no guarantee of childbearing. Moreover, frozen oocytes were considered as very precious goods since even if they would meet ‘mister right’ in the near future they would only use the frozen oocytes in last instance, after having tried to become pregnant spontaneously. These findings can add to the formulation of guidelines for counselling for this very specific population.

O-037 Conflicts between infertility patients’ embryo disposition decisions and their desire for a child

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Introduction: Cryopreservation of supernumerary embryos of patients who undergo in vitro fertilization offers them extra chances to conceive. From qualitative studies we know that patients know little about this cryopreservation and that they have misconceptions such as the belief that the quality of the embryo diminishes during the storage period (the embryo has an expiry date). The objective of this study is to describe patients’ decisions about (dis)continuing storage of their cryopreserved embryos in the light of their treatment goal.

Material and Methods: An anonymous mail questionnaire was sent between January 2007 and July 2007 to patients who had embryos in storage at the Infertility Center of the University Hospital Ghent (Belgium).

Results: 448 patients were included. In 36 cases the patient moved without notifying the clinic and could not be reached. The response rate was 79% (326/412). Patients who were still in a relationship with their partner who was also a gamete provider for the embryo and patients, for whom data was provided on both partners’ desire to have a child, were included in this analysis (297/326). Before cryopreservation, all patients had received information and signed a form to allow medical staff to cryopreserve supernumerary embryos. 38.7% of the patients (N = 115) wanted to continue while 60.3% (N = 179) wanted to discontinue the storage of their embryos. Three patients (1.0%) were undecided.

Two types of problematic decisions were documented in 48 patients (16.2%).
1) One group of patients (N = 10; 3.4%) opted for continued storage or were undecided (and thus no decision was communicated to the centre and storage was continued) while neither of the partners still had a desire to have child. This is interesting in light of the substantial numbers of patients of fertility centers worldwide who fail to respond to requests to make a disposition decision.
2) Another group of patients (N = 38; 12.8%) decided to discontinue storage while they both had a desire for a child, were both uncertain, or where one partner wanted another child while the other was uncertain. About half of those patients (N = 18) wanted to discontinue storage because of spontaneously conceived pregnancy or shifted focus to adoption, age-related considerations, having lost their hope of a positive outcome, or the burden of treatment being considered too high. For the other patients (N = 20) other explanations should be sought. There are indications (such as in answers to open questions) that a number of these patients believe that fresh embryos (or embryos cryopreserved at a later date compared to ‘older’ ones) offer a better chance of treatment success.

Conclusions: These two types of inconsistencies between patients’ embryo disposition decision and the presence or absence of the aspiration to conceive a child show that these decisions are (at least partly) based on other considerations than the rationale for offering this type of treatment: an extra chance to conceive. Especially the second type of conflict, where patients dispose of embryos while they still have a desire for a child, has received little attention in the literature and probably goes largely unnoticed by medical staff. In terms of (society’s or patients’) health care costs, additional treatment burden, and loss of treatment chances these inconsistencies should be prevented. Therefore, the procedure of informed consent should be re-examined. Adjustments to either the nature of the information (for instance not only informing about the arrest of the development of the cryopreserved embryo but also addressing misconceptions such as the expiry date) and/or to the timing of informing (also at the time of the disposition decision) could offer prospects of improving care.

O-038 Measuring quality of life in infertility using the FertiQoL questionnaire

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Introduction: Infertility and its accompanying treatments can have a significant impact on a person’s overall sense of wellbeing. Measuring quality of life (QoL) among infertile couples helps health care providers to understand how big this impact is, and which patients need extra attention. General measurement instruments, like the Hospital Anxiety and Depression Scale (HADS), are commonly used to determine patients’ affect. However, some argue that disease-specific QoL measures could provide more distinct information on a patient’s psychological state. In this context, an international collaboration of experts developed the FertiQoL-questionnaire to measure QoL in people experience fertility problems. This study aimed to examine the relatedness of general wellbeing as assessed by the HADS and the disease-specific FertiQoL.

Material and Methods: The Dutch version of the FertiQoL-questionnaire was sent to a random cross-sectional sample (n = 1089) of couples attending 29 Dutch clinics for a fertility treatment. The FertiQoL-questionnaire consisted of 24 items, assessing the impact of fertility problems in the emotional, mind-body, relational and social domains: higher scores mean better QoL. The Treatment-Module was left out. In addition, the Dutch version of the HADS was included to a subset of patients (n = 785). This questionnaire encompassed 14 items, subdivided into two scales measuring Anxiety and Depression: higher scores mean more anxiety and/or depression. First, this Dutch version of the FertiQoL was psychometrically tested for reliability. Total scores and subscale scores were determined for both the FertiQoL and the HADS. Pearson’s correlation coefficients were calculated between subscales of the FertiQoL and the HADS. Using an independent t-test, differences between patient subgroups were computed (pregnant versus non-pregnant; IVF/ICSI versus non-IVF/ICSI) for both measurement instruments (p < 0.05).

Results: In total, 875 patients completed the FertiQoL questionnaire (74%) and 577 filled out the HADS. Participants’ treatment was in 51% IVF/ICSI, in 41% insemination, and in 6% ovulation induction. Their median duration of infertility was 34 months. Psychometric analyses revealed that reliability of all FertiQoL scales were high. Significant negative correlations were found between the FertiQoL subscales and scores for Anxiety and Depression, ranging from -0.285 (between relational domain and anxiety) to -0.657 (between mind-body domain and depression). On a scale from 1 to 100, the average FertiQoL score for non-pregnant women was 70.79 (SD 13.85). The mean scores on the emotional, mind-body, relational, and social domains were respectively 59.82 (SD 18.71), 70.82 (SD 19.45), 78.23 (SD 14.49) and 74.03 (SD 16.57). The independent sample t-test revealed significant differences in means between pregnant and non-pregnant women on the total FertiQoL score, and on the mind-body and social subscales. Pregnant women had a higher QoL than non-pregnant women. In addition, IVF/ICSI-treated couples had significantly higher scores on the total FertiQoL, and the relational and social subscales than non-IVF/ICSI-treated couples.

The mean scores on the Anxiety and Depression subscales were respectively 5.5 (SD 3.9) and 3.3 (SD 3.2) on a scale from 0 to 21, in which a score higher than 8 indicates a psychiatric condition. The Total HADS score was averagely 9.1 (SD 6.61). The average FertiQoL-total-score of patients scoring above this threshold on Anxiety is 58.8 (SD 12.7), whereas it is on Depression 51.9 (SD 13.6). Pregnant and non-IVF-treated patients had significantly lower scores on the total HADS and on the HADS-depression scale than non-pregnant and IVF-treated patients.

Conclusions: Our study confirms the expected negative relation between QoL and anxiety and depression. Non-pregnant patients with a non-IVF/ICSI-treatment had the lowest QoL. This data support that the FertiQoL, specifically created for infertile couples, reliably measures the wellbeing of patients undergoing fertility treatment. The optional FertiQoL Treatment-Module could
Cry. This states that circannual timing is an integral part of a cyclic life history programme where the cycles are regulated by developmental control genes that annually recapitulate events of ontogeny. Different physiological systems (e.g. controlling the prolactin-pelage and gonadotropin-gonadal axes) are thought to have their own histogenetic pacemaker mechanisms, with the hypothalamus and pituitary providing the intrinsic, species-specific, temporal coordination and synchrony to the seasonal environment.

O-039 Molecular clocks and reproductive cycles

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Endogenous circannual clocks regulate internal time domains over months and years. They drive long-term rhythms in reproduction, metabolism, hibernation and moult as a pre-emptive strategy – allowing physiological change to be complete in advance of environmental change. The endogenous nature of circannual clockwork is well established for many different long-lived organisms, based on free-running and entrainment properties of seasonal rhythms. The underlying timing mechanisms that dictate the circannual time domain remain a mystery. We have begun to characterise a mammalian circannual pacemaker in our Soay sheep model where the neuroendocrinology is simplified by hypothalamo-pituitary disconnection (HPD). Remarkably, HPD sheep express 10-monthly, free-running, circannual rhythms in prolactin (PRL) secretion under constant long photoperiod indicative of pituitary control (Science 314, pp 1941-44, 2006). Chronic manipulation of adrenal glucocorticoid secretion in HPD sheep alters the timing of circannual PRL rhythms over prolonged periods, with the effects varying with the phase of treatment. These data support a new hypothesis proposing that circannual clocks are generated by a protracted mechanism of tissue regeneration and decline that is sensitive to glucocorticoids - the histogenesis hypothesis. This states that circannual timing is an integral part of a cyclic life history programme where the cycles are regulated by developmental control genes that annually recapitulate events of ontogeny. Different physiological systems (e.g. controlling the prolactin-pelage and gonadotropin-gonadal axes) are thought to have their own histogenetic pacemaker mechanisms, with the hypothalamus and pituitary providing the intrinsic, species-specific, temporal coordination and synchrony to the seasonal environment.

O-040 Chronobiology and assisted conception

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Animals and humans are entrained to their environment via light perception through the retina and the transfer of this information to the suprachiasmatic nucleus (SCN) in the hypothalamus. The SCN expresses endogenous rhythmicity of cellular neural activity which is entrained by light. This master clock organises physiological rhythmicity through hormonal and neural output pathways. Recent reports in the field of chronobiology (the study of biological rhythms) have uncovered striking changes in cellular function across the day in a wide range of cells and tissues, not just the SCN. Indeed it has been estimated, based upon microarray studies, that up to 10% of the transcriptome in various organs (e.g., liver, muscle, adipose, etc.) is rhythmically expressed. A suite of transcription factors, operating via both positive and negative feedback loops drives endogenous circadian rhythms of gene expression in cells. Two genes in particular, Clock and Bmal1, are considered to be pivotal in cellular rhythmicity, driving the expression of the period (Per) and cryptochrome (Cry) genes, whose protein products in turn suppress their own transcription by inhibiting CLOCK and BMAL1 action. Interestingly the CLOCK/BMAL1 heterodimeric protein complex also binds to E-boxes in the promoters of a large number of other transcription factors and functional genes imparting rhythmicity on their expression.

Evidence is emerging that this cellular timing system is present in reproductive organs, is entrained by the SCN and thus could be of relevance for infertility and assisted reproduction. For example there is intensive research being undertaken to improve the efficiency of assisted reproductive technologies and special effort to improve the embryo culture conditions prior to embryo transfer by the addition of various growth factors and other additives to culture medium. Presumably the aim is to try to re-create as closely as possible the in vivo milieu the developing embryo is exposed to, but the culture conditions clearly are not designed to replicate any maternal rhythmicity. Whether this impairs embryo development and outcomes is not known.

In this presentation I will discuss the molecular mechanisms underpinning the cellular timing system and review evidence for the role(s) of clock gene transcription factors in reproduction.

O-041 Data from the ESHRE PGD consortium

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1Genetics and IVF Institute, Preimplantation Genetic Diagnosis Laboratory, Fairfax VA, U.S.A.

Introduction: The ESHRE PGD Consortium was set up in 1997 and has been actively collecting data on PGD and PGS since then. The PGD Consortium has set up five working groups to look at important aspects of PGD: data collection and database, accreditation, misdiagnosis monitoring and audit, best practice guidelines and sharing of molecular methods.

Methods: There have been eleven collections of data on PGD/PGS, mostly using a filemaker Pro database. Currently there are 102 registered centres including centres from Europe, Argentina, Australia, Brazil, Egypt, India, Israel, Japan, Korea, Russia, Singapore, South Africa, Thailand, Taiwan, United Arab Emirates, Pakistan and the USA.

Results: The Consortium has analysed eleven sets of data on 32838 cycles. The indications analysed are chromosomal abnormalities (inherited)(5057 cycles), monogenic disorders (5720 cycles), sexing for X linked disease (1243 cycles) and for social reasons (786 cycles), and aneuploidy screening for infertility (PGS)(20032 cycles) Detailed analysis of 7273 clinical pregnancies and 4824 babies born has also been conducted. Over the eleven years there has been a change in the methods used for biopsy; with a gradual increase in the number of cycles with polar body biopsy (data set eleven showed 16.7% polar body, 81.1% cleavage and 0.1% blastocyst biopsy). There has also been a change in the methods used for the diagnosis, with data set eleven showing 72/5176 cases being done using whole genome amplification. Since 2006 there has been a change in the number of PGS cases being performed. In 2006, PGS made up 66% of the total cases being performed and this changed to 64% in 2007 and 62% in 2008. In 2009, the accreditation working group published a paper in Human Reproduction detailing quality management and quality assurance in PGD and recently held a second ESHRE campus workshop in London on the same topic. The misdiagnosis monitoring and audit working group is currently collecting data on embryo follow-up after PGD for both amplification-based PGD as well as FISH-based PGD/PGS. The best practice guidelines working group has completed the guidelines and four documents will soon be submitted for publication. The guideline documents will consist of set up of a PGD centre,