ESHRE 2021 Virtual (26 June – 1 July 2021)

Questions for the speakers

PCC15: MSRM course: Could we increase success in IVF - unsolved issues in ART

Laboratory KPI's - are we optimizing lab performance? - Basak Balaban (Turkey)

Q: In order to fulfil all task what is appropriate number of cycles per embryologist

A: Based on revised guidelines for good practice in IVF laboratories ESHRE 2015) the number of laboratory staff should reflect the number of cycles performed per year. As an approximate guide, clinics that perform up to 150 retrievals and/or cryopreservation cycles per year should have always a minimum of two qualified clinical embryologists. The ASRM revised guidelines for human embryology and andrology labs. (2008) recommends minimum 2 embryologists per 1-150 cycles, 3 for 151-300, 4 for 301-600 and >600 1 additional embryologist per additional 200 cycles.

It's important to address that these initial numbers will not only increase depending on the number of treatments, but also on the complexity of the procedures, techniques and tasks undertaken within the laboratory. For ex. The no. of stuff in an IVF lab. that performs many/all PGT cycles, or an IVF lab. that performs only freeze all cycles with all embryos produced being vitrified may not be the same. The ideal approach would be to reconsider periodically the number of qualified embryologists according to the increasing utilization of novel technologies such as timelapse, detailed witnessing systems etc..

Is there any benefit in dual triggering? - Omar Sefrioui (Morocco)

Q: When using dual trigger for PORs,do you put agonist and hcg at the same time or sart with Gnrh than hcg 4hours later as reported by some teams?

A: AT THE SAME TIME NO NEED TO POSTPONE ONE FROM THE OTHER

Q: With dual trigger, where we give gnrha and inj hcg , can we rescue luteal phase with another dose of gnrha, along with estrogen and progesterone?

A: There seems a benefit to give 0.2mg of triptoreline on day 5 post pick up for poor rezsponders added to progesterone. There is no benefit to add estradiol

Q: Do you think that using HCG and recombinant LH will overcome empty follicle syndrome or less eggs than number of mature follicles?

A: There is no data demonstrating the benefit of adding LHR TO HCG for empty follicle syndrome

What we know is that dual trigger reduces the risk of EFS

Q: Can agonist dose be given 0.1mg instead of 0.2mg?

A: THE BEST DOSAGE FOR AGONIST TO INDUCE THE LH SURGE IS 0.2MG

Q: Will there be a difference in giving the Agonist trigger before the HCG? Or are they been given at the same time?

A: IT S BETTER TO GIVE THEM AT THE SAME TIME

Q: In dual trigger and 'fresh transfer'- do we need to give hCG during luteal phase support?

A: NO NEED TO ADD HCG DURING LUTEAL PHASE

IT SEEMS INTERSTING TO ADD 0.2MG OF TRIPTORELINE ON DAY 5 POST PICK UP

Q: In dual trigger and 'fresh transfer'- do we need to give hCG during luteal phase support?

A:

Q: What is the ideal dual trigger regimen for poor responders in your opinion after all the data?

A: GIVING 2 OVITRELLE AND 0.2MG OF TRIPTORELINE WITH A PICK UP AFTER 36-37HOURS NOT LESS

THE ONLY EXCEPTION IS OLDEST PATIENTS WITH ONE OR 2 FOLLICLES PICCK UP SHOULD BE DONE EARLIER 35H TO AVOIR A PREMATURE OVULATION

Q: In your view also what is the ideal luteal support regimen with dual trigger?

A: THE IDEAL REGIMEN SUPPORT AFTER DUAL TRIGGER IS PROGESTRONE 600MG OR SUBCUTANEOUS PROGESTERONE AND TRIPTORELINE 0.2MG ON SOT ON DAY 5

Q: What is your opinion of Double trigger vs Dual trigger?

A: DOUBLE TRIGGER HAS A DIFFERENT GOAL THATN DUAL TRIGGER

IT S A RESCUE REGIMEN TO AVOID OHSS AND AUTHORIZE FRESH TRANSFER BUT IT SHOULD BE DONE WITH HIGH PRECAAUTION AND IF U HAVE KLESS THAN 18 FOLLICLES

FOR 18 OR MORE NO PLACE FOR DOUBLE TREGGER

Q: Is it better to do both same time with dual trigger or Gnra preceding hcg and by how long?

A: SAME TIME SEEMS BETTER BUT MORE DATAS ARE NEEDED

Q: Timing of egg collection best with dual trigger timing from injections?

A: 36-37HOURS

Q: If the woman has lh receptor gene polymorphisms, will any trigger help?

A: LH POLYMORPHISM NEEDS MORE DOSES OF FSH

NO DATA ABOT DUAL TRIGGER IN THESE CASES BUT IT SEEMS RATIONAL TO D IT

Q: In your experience do you advice dual trigger for normal responders?

A: SOMETIMES WHEN I HAD OTHER ATTEMPT WITH LESS OOCYTES THAT EXPECTED

Q: What is your opinion of giving GnRH agonist trigger 12hrs apart?

A: SOME DATAS PROPOSED THAT WITH FEW BENEFITS COMPARED TO THE SAME TIME

Poor responders stimulation modalities - Improving oocyte quality and oocyte number - Tatjana Motrenko Simic (Montenegro)

Q: If you downregulate or give estrogen priming, then when would you trigger ovulation?

A: For downregulated cycles by agonist when follicles reach 20 mm size, not before, even with estrogen priming in antagonist cycle I would rather wait follicles to reach 17 mm. In one third of poor responders oocytes are mature even in small follicles and could be rationale to give stop injection earlier. Unfortunately it is not known who are those patients without data from previous stimulation – treatment of patients is not just treatment it is also diagnostic, since provide many valuable information about patient's peculiarity. For LH primed cycles, stop injection originally was given at 17 mm, I rather wait 18-19 mm.

Q: Testosterone pre-treatment results?

A: Depending from study to study, there is no clear answer based on RCT evidence, we are waiting T-TRANSPORT trial results, but it seems it will be longer then estimated due recruitment problem. Personally, I would rather avoid systemic application of androgens and effect on whole body for purpose of raising it in target organ. LH seems more logical to try it by LH priming. Study about LH priming in older poor responder hopefully will be soon finished and we will have some results about local effect in A lifting.

Q: Can you relate your experience with coQ10?

A: Many colleagues from surrounding are prescribing, me personally not. According literature it seems some limited improvements are possible, still without clear answer. I think we need more discussion related to adjuvant therapy.

Manipulating the endometrium: can recurrent implantation failure be managed by the use of novel research therapies? - Antonis Makrigiannakis (Greece)

Q: What is your comment on intra uterine infusion of PRP? And should it be infused on the day of diagnostic hysteroscopy or afterwards? If afterwards then on which cycle day of FET it should be infused?

A: We usually administer PRP from 1 week to two days prior to embryo transfer

Q: Do you personally recommend Intrauterine HCG? When and how ?

A: I am not supporting HCG

Q: A patient for FET persistently had thin ET after different protocols - natural, hormonal with E2 and mild FSH stimulation, what else can we try?

A: The current alternatives are PRP, C-GCF and GH. GH is an expensive choice, while the others are based on growing evidence which currently is not strong

Q: Do you recommend intrauterine installation of PRP, some practitioners inject the PRP sure endometrial via hysteroscopy what is your experience?

A: I do not use PRP during hysteroscopy

Q: Do you do a repeat endometrial sample (test of cure)in cases of NLD after you treat them?

A: Yes, this is a reasonable option

Q: How long is endometrial microbiome test valid?

A: The microbiome profile is valid for a short period of time (I would suggest for not more than 2 months)

Q: Have you experienced any problems with infections after intrauterine application of PBMC or PRP?

A: No. All procedures are performed following aseptic protocols.

Q: What is your strategy for patients with thin endometrium due previous curettage, after hysteroscopy with thin adhesion resection and normal cavity after?

A: We usually administer estrogen followed by intra-uterine PRP

Q: In your practice when is it ideal to do PRP, how many days prior to ET?

A: I would suggest PRP not to be administered the last 2 days prior to ET

To transfer or not to transfer in fresh cycle-the question is now - Pro - Biljana Popovic - Todorovic (Belgium)

No questions from the participants