



Aalborg Universitet

AALBORG UNIVERSITY
DENMARK

A systematic review on concurrent aneuploidy screening and preimplantation genetic testing for hereditary disorders

What is the prevalence of aneuploidy and is there a clinical effect from aneuploidy screening?

Toft, Christian Liebst Frisk; Ingerslev, Hans Jakob; Kesmodel, Ulrik Schiøler; Diemer, Tue; Degn, Birte; Ernst, Anja; Okkels, Henrik; Kjartansdóttir, Kristín Rós; Pedersen, Inge Søkilde

Published in:
Acta Obstetrica et Gynecologica Scandinavica

DOI (link to publication from Publisher):
[10.1111/aogs.13823](https://doi.org/10.1111/aogs.13823)

Publication date:
2020

Document Version
Accepted author manuscript, peer reviewed version

[Link to publication from Aalborg University](#)

Citation for published version (APA):

Toft, C. L. F., Ingerslev, H. J., Kesmodel, U. S., Diemer, T., Degn, B., Ernst, A., Okkels, H., Kjartansdóttir, K. R., & Pedersen, I. S. (2020). A systematic review on concurrent aneuploidy screening and preimplantation genetic testing for hereditary disorders: What is the prevalence of aneuploidy and is there a clinical effect from aneuploidy screening? *Acta Obstetrica et Gynecologica Scandinavica*, 99(6), 696-706.
<https://doi.org/10.1111/aogs.13823>

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- ? Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- ? You may not further distribute the material or use it for any profit-making activity or commercial gain
- ? You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us at vbn@aub.aau.dk providing details, and we will remove access to the work immediately and investigate your claim.

MR CHRISTIAN LIEBST FRISK TOFT (Orcid ID : 0000-0002-5012-3143)

PROFESSOR ULRIK SCHIØLER KESMODEL (Orcid ID : 0000-0003-3868-106X)

MS KRISTÍN RÓS KJARTANSDÓTTIR (Orcid ID : 0000-0002-5042-574X)

Article type : Systematic review

A systematic review on concurrent aneuploidy screening and preimplantation genetic testing for hereditary disorders: what is the prevalence of aneuploidy and is there a clinical effect from aneuploidy screening?

Christian Liebst Frisk TOFT¹, Hans Jakob INGERSLEV³, Ulrik Schiøler KESMODEL³, Tue DIEMER⁴, Birte DEGN¹, Anja ERNST¹, Henrik OKKELS¹, Kristín Rós KJARTANSDÓTTIR⁵, Inge Søkilde PEDERSEN^{1,2}

¹Department of Molecular Diagnostics, Aalborg University Hospital, Aalborg, Denmark

²Department of Clinical Medicine, Aalborg University, Aalborg, Denmark

³Fertility Unit, Aalborg University Hospital, Aalborg, Denmark

⁴Department of Clinical Genetics, Aalborg University Hospital, Aalborg, Denmark

⁵Department of Clinical Genetics, Rigshospitalet University Hospital, Copenhagen, Denmark

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/aogs.13823](https://doi.org/10.1111/aogs.13823)

This article is protected by copyright. All rights reserved

Corresponding author:

Christian Liebst Frisk Toft

Department of Molecular Diagnostics, Aalborg University Hospital, Reberbansgade 15, 9000
Aalborg, Denmark

E-mail: christian.toft@rn.dk

Conflicts of interest

None

Funding information:

No external funding was applied for or obtained.

ABSTRACT:

Introduction: In assisted reproductive technology, aneuploidy is considered a primary cause of failed embryo implantation. This has led to the implementation of preimplantation genetic testing for aneuploidy in some clinics. The prevalence of aneuploidy and the use of aneuploidy screening during preimplantation genetic testing for inherited disorders has not previously been reviewed.

Here, we systematically review the literature to investigate the prevalence of aneuploidy in blastocysts derived from patients carrying or affected by an inherited disorder, and whether screening for aneuploidy improves clinical outcomes. **Material and methods:** PubMed and Embase were searched for articles describing preimplantation genetic testing for monogenic disorders and/or structural rearrangements in combination with preimplantation genetic testing for aneuploidy. Original articles reporting aneuploidy rates at the blastocyst stage and/or clinical outcomes (Positive human chorionic gonadotropin, gestational sacs/implantation rate, fetal heartbeat/clinical pregnancy, ongoing pregnancy, miscarriage, or live birth/delivery rate on a per transfer basis) were included. Case studies were excluded. **Results:** Of the 26 identified studies, none were randomized controlled trials, three were historical cohort studies with a reference group

not receiving aneuploidy screening, and the remaining were case series. In weighted analysis, 34.1 % of 7749 blastocysts were aneuploid. Screening for aneuploidy reduced the proportion of embryos suitable for transfer, thereby increasing the risk of experiencing a cycle without transferable embryos. In pooled analysis the percentage of embryos suitable for transfer was reduced from 57.5 to 37.2 % following screening for aneuploidy. Among cohort studies, one reported significantly improved pregnancy and birth rates but did not control for confounding, one did not report any statistically significant difference between groups, and one properly designed study concluded that preimplantation genetic testing for aneuploidy enhanced the chance of achieving a pregnancy while simultaneously reducing the chance of miscarriage following single embryo transfer. **Conclusion:** On average aneuploidy is detected in 34 % of embryos when performing a single blastocyst biopsy derived from patients carrying or affected by an inherited disorder. Accordingly, when screening for aneuploidy, the risk of experiencing a cycle with no transferable embryos increases. Current available data on the clinical effect of preimplantation genetic testing for aneuploidy performed concurrently with preimplantation genetic testing for inherited disorders is sparse, rendering the clinical effect from preimplantation genetic testing for aneuploidy difficult to access.

Keywords

Preimplantation genetic testing, Clinical outcomes, Aneuploidy screening, Comprehensive chromosome screening, Systematic review, preimplantation genetic diagnosis; preimplantation screening

Abbreviations:

aCGH	array comparative genomic hybridization
ART	assisted reproductive technology
ESHRE	European Society for Human Reproduction and Embryology
FISH	fluorescence in situ hybridization
MFA	mean female age

PGT	preimplantation genetic testing
PGT-A	PGT for aneuploidy
PGT-M	PGT for monogenic disorders
PGT-SR	PGT for structural rearrangements
PRISMA	Preferred reporting items for systematic reviews and meta-analyses

Key message:

One third of embryos derived from patients carrying or affected by an inherited disorder are aneuploid. Hence, prioritizing embryos by ploidy status should in theory improve clinical success rates per transfer. The design and quality of the current available data does not allow a conclusion.

INTRODUCTION

Preimplantation genetic testing (PGT) is defined as genetic testing of biopsied material from in vitro fertilized pre-implantation embryos from couples carrying or affected by a hereditary disorder with the aim of identifying unaffected embryos for transfer. The first case of PGT for an inherited disorder was reported by Handyside et al. in 1989 on a couple at risk of transmitting an X-linked recessive disease.¹ Gender selection was performed on biopsied material from cleavage stage embryos by Sanger sequencing followed by transfer of female embryos. Shortly thereafter, Sanger sequencing was adapted for direct analysis of monogenic mutations,² and increased diagnostic accuracy was obtained by simultaneous analysis of short tandem repeats.³

Technological developments led to the introduction of fluorescence in situ hybridization (FISH), array comparative genomic hybridization (aCGH), single nucleotide polymorphism arrays, karyomapping and next generation sequencing, making PGT possible not only for monogenic disorders but also for chromosomal insertions, duplications, deletions and translocations. PGT performed for monogenic diseases and chromosomal structural rearrangements are referred to as PGT-M and PGT-SR, respectively.⁴ Based on data collected from transfer of 6277 embryos in 4025 PGT cycles by the European Society of Human Reproduction and Embryology (ESHRE) PGT consortium, PGT for inherited diseases is currently performed with clinical implantation rates (fetal heartbeat/embryo transferred), clinical pregnancy rates (positive heartbeat/embryo transfer) and delivery rates (delivery/embryo transfer) of 23, 31 and 25 %, respectively.⁵

The current gold standard for prioritization of embryos for transfer during assisted reproductive technology (ART) is based upon morphological and developmental assessment of individual embryos sometimes aided by time-lapse imaging,⁶ which is biased by its inherently subjective scoring systems.⁷ It has been acknowledged that aneuploidy is common in human preimplantation embryos, affecting approximately 25 % of embryos derived from young women, and increases with female age in women receiving ART.⁸ Furthermore, aneuploidy is prevalent in products of conception from miscarriages.⁹ Altogether, these facts indicate that selection against aneuploidy could benefit clinical outcomes. Although some degree of correlation between the morphology grade and the ploidy state of the embryo exists,¹⁰⁻¹³ aneuploidy cannot reliably be predicted based

on embryo morphology alone.^{14,15} Preimplantation genetic testing for aneuploidy (PGT-A) is numerical chromosomal analysis of biopsied cells from embryos with the purpose of transferring euploid embryos and has previously been used in ART in order to optimize clinical outcomes on indications such as advanced maternal age, repeated implantation failure, recurrent miscarriages and severe male factor infertility. PGT-A was initially performed by FISH (PGT-A version 1.0), which allowed the enumeration of a limited number of chromosomes (originally limited to chromosome Y, X, 13, 18 and 21), on biopsies from cleavage stage embryos.¹⁶ Despite the expectations that cleavage stage biopsy and FISH would enhance clinical outcomes, numerous randomized controlled trials failed to show any improvements of live birth rates and even showed decreased live birth rates in women of advanced maternal age.¹⁷

The lack of clinical effect of PGT-A version 1.0 was attributed to a variety of factors, such as the limited number of chromosomes examined by FISH, since aneuploidy may affect all chromosomes.^{18,19} Further, cleavage stage embryos are more prone to mosaicism and aneuploidy than blastocysts,^{14,20,21} and hence does not accurately predict the chromosomal profile of the resulting blastocyst.^{22,23} Finally, a negative impact on embryo implantation potential seems to be caused by biopsy at the cleavage stage compared with biopsy at the blastocyst stage.^{24,25} Hence, FISH and cleavage stage biopsy are now rarely used as tools for PGT-A, with laboratories switching to biopsy at the blastocyst stage and to techniques that allow screening of the entire chromosome set, such as aCGH, single nucleotide polymorphism array (later also commercialized as karyomapping), and next generation sequencing, also referred to as PGT-A version 2.0 and comprehensive chromosome screening. Importantly, although the mentioned techniques allow screening of the entire chromosome set, they all have their own limitation. One of the more common problems is the detection of sequence-identical chromosomal duplications, such as mitotic trisomies or uniparental disomy.

The combination of comprehensive chromosome screening and blastocyst biopsy was by some expected to be able to succeed where PGT-A version 1.0 failed. Initially, a systematic review and a meta-analysis independently concluded that comprehensive chromosome screening enhanced clinical outcomes in patients with normal ovarian reserve.^{26,27} However, others claimed that the small size of the limited number of RCTs currently published, did not justify the use of comprehensive chromosome screening in clinical practice.²⁸ A recent multicenter study comparing clinical outcomes following next generation sequencing-based PGT-A and

morphological analysis showed an effect of PGT-A in older patients (35-40 years) only.²⁹ Thus, a recent consensus report from the American Society of Reproductive Medicine stated that “*At present, however, there is insufficient evidence to recommend the routine use of blastocyst biopsy with aneuploidy testing in all infertile patients*”.³⁰ Recently, and published after the publication of the statement by the American Society of Reproductive Medicine, a large historical cohort study reported a statistically significant improvement on live births/cycle following PGT-A in women \leq 40 years compared to a group not receiving PGT-A. Furthermore, implantation and live birth rates were unchanged across female age following PGT-A.³¹ From a purely biological perspective, selecting euploid embryos should increase clinical success rates on a per transfer basis, but factors such as quality of embryo culture and biopsy technique, as well as diagnostic methods applied, may explain the somewhat divergent findings currently reported in the literature.

The application of PGT-A in patients referred to PGT for inherited disorders has not been systematically reviewed. Hence, we looked at the available literature reporting on concurrent PGT-A and PGT-M/SR with the aim of investigating the prevalence of aneuploidy and clinical effect of aneuploidy screening. Since blastocyst stage biopsy has been shown to be superior to cleavage stage biopsy with respect to analytic precision and clinical outcomes,^{14,20–25} only studies performing biopsy on blastocysts were considered relevant for this review.

MATERIAL AND METHODS

This review was performed and written in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, including the PRISMA flowchart and checklist.

In- and exclusion criteria

Inclusion criteria were 1) that PGT-SR or PGT-M was performed in combination with PGT-A and 2) that aneuploidy rates and/or clinical outcomes were reported. Clinical outcomes were defined as either positive human chorionic gonadotropin gestational sacs/implantation rate, fetal

heartbeat/clinical pregnancy, ongoing pregnancy, miscarriage/spontaneous abortion, ongoing pregnancy or live birth/delivery rate reported on a per transfer basis.

Exclusion criteria were 1) Case-studies, 2) Studies not performing trophoctoderm biopsy or where aneuploidy or clinical outcomes specific for trophoctoderm biopsies could not be extracted, 3) Reviews, 4) Redundant publications (Same data used for two publications) and 5) Studies lacking important meta data relevant for interpreting and/or understanding the data.

Literature search

Searches were performed in PubMed and Embase to identify publications regarding concurrent PGT-A and PGT-M/SR. This was done using separate comprehensive search strategies for PubMed and Embase. The search strings can be seen in Supporting Information Appendix S1. Abstracts were screened by C.L.F. Toft and full text reviewed by I.S. Pedersen and C.L.F. Toft, who also agreed on the final selection of papers.

Data extraction pooling

Data was extracted directly from the articles and/or supplementary material when needed. P-values were reported here as reported by the authors in the original article. In case p-values were not reported, they were calculated where needed. In cases where data or statistical calculations seemed to have been misreported, the corresponding author was contacted for clarification.

Authors were not contacted to obtain meta data. Data was pooled and weighted regarding the number of embryos analyzed to obtain a weighted average aneuploidy rate and weighted average proportions of suitable embryos prior to and post PGT-A. Even though measured aneuploidy rates are in theory affected by the platform used for PGT-A, the potential differences caused by different platforms were considered neglectable. Hence, weighted aneuploidy rates were performed across studies utilizing different PGT-A platforms. Since the aim was to report on aneuploidy in PGT in general, differences in mean female age (MFA) was not considered an issue when calculating the weighted aneuploidy rate. Data pooling with respect to clinical outcomes was not possible due to the heterogeneity of the studies.

Tools for assessment of risk of bias are mainly developed for randomized controlled trials, cohort and case-control studies. Since the vast majority of studies included in this review were case series with no reference group, no formal assessment of risk of bias was performed, as the risk would in any case be considerable.

Statistical analyses

All statistical analyses were performed using R version 1.1.453 (<https://support.rstudio.com/>).

Testing for the null hypothesis that proportions (both aneuploidy and clinical outcomes) in two groups were the same were performed using chi-squared test or Fisher's exact test. P-values less than 0.05 were considered statistically significant.

RESULTS

Literature search and study characteristics

A total of 1717 publications were identified through Medline (840) and PubMed (877). Screening for duplicates resulted in 1291 unique publications. Title and abstract screening resulted in 73 papers. Full text screening resulted in 26 publications fulfilling the inclusion criteria^{18,32,41–50,33,51–56,34–40}. Interestingly, no randomized controlled trials were identified. Three historical cohort studies with a reference group not receiving aneuploidy screening were identified, while the remaining studies were case series without a reference group. The search was last updated on the first of July 2019. A flow diagram of the screening process is shown in Figure 1. Table 1 summarizes the main characteristics of the 26 studies included in this review in chronological order of publication date.

The included studies were published between 2011 and 2019. The number of patients receiving trophoctoderm biopsy was not available in 4 studies. MFA of patients receiving trophoctoderm biopsy was available in 15 studies and ranged from 29.2 to 38.1 years. The number of embryos successfully analyzed for both aneuploidy and genetic disorder ranged from 12 to 1498. No studies reported performing sequential biopsies or rebiopsy. All included studies reported aneuploidy rates. 17 studies reported clinical outcomes with three retrospective studies included a reference group. CGH, aCGH, next generation sequencing, single nucleotide polymorphism

array/karyomapping and quantitative PCR were used for aneuploidy detection (Table 1).

Diagnosis of x-linked disorders was classified as PGT-M in all of the included studies.

Prevalence of aneuploidy in patients carrying or affected by a genetic disorder

The reported aneuploidy rates are listed in Table 1 and illustrated in Figure 2. The aneuploidy rate ranged from 17.2 to 83.3 %. The weighted average aneuploidy rate of the 7749 embryos was 34.1 % (95 % CI; 33.1 % to 35.2 %) (Figure 2, top bar). For PGT-M, aneuploidy ranged from 19.0 to 83.3 % with a weighted average of 35.9 %. For PGT-SR, aneuploidy ranged from 17.2 to 53.3 % with a weighted average of 32.5 %. Comparing PGT-M and PGT-SR there was a small but statistically significant difference between the two groups with aneuploidy being more prevalent in the PGT-M group ($P = 0.002$).

The effect of PGT-A on the number of transferable embryos

The percentage of embryos suitable for transfer prior to and post PGT-A are shown in Figure 3A. Combining the data, the weighted average number of embryos being suitable for transfer prior to and post PGT-A dropped from 57.5 to 37.2 % (95 % CI; prior: 56.3 % to 58.6 %, post: 36.1 % to 38.4 %) (Figure 3A, top bar). 17 of 22 studies reported a statistically significant difference in the number of suitable blastocysts for transfer prior to and post PGT-A (Figure 3A). Comparing PGT-M and PGT-SR, there were no statistically significant difference between the percentage of blastocysts suitable for transfer prior to and post PGT-A ($P = 0.8$ and $P = 0.6$, respectively, Figure 3B).

The effect of PGT-A on the percentage of cycles with no transfer

Screening for aneuploidy significantly increased the percentage of non-transferable embryos. In one study, embryo transfer was performed in 81 % of cycles (1688/2084) while only 67 % of cycles had transferable embryos following screening for aneuploidy (212/317).⁵⁴ In another study, out of 304 cycles, 71 % of cycles had suitable embryos for transfer following PGT-M/SR, which was reduced to 60 % following aneuploidy screening.³⁶ Minasi *et al.* reported the percentage of cycles with no transferable embryos following aneuploidy screening to be similar in patients

affected by monogenic disorders and structural rearrangements. The remaining studies did not provide any data on the increase in frequency of cycles with no transfer following aneuploidy screening.

Clinical outcomes of concurrent PGT-A and PGT-M/SR

Of the reviewed literature, 17 publications reported on clinical outcomes following PGT-A (Table 1). Only three studies included a reference group not receiving PGT-A (Table 1, Figure 4).^{34,50,54} The average number of embryos transferred in the PGT-A and reference group for the three historical cohort studies are shown in Figure 4D. Only Hou *et al.* performed single embryo transfer in both groups where the Goldman *et al.* and Rechitsky *et al.* transferred more embryos in the reference group compared with the PGT-A group. Of the three studies, one did not achieve statistically significant results (Figure 4B).⁵⁰ The other two studies reported significantly improved clinical outcomes compared to the reference group (Figure 4A and C).^{34,54} The study by Hou *et al.* contained age-matched cohorts (MFA of 29.02 vs. 29.34, $P = 0.328$) while the study by Rechitsky *et al.* did not disclose the MFA of the reference group. Hence, it cannot be excluded that the reported clinical effect from PGT-A reported by Rechitsky *et al.* might be caused by comparison of non-age-matched cohorts. Furthermore, it should be noted that the study by Rechitsky *et al.* performed both cleavage and blastocyst stage biopsy and even though clinical outcomes following blastocyst biopsy could be deferred from the article in case of the PGT-A data, this was not possible for the reference group. Of the 196 embryo transfers, 158 and 38 were following blastocyst and cleavage stage biopsy, respectively. Contrary to previous reports in the literature,^{14,20,22,23} the data from Rechitsky *et al.* showed no significant differences in clinical outcomes between the two biopsy stages for any of the three parameters reported ($P > 0.95$ for all three parameters).

Mosaicism

Of the 26 publications, six studies reported on the prevalence of mosaicism. One publication reported mosaicism on a per chromosome level only.⁵¹ The remaining five publications reported on mosaicism ranging from 0 % (0/175 and 0/18 embryos) to 10.8 % (11/102 embryos) with the two largest studies reporting 3.7 (42/1122 embryos) and 6.8 % (44/646).^{34,36,39,43,46} Three of the six

studies details their classification and transfer policy with respect to mosaic embryos,^{34,39,51} with two never transferring mosaic embryos,^{34,39} and one considering mosaic embryos for transfer in the case that there was no euploid embryos available and that the level of mosaicism was 40 % or less.⁵¹ The remaining three studies do not detail their classification of or transfer policy with respect to mosaic embryos.^{36,43,46}

DISCUSSION

This review presents data from the 26 publications currently published about concurrent PGT-A and PGT-M/SR, which report on aneuploidy rates and/or clinical outcomes. Only three studies included a reference group. All three were historical cohort studies.

Despite the relatively young age of the patient cohort (ranging from 29.2 to 38.1), a significant proportion of embryos (34.1 %, 95 % CI; 33.1 % to 35.2 %) were aneuploid, indicating that a substantial fraction of embryos derived from couples seeking PGT for inherited disorders might be unsuitable for transfer. A wide range of aneuploidy frequencies were observed ranging from 17.2 to 83.3 %. Removing the bias introduced by analyzing a small number of embryos (by including studies of more than 100 embryos) resulted in an aneuploidy frequency from 21.5 to 56.5 %. This is still a wide range that cannot be explained simply by differences in MFA, but more likely by variations in the embryo handling procedures and diagnostic setups of individual clinics and laboratories. This underlines the need for further evaluation of the use of PGT-A.

Although aneuploidy was significantly more prevalent in PGT-M compared to PGT-SR (35.9 versus 32.5 %, $P = 0.002$) this finding is of little value since the data does not allow control for confounding variables, the most important being female age in the case of aneuploidy.

Aneuploidy is considered a significant contributor to implantation failures experienced during ART, but it is unknown if infertile couples are especially prone to create aneuploid embryos compared to fertile couples. Since most couples referred for PGT-M/SR are fertile, comparison of the ART and PGT cohort might help answer this question. Although the data presented here does not allow a strict age-matched comparison of prevalence of aneuploidy between the fertile (PGT-M/SR) and infertile patient (ART) cohorts, the weighted aneuploidy rate of 34.1 % in the PGT-M/SR cohort is comparable to that previously reported in a large ART study within the same age range, varying from about 22 to 49 %.⁸

PGT-A substantially increases the number of non-transferable embryos compared to PGT-M/SR alone (Figure 3A). All but four studies reported a statistically significant reduction in the percentage of embryos being suitable for transfer before and after PGT-A. The remaining four studies most likely failed to reach statistically significant differences due to the small sample size.^{43,44,53,55} As a direct consequence of this, opting for PGT-A will most likely increase the risk of experiencing a cycle with no transferable embryos, and patients should therefore be informed about this risk during counseling on when to opt for PGT-A or not as well as about the on-going discussion of a clinical effect. This risk is expected to increase with both female age (as aneuploidy increases) and with decreasing ovarian reserve, meaning that risk counseling should consider these factors.

With respect to clinical outcomes, the currently published studies either lack an (age-matched) reference group, proper sample size and/or control of confounding variables such as the stage of biopsy, MFA and the number of embryos transferred per transfer, to allow a proper evaluation of the effect of PGT-A. We only identified three studies which had included a reference group of which two reported improved clinical outcomes,^{34,54} while one failed to show an effect.⁵⁰ They were all historical cohort studies. One study performed both cleavage and blastocyst stage biopsy, of which the ratio with respect to the reference group was undisclosed,⁵⁴ complicating comparison as implantations rates are affected by the stage of embryo biopsy.^{24,25} The study by Goldman *et al.* included only 32 and 8 patients in the PGT-A and reference group, respectively, making it difficult to detect small but significant differences. The last study indicated a benefit from PGT-A with respect to clinical outcomes.³⁴ Comparison to clinical outcomes reported in most recent report from the ESHRE PGT consortium would have been interesting but are not meaningful due to the degree of heterogeneity between the two datasets. In conclusion, randomized controlled trials of sufficient size are needed to draw final conclusions on a clinical effect of PGT-A.

The issue of PGT-A is presently intensely discussed. In that regard, it is important that any debate and evaluation of PGT-A with respect to clinical outcomes is based and performed on a per transfer basis. This is important, since the purpose of PGT-A is to aid in prioritization of embryos for transfer. Hence, PGT-A is unlikely to enhance cumulative live birth rates, as cumulative transfer will ultimately lead to transfer of the “best” embryo in a given embryo cohort. In worst case, PGT-A might even decrease cumulative live birth rates as misdiagnosis can lead to viable embryos being discarded. On the other hand, PGT-A might decrease miscarriage rates, and reduce

time to live birth. One of the main arguments against the use of PGT-A is the current limited knowledge on how to interpret the result of a trophectoderm biopsy due to embryonic mosaicism, the presence of one or more genetically distinct cell lines within the embryo, which is reported to affect 3-24 % of human blastocysts.²¹ This may lead to false conclusions e.g. in case of isolated aneuploid groups of cells within the trophectoderm in an embryo with an euploid inner cell mass or vice versa. Only a few of the included publications report on mosaicism making it difficult to assess the impact. On top, information regarding how mosaic embryos are classified, and their corresponding transfer policy were rarely clear or provided. It should be kept in mind that aneuploidy rates will differ depending on whether mosaic embryos are classified as aneuploid or not, which is why this should always be detailed. The few rates of mosaicism reported in the included studies is in line with previous studies, showing that mosaic embryos constitute a small but potentially significant part of the embryo cohort, with potential to produce liveborn offspring.⁵⁷ In general, if aneuploidy screening is performed, and there is no euploid embryos available, mosaic embryos could be prioritized based on the chromosome(s) affected by aneuploidy, the type of aneuploidy and the degree of mosaicism detected,⁵⁷⁻⁶⁰ preferably according to guidelines presented by the Preimplantation Genetic Diagnosis International Society (PGDIS) and Controversies in Preconception, Preimplantation and Prenatal Diagnosis (COGEN).^{61,62} In general, each center utilizing PGT-A should develop evidence-based guidelines for embryo prioritization to ensure standardization of the treatment and transparency to both patients and peers.⁶³ Given the multitude of different factors influencing clinical outcomes following PGT-A, including the complex issue of mosaicism, even well documented guidelines need validation and may not be transferable from one center to another. Hence, comprehensive validation of PGT-A prior to clinical implementation seems necessary. Prospective, blinded, non-selection studies as performed and described by Scott *et al.* seems essential to evaluate the predictive value of PGT-A on a per center basis.⁶⁴ Such a study design allows direct measurement of the predictive value of ploidy calls with regard to their effect on clinical outcomes and hence provide the best possible data to guide the decisions on whether to apply PGT-A or not in PGT-M/SR in a given clinical setting. The predictive values might even be provided to patients when deciding whether to opt for PGT-A.

CONCLUSION

The current published literature reveals that aneuploidy affects one third of preimplantation human blastocysts, which upon transfer might lead to implantation failure, abortion or birth of affected children. Given these numbers, PGT-A concurrently with PGT-M/SR should in theory be able to enhance clinical outcomes on a per transfer basis, but the current available literature is sparse or of insufficient quality. Importantly, studies should seek to minimize impact from confounding variables such as the stage of biopsy and number of embryos transferred between the treatment and control group as well as seeking to compare age-matched cohorts. Although the available data may indicate an improvement in crude clinical outcome in accordance with expectations based on biological facts, routine use of PGT-A concurrently with PGT-M/SR with the aim of improving clinical outcomes are not supported by substantial evidence. Hence, randomized controlled trials are warranted and, preferably, should be accompanied by on site non-selection studies prior to implementation of PGT-A.

References:

1. Handyside AH, Penketh RJA, Winston RML, Pattinson JK, Delhanty JDA, Tuddenham EGD. Biopsy of Human Preimplantation Embryos and Sexing By Dna Amplification. *Lancet* 1989; 333: 347–349.
2. Harton GL, Tsipouras P, Sisson ME, et al. Preimplantation genetic testing for Marfan syndrome. *Mol Hum Reprod* 1996; 2: 713–5.
3. Verlinsky O, Rechitsky S, Cieslak J, et al. Preimplantation diagnosis of single disorders. *Tsitol Genet* 1998; 32: 14–22.
4. Zegers-Hochschild F, Adamson GD, Dyer S, et al. The International Glossary on Infertility and Fertility Care, 2017. *Fertil Steril* 2017; 108: 393–406.
5. De Rycke M, Goossens V, Kokkali G, Meijer-Hoogeveen M, Coonen E, Moutou C. ESHRE PGD Consortium data collection XIV-XV: Cycles from January 2011 to December 2012 with pregnancy follow-up to October 2013. *Hum Reprod* 2017; 32: 1974–1994.

6. Kirkegaard K, Ahlström A, Ingerslev HJ, Hardarson T. Choosing the best embryo by time lapse versus standard morphology. *Fertility and Sterility* 2015; 103: 323–332.
7. MacHtinger R, Racowsky C. Morphological systems of human embryo assessment and clinical evidence. *Reprod Biomed Online*. 2013;26:210-21.
8. Franasiak JM, Forman EJ, Hong KH, et al. The nature of aneuploidy with increasing age of the female partner: A review of 15,169 consecutive trophoctoderm biopsies evaluated with comprehensive chromosomal screening. *Fertil Steril* 2014; 101: 656-663.e1.
9. Menasha J, Levy B, Hirschhorn K, Kardon NB. Incidence and spectrum of chromosome abnormalities in spontaneous abortions: new insights from a 12-year study. *Genet Med* 2005; 7: 251–263.
10. Barash OO, Ivani KA, Willman SP, et al. Association between growth dynamics, morphological parameters, the chromosomal status of the blastocysts, and clinical outcomes in IVF PGS cycles with single embryo transfer. *J Assist Reprod Genet* 2017; 34: 1007–1016.
11. Capalbo A, Rienzi L, Cimadomo D, et al. Correlation between standard blastocyst morphology, euploidy and implantation: An observational study in two centers involving 956 screened blastocysts. *Hum Reprod* 2014; 29: 1173–1181.
12. Minasi MG, Colasante A, Riccio T, et al. Correlation between aneuploidy, standard morphology evaluation and morphokinetic development in 1730 biopsied blastocysts: A consecutive case series study. *Hum Reprod* 2016; 31: 2245–2254.
13. Taylor TH, Gitlin SA, Patrick JL, Crain JL, Wilson JM, Griffin DK. The origin, mechanisms, incidence and clinical consequences of chromosomal mosaicism in humans. *Hum Reprod Update* 2014; 20: 571–581.
14. Fragouli E, Alfarawati S, Spath K, Wells D. Morphological and cytogenetic assessment of cleavage and blastocyst stage embryos. *Mol Hum Reprod* 2014; 20: 117–126.
15. Alfarawati S, Fragouli E, Colls P, et al. The relationship between blastocyst morphology, chromosomal abnormality, and embryo gender. *Fertil Steril* 2011; 95: 520–524.
16. Munné S, Lee a, Rosenwaks Z, Grifo J, Cohen J. Diagnosis of major chromosome

- aneuploidies in human preimplantation embryos. *Hum Reprod* 1993; 8: 2185–2191.
17. Mastenbroek S, Twisk M, van der Veen F, Repping S. Preimplantation genetic screening: A systematic review and meta-analysis of RCTs. *Hum Reprod Update* 2011; 17: 454–466.
 18. Treff NR, Northrop LE, Kasabwala K, Su J, Levy B, Scott RT. Single nucleotide polymorphism microarray-based concurrent screening of 24-chromosome aneuploidy and unbalanced translocations in preimplantation human embryos. *Fertil Steril* 2011; 95: 1606-1612.e2.
 19. Ghevaria H, SenGupta S, Shmitova N, Serhal P, Delhanty J. The origin and significance of additional aneuploidy events in couples undergoing preimplantation genetic diagnosis for translocations by array comparative genomic hybridization. *Reprod Biomed Online* 2016; 32: 178–189.
 20. Fragouli E, Alfarawati S, Spath K, et al. The origin and impact of embryonic aneuploidy. *Hum Genet* 2013; 132: 1001–1013.
 21. Harton GL, Cinnioglu C, Fiorentino F. Current experience concerning mosaic embryos diagnosed during preimplantation genetic screening. *Fertil Steril*. 2017; 107: 1113–1119.
 22. Capalbo A, Bono S, Spizzichino L, et al. Sequential comprehensive chromosome analysis on polar bodies, blastomeres and trophoblast: Insights into female meiotic errors and chromosomal segregation in the preimplantation window of embryo development. *Hum Reprod* 2013; 28: 509–518.
 23. Liñán A, Lawrenz B, Khatib I El, et al. Clinical reassessment of human embryo ploidy status between cleavage and blastocyst stage by Next Generation Sequencing. *PLoS One* 2018; 1-13.
 24. Scott KL, Hong KH, Scott RT. Selecting the optimal time to perform biopsy for preimplantation genetic testing. *Fertil Steril* 2013; 100: 608–614.
 25. Scott RT, Upham KM, Forman EJ, Zhao T, Treff NR. Cleavage-stage biopsy significantly impairs human embryonic implantation potential while blastocyst biopsy does not: A randomized and paired clinical trial. *Fertil Steril* 2013; 100: 624–630.
 26. Dahdouh EM, Balayla J, García-Velasco JA. Comprehensive chromosome screening

- improves embryo selection: A meta-analysis. *Fertil Steril* 2015; 104: 1503–1512.
27. Lee E, Illingworth P, Wilton L, Chambers GM. The clinical effectiveness of preimplantation genetic diagnosis for aneuploidy in all 24 chromosomes (PGD-A): Systematic review. *Hum Reprod* 2015; 30: 473–483.
28. Gleicher N, Orvieto R. Is the hypothesis of preimplantation genetic screening (PGS) still supportable? A review. *J Ovarian Res* 2017; 10: 21.
29. Munné S, Kaplan B, Frattarelli JL, et al. Preimplantation genetic testing for aneuploidy versus morphology as selection criteria for single frozen-thawed embryo transfer in good-prognosis patients: a multicenter randomized clinical trial. *Fertil Steril*. 2019;112:1071-1079.e7.
30. Penzias A, Bendikson K, Butts S, et al. The use of preimplantation genetic testing for aneuploidy (PGT-A): a committee opinion. *Fertil Steril* 2018; 109: 429–436.
31. Anderson RE, Whitney JB, Schiewe MC. Clinical benefits of preimplantation genetic testing for aneuploidy (PGT-A) for all in vitro fertilization treatment cycles. *Eur J Med Genet* 2019; 103731.
32. Tan Y, Yin X, Zhang S, et al. Clinical outcome of preimplantation genetic diagnosis and screening using next generation sequencing. *Gigascience* 2014; 3: 30.
33. Wang J, Zeng Y, Ding C, et al. Preimplantation genetic testing of Robertsonian translocation by SNP array-based preimplantation genetic haplotyping. *Prenat Diagn* 2018; 38: 547–554.
34. Hou W, Xu Y, Li R, et al. Role of aneuploidy screening in preimplantation genetic testing for monogenic diseases in young women. *Fertil Steril* 2019; 111: 928–935.
35. Tobler KJ, Brezina PR, Benner AT, Du L, Xu X, Kearns WG. Two different microarray technologies for preimplantation genetic diagnosis and screening, due to reciprocal translocation imbalances, demonstrate equivalent euploidy and clinical pregnancy rates. *J Assist Reprod Genet* 2014; 31: 843–850.
36. Minasi MG, Fiorentino F, Ruberti A, et al. Genetic diseases and aneuploidies can be detected with a single blastocyst biopsy: A successful clinical approach. *Hum Reprod* 2017;

- 32: 1770–1777.
37. Xie Y, Xu Y, Wang J, et al. Preliminary analysis of numerical chromosome abnormalities in reciprocal and Robertsonian translocation preimplantation genetic diagnosis cases with 24-chromosomal analysis with an aCGH/SNP microarray. *J Assist Reprod Genet* 2018; 35: 177–186.
38. Tan YQ, Tan K, Zhang SP, et al. Single-nucleotide polymorphism microarray-based preimplantation genetic diagnosis is likely to improve the clinical outcome for translocation carriers. *Hum Reprod* 2013; 28: 2581–2592.
39. Bono S, Biricik A, Spizzichino L, et al. Validation of a semiconductor next-generation sequencing-based protocol for preimplantation genetic diagnosis of reciprocal translocations. *Prenat Diagn* 2015; 35: 938–944.
40. Volozonoka L, Perminov D, Korņejeva L, et al. Performance comparison of two whole genome amplification techniques in frame of multifactor preimplantation genetic testing. *J Assist Reprod Genet* 2018; 35: 1457–1472.
41. Christodoulou C, Dheedene A, Heindryckx B, et al. Preimplantation genetic diagnosis for chromosomal rearrangements with the use of array comparative genomic hybridization at the blastocyst stage. *Fertil Steril* 2017; 107: 212-219.e3.
42. Del Rey J, Vidal F, Ramírez L, et al. Novel Double Factor PGT strategy analyzing blastocyst stage embryos in a single NGS procedure. *PLoS One* 2018; 13: e0205692.
43. Fan J, Wang L, Wang H, et al. The clinical utility of next-generation sequencing for identifying chromosome disease syndromes in human embryos. *Reprod Biomed Online* 2015; 31: 62–70.
44. Xu J, Zhang Z, Niu W, et al. Mapping allele with resolved carrier status of Robertsonian and reciprocal translocation in human preimplantation embryos. *Proc Natl Acad Sci* 2017; 201715053.
45. Alfarawati S, Fragouli E, Colls P, Wells D. First births after preimplantation genetic diagnosis of structural chromosome abnormalities using comparative genomic hybridization and microarray analysis. *Hum Reprod* 2011; 26: 1560–1574.

46. Li G, Niu W, Jin H, et al. Importance of embryo aneuploidy screening in preimplantation genetic diagnosis for monogenic diseases using the karyomap gene chip. *Sci Rep*. 2018;8:3139.
47. Ben-Nagi J, Wells D, Doye K, et al. Karyomapping: a single centre's experience from application of methodology to ongoing pregnancy and live-birth rates. *Reprod Biomed Online*. 2017;35:264-271.
48. Colls P, Escudero T, Fischer J, et al. Validation of array comparative genome hybridization for diagnosis of translocations in preimplantation human embryos. *Reprod Biomed Online* 2012; 24: 621–629.
49. Idowu D, Merrion K, Wemmer N, et al. Pregnancy outcomes following 24-chromosome preimplantation genetic diagnosis in couples with balanced reciprocal or Robertsonian translocations. *Fertil Steril* 2015; 103: 1037–1042.
50. Goldman KN, Nazem T, Berkeley A, Palter S, Grifo JA. Preimplantation Genetic Diagnosis (PGD) for Monogenic Disorders: the Value of Concurrent Aneuploidy Screening. *J Genet Couns* 2016; 25: 1327–1337.
51. Zhang W, Liu Y, Wang L, et al. Clinical application of next-generation sequencing in preimplantation genetic diagnosis cycles for Robertsonian and reciprocal translocations. *J Assist Reprod Genet* 2016; 33: 899–906.
52. Zhang S, Lei C, Wu J, et al. The establishment and application of preimplantation genetic haplotyping in embryo diagnosis for reciprocal and Robertsonian translocation carriers. *BMC Med Genomics* 2017; 10: 60.
53. Treff NR, Fedick A, Tao X, Devkota B, Taylor D, Scott RT. Evaluation of targeted next-generation sequencing-based preimplantation genetic diagnosis of monogenic disease. *Fertil Steril* 2013; 99: 1377-1384.e6.
54. Rechitsky S, Pakhalchuk T, San Ramos G, Goodman A, Zlatopolsky Z, Kuliev A. First systematic experience of preimplantation genetic diagnosis for single-gene disorders, and/or preimplantation human leukocyte antigen typing, combined with 24-chromosome aneuploidy testing. *Fertil Steril* 2015; 103: 503–512.

55. Yin X, Tan K, Vajta G, et al. Massively Parallel Sequencing for Chromosomal Abnormality Testing in Trophectoderm Cells of Human Blastocysts. *Biol Reprod.* 2013;88:69.
56. Zimmerman RS, Jalas C, Tao X, et al. Development and validation of concurrent preimplantation genetic diagnosis for single gene disorders and comprehensive chromosomal aneuploidy screening without whole genome amplification. *Fertil Steril* 2016;105:286–294.
57. Greco E, Minasi MG, Fiorentino F. Healthy Babies after Intrauterine Transfer of Mosaic Aneuploid Blastocysts. *N Engl J Med.* 2015;373:2089–2090.
58. Sachdev NM, Maxwell SM, Besser AG, Grifo JA. Diagnosis and clinical management of embryonic mosaicism. *Fertil Steril.* 2017;107:6–11.
59. Spinella F, Fiorentino F, Biricik A, et al. Extent of chromosomal mosaicism influences the clinical outcome of in vitro fertilization treatments. *Fertil Steril.* 2018;109:77–83.
60. Victor AR, Tyndall JC, Brake AJ, et al. One hundred mosaic embryos transferred prospectively in a single clinic: exploring when and why they result in healthy pregnancies. *Fertil Steril.* 2019;111:280–293.
61. COGEN Position Statement on Chromosomal Mosaicism Detected in Preimplantation Blastocyst Biopsies - IVF-Worldwide, <https://ivf-worldwide.com/cogen/oep/publications/cogen-position-statement-on-chromosomal-mosaicism-detected-in-preimplantation-blastocyst-biopsies.html> (accessed 26 November 2019).
62. Cram D, Leigh D, Handyside A, et al. PGDIS Position Statement on the Transfer of Mosaic Embryos 2019. *Reprod Biomed Online.* 2019;39 Suppl 1:e1-e4.
63. Dimitriadou E, Melotte C, Debrock S, et al. Principles guiding embryo selection following genome-wide haplotyping of preimplantation embryos How to select and prioritize embryos during PGD following genome-wide haplotyping? *Hum Reprod* 2017; 32: 687–697.
64. Scott RT, Ferry K, Su J, Tao X, Scott K, Treff NR. Comprehensive chromosome screening is highly predictive of the reproductive potential of human embryos: A prospective, blinded, nonselection study. *Fertil Steril* 2012; 97: 870–875.

Supporting information legend:

Appendix S1. PubMed and Embase search strings.

Table and figure legends:

Table 1: Overview of the articles fulfilling criteria for inclusion.

Figure 1: PRISMA flowchart describing the screening process. PGT-M, preimplantation genetic testing for monogenic disorders; PGT-SR, preimplantation genetic testing for structural rearrangements; PGT-A, preimplantation genetic testing for aneuploidy.

Figure 2: Aneuploidy rates reported in human preimplantation blastocyst derived from couples receiving preimplantation genetic testing for inherited disorders. Aneuploidy rates for individual studies and weighted average (Top bar) is shown. Bars are ordered in descending order by the number of embryos analysed. MFA, mean female age.

Figure 3A: Proportion of embryos being suitable for transfer prior to (green) and post (blue) aneuploidy screening in couples receiving preimplantation genetic testing for inherited disorders. Individual studies and weighted average (Top bar) are shown sorted in descending order by the number of embryos analysed. P-values were calculated using Chi square test. PGT-A, preimplantation genetic testing for aneuploidy.

Figure 3B: The effect of aneuploidy screening on the proportion of embryos being suitable for transfer in couples receiving preimplantation genetic testing for monogenic disorders (blue) or

structural rearrangements (green). P-values were calculated using Chi square test. PGT-M: Preimplantation genetic testing for monogenic disorder; PGT-SR: Preimplantation genetic testing for structural rearrangements.

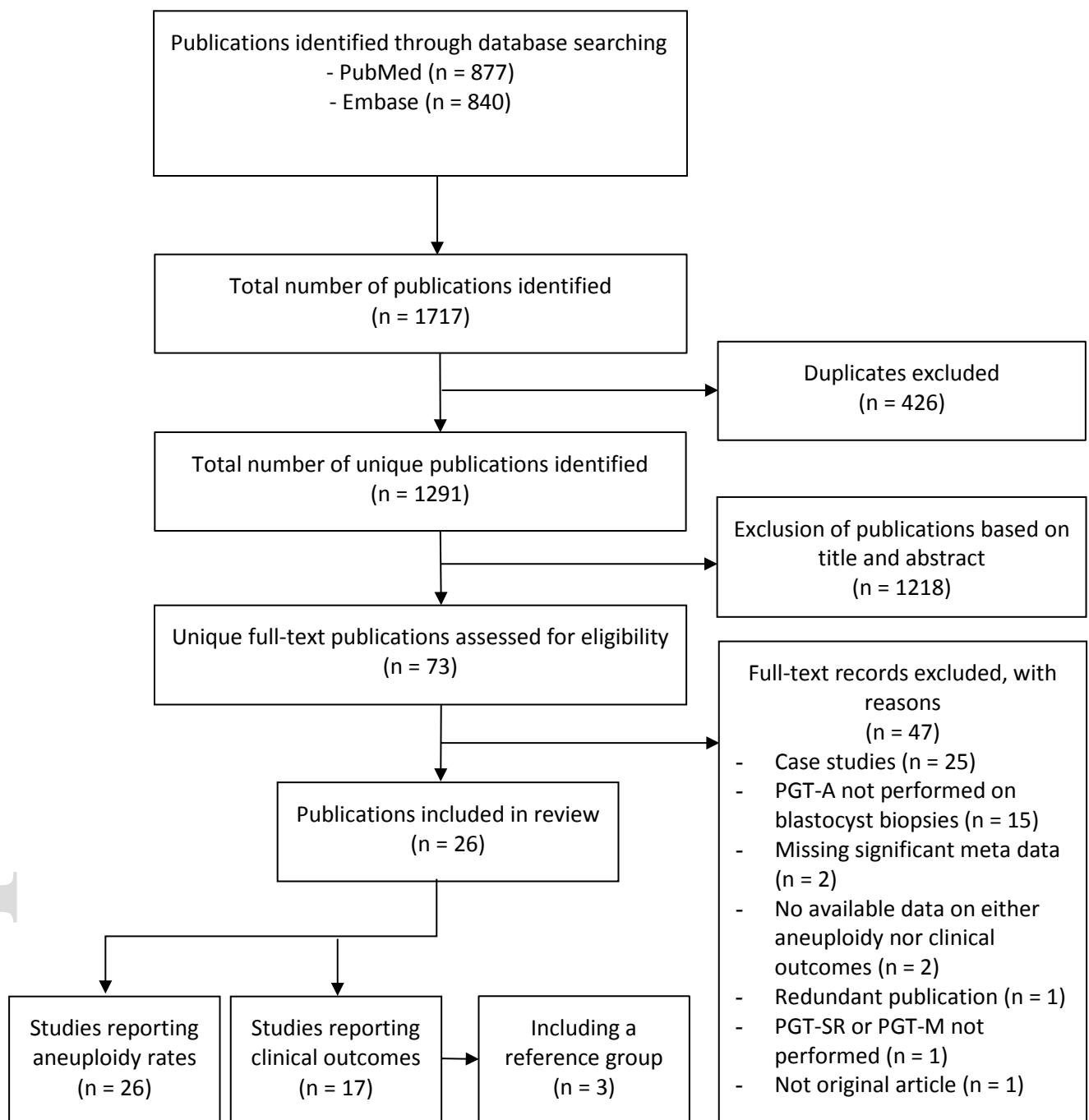
Figure 4: Clinical outcomes in the reference (blue) and PGT-A (green) groups reported by the three historical cohort studies by A) Rechitsky *et al.*,⁵⁴ B) Goldman *et al.*,⁵⁰ and C) Hou *et al.*.³⁴ D) The average number of embryos transferred in the reference and PGT-A groups in the four historical cohort studies. P-values marked with * were reported by the authors, while unmarked p-values were calculated for the purpose of this review using two sided Fischer's exact test. It should be noted that the p-value for differences in live birth rates reported by Goldman *et al.* was 1, which is impossible with the outcomes given.⁵⁰ Hence the correct p-value was calculated, and the corresponding author contacted to verify the correct P-value, which she reported as 0.43 in agreement with our calculation. Underlying numbers were not reported by Goldman *et al.*, which indicated by (-/-) in the figure 4B. PGT-A: Preimplantation genetic testing for aneuploidy.

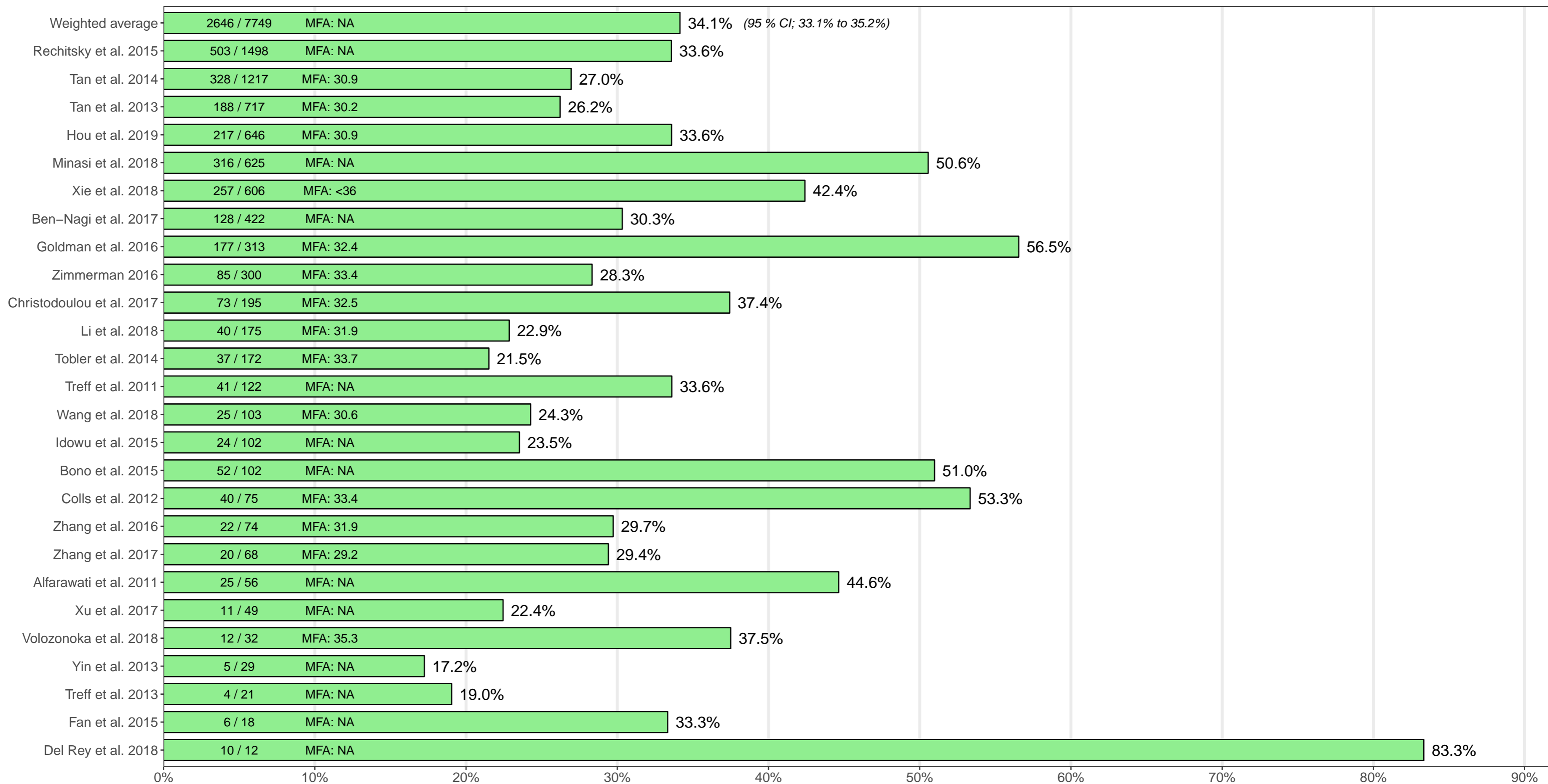
Table 1: Overview of the articles fulfilling criteria for inclusion.

Reference	Indication	Patients with blastocyst biopsy	Mean female age	Blastocysts successfully analyzed	PGT-A platform	Aneuploidy rate (%)	Clinical outcomes	Reference group included
Alfarawati <i>et al.</i> , 2011 ⁴⁵	PGT-SR	8	NA	56	CGH + aCGH	44.6	No	No
Treff <i>et al.</i> , 2011 ¹⁸	PGT-SR	18/15	NA/31.2	122	SNP array	33.6	Yes ^{a,b,c,e,f}	No
Colls <i>et al.</i> , 2012 ⁴⁸	PGT-SR	10	33.4	75	aCGH	53.3	No	No
Tan <i>et al.</i> , 2013 ³⁸	PGT-SR	169	30.2	717	SNP array	26.2	Yes ^{b,c,d,f}	No
Treff <i>et al.</i> , 2013 ⁵³	PGT-M	6	NA	21	NGS	19.0	No	No
Yin <i>et al.</i> , 2013 ⁵⁵	PGT-SR	14	NA	29	NGS	17.2	No	No
Tan <i>et al.</i> , 2014 ³²	PGT-SR	297	30.9	1217	NGS or SNP array	27.0	Yes ^{b,c,d,e,f}	No
Tobler <i>et al.</i> , 2014 ³⁵	PGT-SR	NA	NA	172	SNP array or aCGH	21.5	Yes ³	No
Bono <i>et al.</i> , 2015 ³⁹	PGT-SR	28	NA	102	NGS	51.0	No	No
Fan <i>et al.</i> , 2015 ⁴³	PGT-SR	3	NA	18	NGS	33.3	No	No
Idowu <i>et al.</i> , 2015 ⁴⁹	PGT-SR	NA	33.7	102	SNP array	24.0	Yes ^{a,c,f}	No
Rechitsky <i>et al.</i> , 2015 ⁵⁴	PGT-M	NA	NA	1498	SNP array	33.6	Yes ^{d,f,g}	Yes
Goldman <i>et al.</i> , 2016 ⁵⁰	PGT-M	47	32.4	313	aCGH	56.5	Yes ^{b,d,f}	Yes
Zhang <i>et al.</i> , 2016 ⁵¹	PGT-SR	16	31.9	74	NGS	29.7	No	No
Zimmerman <i>et al.</i> , 2016 ⁵⁶	PGT-M	43	33.4	300	qPCR	28.3	Yes ^{a,b,c,f}	No
Ben-Nagi <i>et al.</i> , 2017 ⁴⁷	PGT-M/PGT-SR	67	NA	422	Karyomapping	30.3	Yes ^{b,d,e}	No
Christodoulou <i>et al.</i> , 2017 ⁴¹	PGT-SR	34	32.5	195	aCGH	37.4	Yes ^{a,b,d,e,f}	No
Minasi <i>et al.</i> , 2017 ³⁶	PGT-M/PGT-SR	227	35.4/38.1	1067	aCGH	50.6	Yes ^{a,c,e,f}	No
Xu <i>et al.</i> , 2017 ⁴⁴	PGT-SR	16	NA	108	NGS	22.4	Yes ^f	No
Zhang <i>et al.</i> , 2017 ⁵²	PGT-SR	11	29.2	68	SNP array	29.4	Yes ^{f*}	No
Del Rey <i>et al.</i> , 2018 ⁴²	PGT-M	9	NA	12	NGS	83.3	No	No
Li <i>et al.</i> , 2018 ⁴⁶	PGT-M	36	31.9	175	Karyomapping	22.9	Yes ^c	No
Volozonoka <i>et al.</i> , 2018 ⁴⁰	PGT-M	9	35.3	32	aCGH	37.5	Yes ^{g**}	No
Wang <i>et al.</i> , 2018 ³³	PGT-SR	11	30.6	103	SNP array	24.3	Yes ^{g**}	No
Xie <i>et al.</i> , 2018 ³⁷	PGT-SR	NA	NA	606	SNP array	29.2	No	No

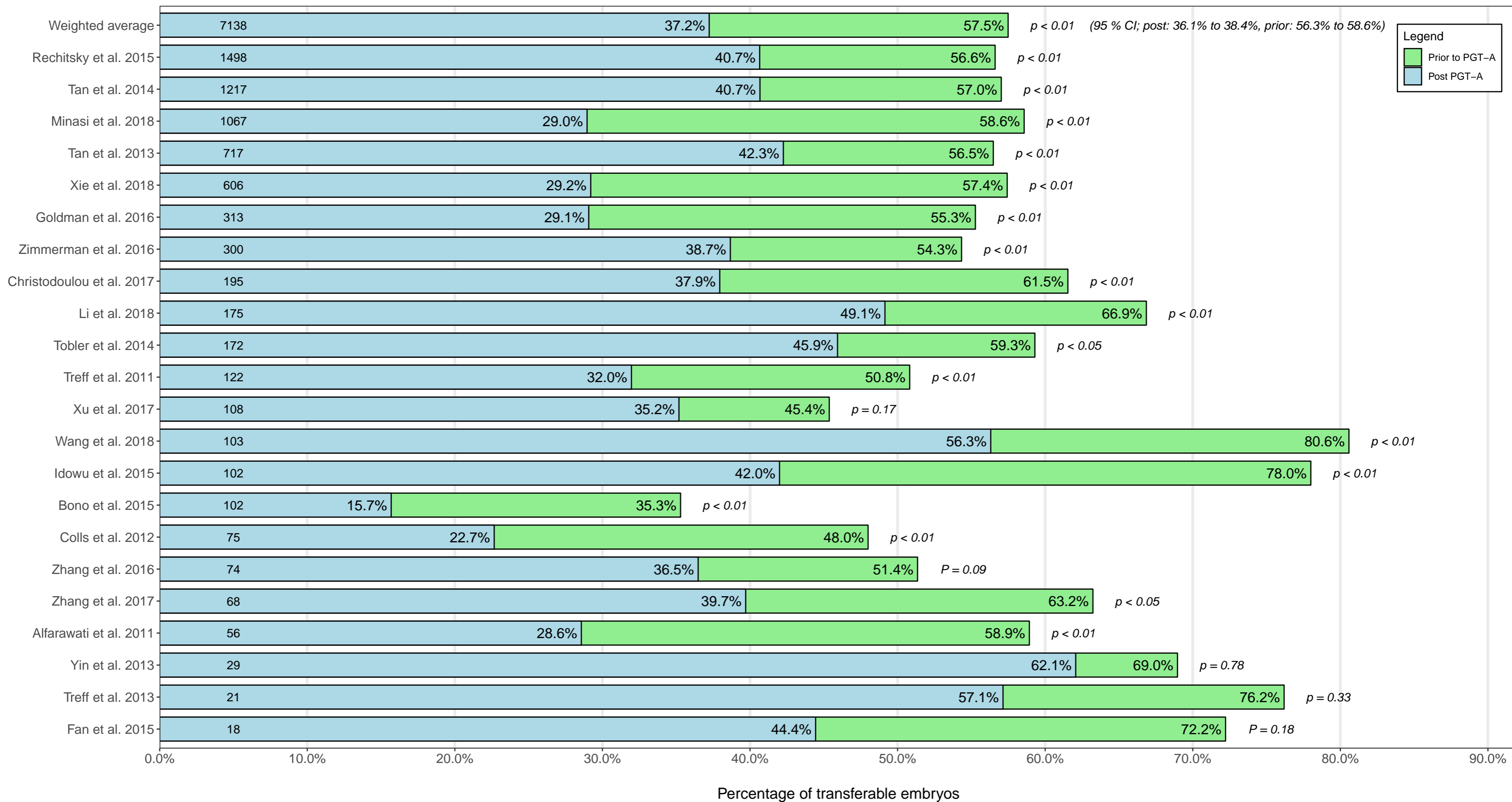
Hou et al., 2019 ³⁴	PGT-M	98	30.9	646	Karyomapping or NGS	33.6	Yes ^{b,d,e,f}	Yes
<p>Clinical outcomes reported: ^aPositive hCG; ^bGestational sacs/implantation rate; ^cFetal heartbeat/clinical pregnancy; ^dMiscarriage/spontaneous abortion; ^eOngoing pregnancy; ^fLive birth/delivery rate; ^gPregnancy (Not defined)</p> <p>*Report on outcomes from embryo transfer in one patient</p> <p>**Report on outcomes from embryo transfers in two patients</p> <p>Abbreviations: aCGH: Array comparative genomic hybridization; CGH: Comparative genomic hybridization; hCG: Human chorionic gonadotropin; NA: Not available; NGS: Next generation sequencing; PGT-A: Preimplantation genetic testing for aneuploidy; PGT-M: Preimplantation genetic testing for monogenic disorders; PGT-SR: Preimplantation genetic testing for structural</p>								

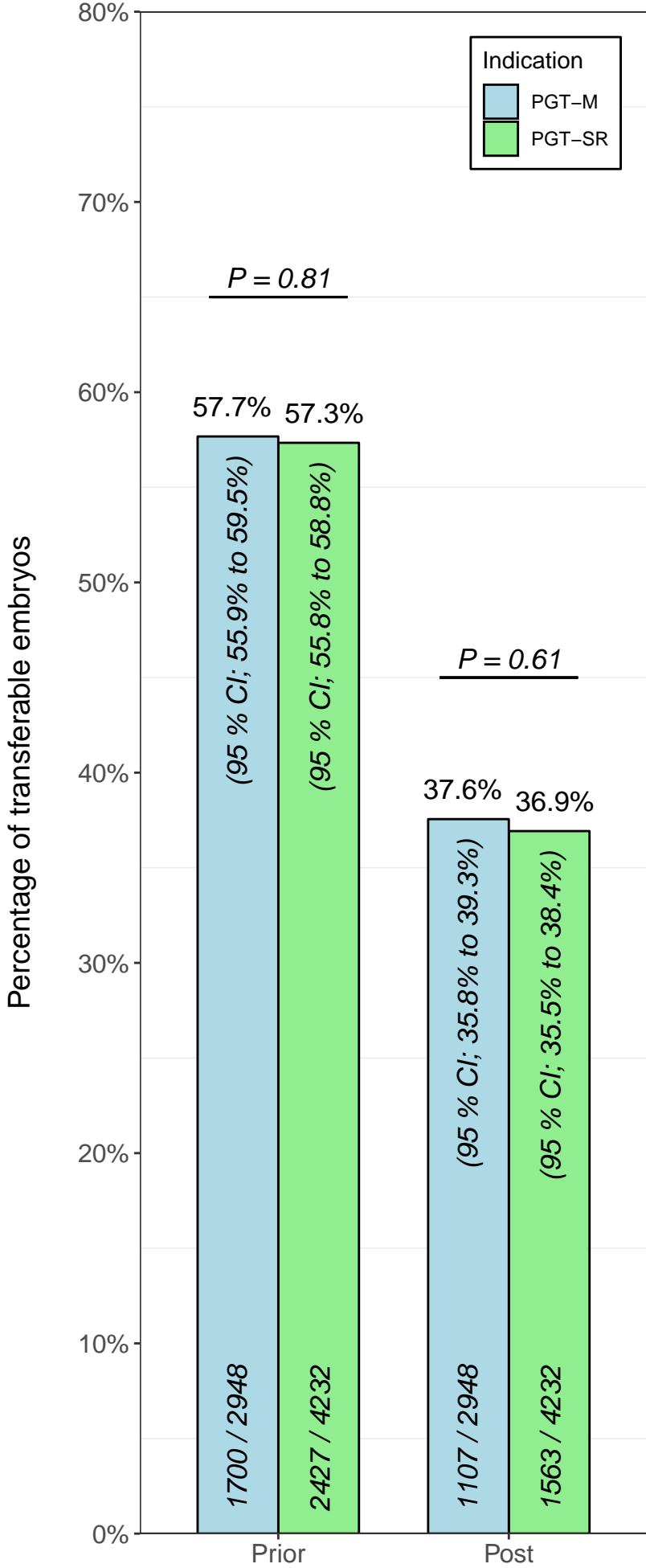
Screening flow diagram



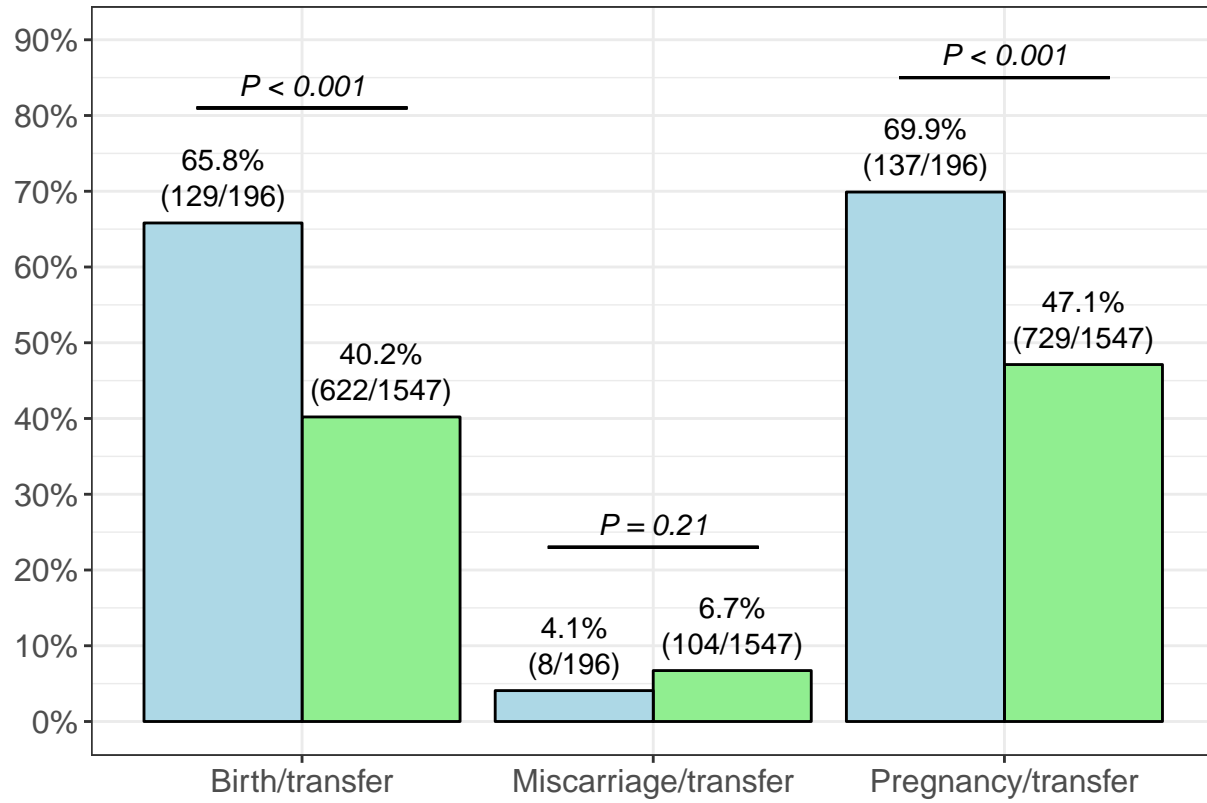


Aneuploidy prevalence

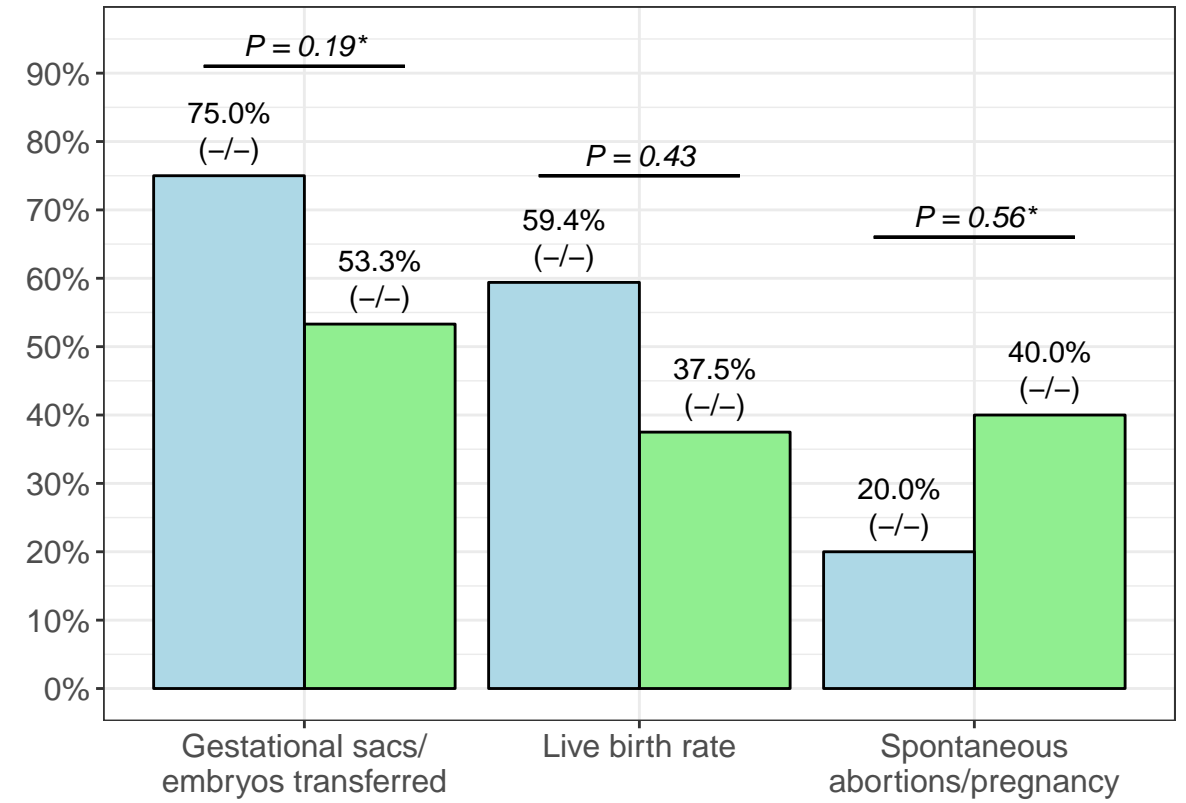




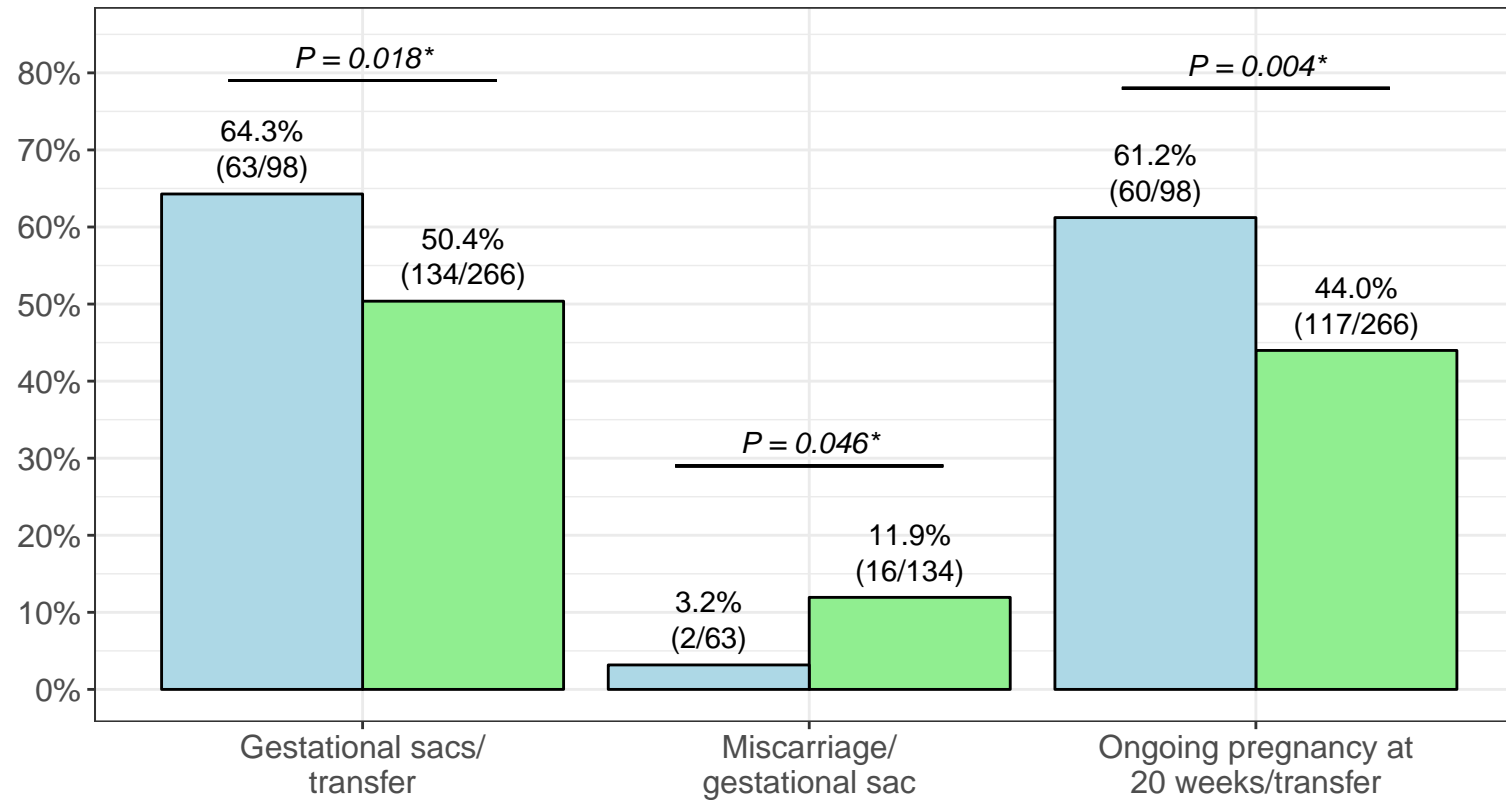
A) Clinical outcomes reported by Rechitsky et al. 2015



B) Clinical outcomes reported by Goldman et al. 2016



C) Clinical outcomes reported by Hou et al. 2019



D) Average number of embryos transferred

