transdermal testosterone for the last 4 weeks and late luteal phase start GH supplementation before the commencement of COH in DOR patients who had previously cancelled/failed IVF/ICSI cycles.

DESIGN: Retrospective analysis.

MATERIALS AND METHODS: We compared 44 cycles in 33 females that had resulted in cancellation or pregnancy failure with 37 cycles where a novel treatment protocol was applied which we called ISIK protocol (IP), consisting of 12 weeks of DHEA 75 mg/d in combination with 25 mg transdermal testosterone gel daily for last 4 weeks and late luteal start 3IU GH administration before the start of COH. We also define a control which was totally 51 patients that had 102 conventional IVF/ICSI cycles.

RESULTS: The duration of COH cycles, number of follicles >14 mm, number of oocytes, number of metaphase 2 oocytes and fertilisation rate were significantly higher in the IP. The clinical pregnancy rate per embryo transfer of the IP was 38.2% (13/34). The cancellation rate of cycles decreased significantly from 54.5 % (24/44) to 8.1% (3/37) with the IP, while the ongoing pregnancy rate was 35.3% (12/34 embryo transfer). However, CPR and OPR in control group were significantly lower than IP (22%, 10% respectively).

TABLE 1. Basal characteristics of study groups

	Conventional Protocol Control Group (n=128)	Conventional Group (n=44)	Isik Protocol (n=37)	p
Age	33,94±3,38	33,34±4,29		NS
FSH	14,49±14,78	11,7±12,9		NS
AMH	0,26±0,15	0,17±0.09		0,038
Duration of infertility	5,67±4,33	4,54±2.91		NS
E2 level on the day of hCG	598,15±683,09	491,68±464,34	520,6±566,78	NS
P4 level on the day of hCG	0,84±1,55	0,77±1,14	0,43±0,25	NS
Endometrium thickness	9,4±1,86	9,43±2,02	9,38±2,14	NS
Duration of COH	8,96±2,21	8,0±3,23	10,44±3,3	0,02
Total Gonadotrophin use	2253,12±1174,36	1869,07±1043,66	2307,03±1238,58	NS
The number of follicle >14mm	3,57±2,14	3,52±2,49	5,38±2,96	0,003
The number of oocytes	3,48±2,06	2,2±2,26	4,31±2,79	0,001
The number of M II	2,09±1,59	1,92±2,06	3,34±1,9	0,003
The number of GV	0,75±1,15	0,41±0,64	0,93±1,28	NS
Fertilisation rate	55,35±35,32	41,31±37,07	67,16±30,96	0,04
The number of transferred embryos	1,26±0,59	1,44±0,51	1,5±0,5	NS
The number of grade 1 embryos	0,32±0,58	0,5±0,61	0,34±0,48	NS
The number of grade 2 embryos	1,0±0,53	0,88±0,75	1,14±0,64	NS

CONCLUSION: Our study has shown that even the poorest responders could achieve clinical pregnancy after inducing ovarian folliculogenesis with a combination of transdermal testosterone, DHEA and GH.

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TEN YEARS EXPERIENCE WITH POOR RESPONDER PATIENTS FULFILLING BOLOGNA CRITERIA. B. Ozmen,[a] G. E. Pabuccu,[b] O. Kan,[a] M. Sonmezer,[a] C. S. Atabekoglu,[a] B. Berker,[a] R. Pabuccu.[b] [a]Ob&Gyn, Ankara University, Ankara, Turkey; [b]Ob&Gyn, Ufuk University, Ankara, Turkey.

OBJECTIVE: To compare the cycle outcomes of different regimens in poor responders undergoing IVF/ICSI.

DESIGN: Retrospective cohort study.

MATERIALS AND METHODS: Computerized data concerning COH and embryological outcomes of 534 patients who underwent COH for IVF/ICSI at Ankara University School of Medicine and at Centrum Clinic IVF Center between 2004 and 2013 were retrospectively analyzed. All patients had at least two of the defined features of bologna criteria. Patients were allocated to group 1 (Microdose flare-up, MF), group 2 (luteal estrogen protocol , LE), group 3 (Aromatase Inhibitor,AIs) and group 4 (GnRH antagonist, Gant). A sample size of 75 cases (totally 300 cases) per group is essential detect a difference in retrieved oocyte means (power of 81% and a P value set at 0.05) using a one-way ANOVA study and F-Test.

RESULTS: All data was demonstrated in Table 1. The pregnancy rates and COS outcomes were all found as lower as half in all groups when female partner age > 40 years-old.

Cycle and Stimulation Outcomes among Groups

(mean±sd)	Group 1:MF (n=110)	Group 2:LE (n=75)	Group 3:AIs (n=165)	Group 4: Gant (n=184)	P value
Age (year)	36,1±5,8	36,6±6,2	36,5±5,7	36,5±5,9	NS
Body mass index	24,6±2,6	24,1±1,8	25±2,4	24±2,2	NS
FSH (mIU/mL)	10,1±4,4	11,2±3,1	10,3±3	10,8±3,2	NS
AMH (ng/dL) (b)	1,3±0,7	1,2±0,6	1,1±1,0	1,3±0,8	NS
Gonadotropins used (IU)	3965±1628	3612±1155	3532±1007	3532±1007	NS
Peak E2 (pg/mL)(a)	1564±703	1936±701	839±534	1785±901	p 0,05
Cycle cancellation due to non-retrieved oocytes, or to	25,45% (28/110)	18,6% (14/75)	20,6% (34/165)	25% (46/184)	NS
Mean oocytes retrieved	4,9±0,6	4,8±0,7	4,2±0,6	4,5±0,5	NS
Fertilization rate (%)	78,8±21,0	84,3±22,2	82,8±19,1	82,8±19,1	NS
No. of embryos transferred	1,7±0,6	1,5±0,5	1,4±0,6	1,4±0,5	NS
Implantation rate (%)	9,39% (14/149)	9.37% (9/96)	8,5% (16/187)	9,74% (19/195)	NS
Clinical PRs (%)	12,7% (14/110)	12% (9/75)	9,7% (16/165)	10,3% (19/184)	NS
Clinical PRs (%) excluded cycle cancelations	17,1% (14/82)	14,75% (9/61)	12,21% (16/131)	11,6% (16/138)	NS
Ongoing PRs (%)	10,9% (12/110)	10,6% (7/75)	8,5% (14/165)	8,7% (16/184)	NS
Abortion rate (%)	18% (2/11)	22,2% (2/9)	12,5% (2/16)	15,8% (3/19)	NS

(a) Statistical importance found between group 3 vs others (b) In cases where AMH was studied and taken as a criteria (42.8%, 229/534)

CONCLUSION: Albeit innovations, still clinical and ongoing PRs were disappointing in poor responders fulfilling Bologna criteria.

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IS THERE ANY CLINICAL UTILITY TO MEASURING THE ESTRADIOL FLARE DURING MICRODOSE (MCD) FLARE CYCLES? T. G. Nazem, J. D. Kofinas, D. McCulloh, J. A. Grifo, A. Berkeley. Obstetrics and Gynecology, NYU School of Medicine, New York, NY.

OBJECTIVE: To determine if measuring the estrogen flare effect after two days of MCD Lupron in fresh IVF cycles is predictive of cycle outcome.

DESIGN: Retrospective study in an academic institution.

MATERIALS AND METHODS: A retrospective analysis of fresh MCD flare cycles (n=326) performed during the years 2006 through 2013 was undertaken. Subgroup analyses were performed on a cohort of patients who did not receive oral contraceptives (OCPs) prior to initiation of the cycle (n=89) versus those who did receive OCPs (n=237). MCD was usually initiated day 1 of the patient's menstrual cycle with baseline estradiol levels obtained. Estradiol levels were then repeated 48 hours later before the initiation of gonadotropins. The percent change in estradiol between these two time points was calculated. Main outcome measures included live birth, number of mature oocytes, number of grade 2 or better blasts and cycle cancellation. Receiver operator characteristic (ROC) curves were used to determine the predictive value of each measure.

RESULTS: Of the 326 patients, 72(22%) were cancelled and did not undergo retrieval. Patients were usually cancelled for poor response, defined as 3 or fewer follicles greater than 10mm. The subgroup of patients without OCP priming had 20 cancellations (22%) vs. 51 cancellations (22%) in OCP primed cycles. The area under the curve (AUC) for all patients for cycle cancellation was 0.67. For live birth, number of mature eggs greater than 6, and greater than two blastocysts grade 2 or better, the AUCs were 0.55, 0.56, and 0.58 respectively. Subgroup analysis in patients with no OCP priming showed AUCs for cycle cancellation, live birth, number of mature eggs