10.50 - 11.20

The search for excellence in IVF laboratories: Towards "the best" ESHRE Campus symposium Bologna, Italy 23-24 January 2009

Embryo and Blastocyst Morphology as a reflection of embryo viability

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Learning Objectives:

- > Why morphology for selection?
- > Introduction to the concept of Sequential Embryo Selection (SES) by morphology
- Define timing for SES
- Recap biological anomalies from day 1
- > Introduce biological background to anomalies on Day 2/3
- > Discuss the anomalies in the context of viability

Introduction

Why Morphology? Its All We Have!! (at present) Can it work? Yes if done correctly! If done with biology in mind. If done with strict QC/QA of performers When do you do it? Continually, carefully, <u>timed</u>, according to "biology"

Timing and Sequential Embryo Selection

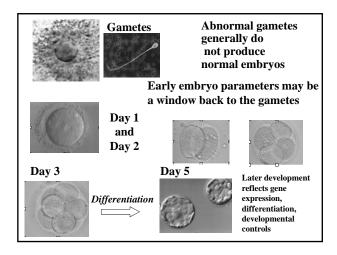
- Gamete and embryo selection needs to be dynamic
- Embryos are not static and more than one point in an embryos development should be used to decide the embryo for transfer
- Using a sequential embryo selection technique (*SES*), a profile of the developing embryo can be drawn/profiled.
- If morphology is coupled to biology the profile can then help in selecting embryos with the maximum potential for implantation.
- The key element in developing a scoring system that can be used in a repeatable manner is timing; when are observations made.

The Next Slide is the only one you need to remember and take home with you. To gather data and build a data base, and to compare data (within your programme and between programmes), you need to be comparing like with like.

SCORING TIME POINTS

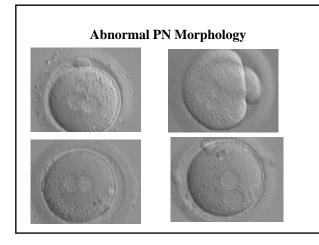
Time	hCG	ER	Insem.	D 1	D 2	D 3	D5
Point				Fert.	2-4 cell	6-8 cell	Blast
Hours/ hCG	0	36-37	40	57-59	82-84	104- 106	152- 154
Hours/ Insem.	0	0	0	17-18	42-43	64-65	112- 114

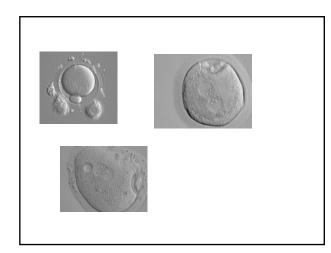
Most ER are 36-37 hours post hCG. Maximum mature (M11) occurs 40-41 h post hCG Time of maturation is important (Montag, 2008) Stabilized PN's are from 16-18 hours post insem. EC will start at 20 h post insem *Timing Timing Timing*



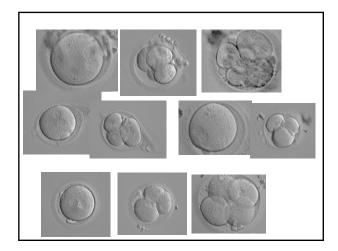
Day 1 Morphology

- > PN Score- Fertilized Oocyte Score
- ➤ Polarity
- > Pre- vs. post- zygotic modifications for aneuploidy
- > Earliest evaluation of the "unique embryo"
- ➤ Timing is crucial
- > Ability to see in 3D is crucial
- > Understanding the 3D nature of the nucleus, the spindle and how it moves is crucial
- > Training/education/ knowledge is more important than a machine





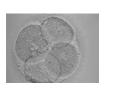


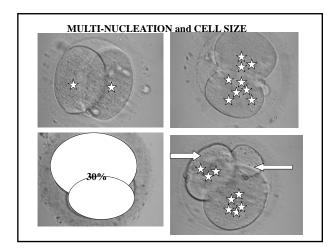


Day 2 Morphology/ Scoring

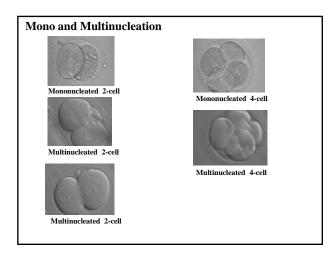
- Cell number
- Blastomere relative size
- Status of nucleation
- Fragmentation
- Timing is important
- Embryos are very dynamic on Day 2

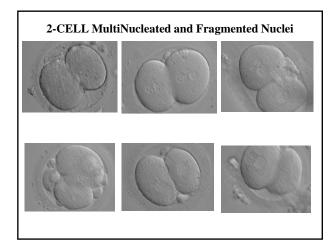








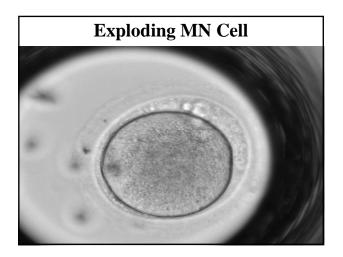


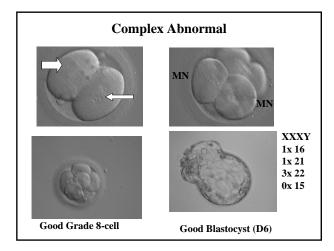




What are the origins of MN? What happens with MN?

- Fragmented Nuclei vs. Multi nucleation (Circay et al.,
- Karyokinesis without Cytokinesis (>1 cell)
- Duplication of the MTOC
- May act like 3PNs and explode
- Result in fragmented nuclei and aneuploidy
- Meriano et al. 2004/ Hardarson et al. 2001/ Moriwaki et al. 2004/Pickering et al. 1995/ Scott et al, 2007/ Kligman et al. 1996, Sorimachi et al., 1998

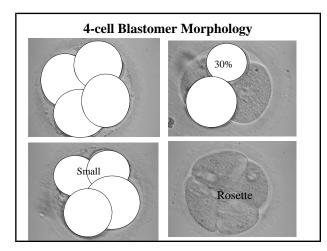




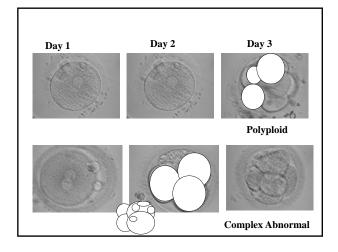


Day 2 Cell Size Why is it important?

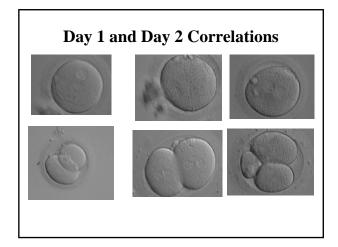
- Polarity
- Distribution of cell components
- Embryo axes
- The meiotic and mitotic spindle
- Hardarson et al., 2001; Van Royen et al., 2001; Hnida et al., 2004 Antczak , 1997 Roux et al.1995, Gardner R, 2066, Ciray et al, 2005



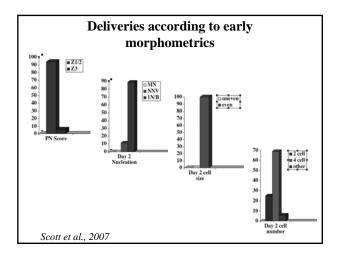




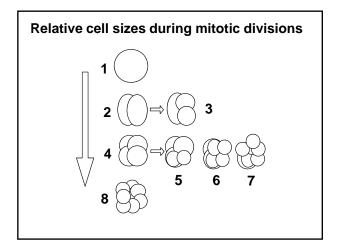




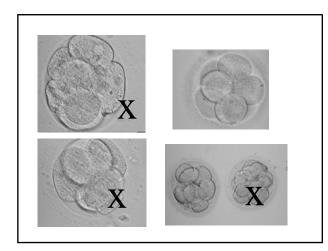




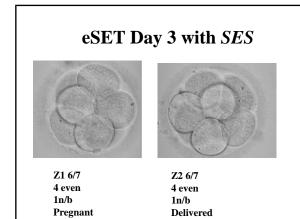


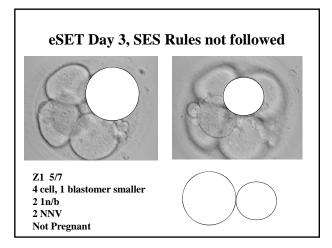


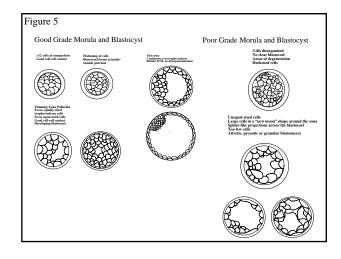




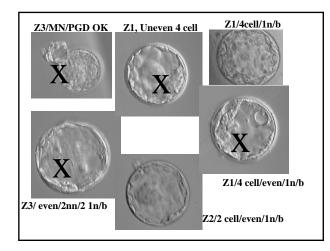




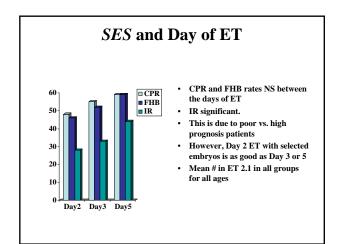












Day 2 ET Criteria Based on previous cycles

- > 3rd cycle without conception
- > Previous cycle with <50% cleavage D2-D3
- Severe male factor with <50% fertilization
- > Previous failed Tesa/Pesa cycle
- ≻ Previous failed PGS cycle

Prospective Randomized Trial Day 2 vs. Day 3

- ≫3 or greater cycle, <38, no severe male factor or female pathology
- >Intended 120 in each arm
- Interim analysis at 60 in each arm, because of a clinical outcome bias we were seeing

