Conclusions: Elevated P levels the day of hCG administration induce a significant alteration on the gene expression profile of the endometrium at the time of implantation, with respect to normal P levels. These data prove the concept that the poorer outcome of IVF cycles when P is high the day of hCG administration is due to an impaired endometrial receptivity.

POSTERS

ETHICS AND LAW

P-306 A five-year experience with gestational surrogacy and the impact of legal changes

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Introduction: Since the introduction in 2007 of a law on artificial reproductive techniques (ART) treatments in Belgium, surrogacy treatment must fit in this legal framework. We want to present our five-year experience in this subject. In this article we restrict us to gestational surrogacy where the role of the surrogate mother is purely gestational and the child is genetically related to both of the intended parents.

The demands, procedure and outcomes of gestational surrogacy in the fertility clinic of the Ghent University were carefully examined during the period of January 2004 up to February 2009.

Material and Methods: We received 26 demands for gestational surrogacy. The medical indications for these requests could be devided in two subgroups: 1) absence of the uterus: a) histerctomy (n = 12), b) Mayer-Rokitansky-Kuster-Hauser syndrome (n = 9), 2) others (5): a) repeated miscarriage (n = 1), b) repeated fallure of IVF (n = 2), c) maternal medical risk caused by pregnancy (n = 2). Requests could only be taken under consideration if the intended parents provided their surrogate mother. No surrogacy on commercial base was accepted.

In 19 out of the 26 demands the candidate surrogate mother was a close family member (n = 7 mothers of the intended mother, n = 6 sisters, n = 1 mother in law, n = 5 sister in law), in 4 requests the candidate surrogate mother was a close friend, in three cases there was no close relationship. The average age of the intended mothers was 30.5 (20-40). The average age of the surrogate mothers was 39.3 (25-56).

Procedure: During a first contact both intended and surrogate mother underwent a profound gynaecological and general medical examination. Next both intended parents and the surrogate mother (and her partner) were counselled by a psychologist. All demands were presented at the fertility staff meeting. If accepted, all parties involved were seen by a psychiatrist (as an independent adviser), who then presented the cases for the ethical committee of our hospital. It is the ethical committee who gives the final advise concerning acceptation for treatment.

Results: Out of the 26 demands, 16 were presented to the ethical committee. Six of these requests received a positive advice to start a treatment. Three of them had a successful treatment that ended in the delivery of a healthy single child. Two couples got healthy twins. Due to unforeseen medical problems of the surrogate mother, one couple could not proceed with a treatment.

All accepted cases had a surrogate mother who was close family to the intended parents. The major medical indication for treatment was the Mayer-Rokitansky-Kuster-Hauser syndrome (5 out of 6). In one case surrogacy was the only solution after a hysterectomy following a severe labour complication in which the foetus deceased.

In 4 out of these 5 cases the adoption procedure was finished successfully. One case is still ongoing.

Compared to a previous evaluation (2007) in which we reported a three year experience of 21 surrogacy requests we can evaluate the impact of the 2007 ART legislation on surrogacy treatment. Where the surrogate mother was before 2007 in most of our cases the mother of one of the intended parents, these requests, due to the introduced age limitations of treatment of the surrogate mother (47 years of age), are now rejected and intended parents have to search for younger candidates.

Conclusions: The introduction in Belgium of an ART legislation in 2007, regulating age limits of treatment, has an impact on the surrogacy requests in our hospital. Where before the surrogate mother was in most of our requests the mother of one of the intended parents, now younger surrogate mothers have to be found. It seems to be more difficult for the intended parents to find a suitable and reliable surrogate mother.

We think there is still a need for a specific legislation on surrogacy to make the process less complex and give involved parties more assurance during the process.

P-307 In limbo: legalization of children born abroad through surrogacy

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People willing to become parents through surrogacy will always find a way to do it – there are countries where surrogacy is perfectly legal (Belarus, India, Russian Federation, Ukraine, USA etc.). Liberal legislation, low prices and closeness to Europe make former "soviet" republics, now members of the C.I.S. (Commonwealth of Independent States) attractive for "reproductive tourists" looking for techniques not available in their countries, surrogacy among them. Of course there is always concern that the surrogate might keep the baby, but there are some countries where it's not an issue anymore (e.g. Armenia, Belarus, Kazakhstan, Kirgizia, Ukraine) no surrogate's consent is required to enter the parents' names in the book of births. So the most important issue is the legal status of a child born through surrogacy and how to return home with a new born.

If for example delivery in a gestational surrogacy program takes place in Russia, commissioning parents obtain a Russian birth certificate with both their names on it, as if intended mother delivered herself. Surrogate's name is never mentioned. Genetic relation to the child (in case of donation) doesn't matter, there is no any requirement for the child to be genetically related to at least one of the commissioning parents (like in Ukraine). No adoption is needed.

Problems might occur only in the consulate when parents apply for national documents for their child. Normally consular officers ask no questions. But sometimes certain consulates' officials (e.g. Germany, Spain, Sweden) suspect that a surrogacy program was arranged and refuse to issue any documents on the grounds that surrogacy is illegal or not regulated in their respective countries.

To address the issue the parents should make an apostille according to the Hague Convention of Oct. 05th, 1961. When it's made, the legal fact of the childbirth and the origin of the child established by Russian authorities should be recognized automatically in any country that signed this convention. Legal facts can be established only once.

So apostille makes the whole issue just paper work. It will have nothing to do with surrogacy anymore. The question is not if a surrogacy program was performed or not. It's whether a foreign birth certificate with an apostille is valid or not in a country where the intended parents come from. And the answer to this question is always positive – yes, it's valid - if their country signed the convention.

In our seven years experience of registering children born to foreigners through surrogacy in Russia and Ukraine there hasn't been a single case when the parents were unable to return home with their new born, it was just an issue of time (3,5 weeks as longest) and how stubborn the consular officers were. In the worst case intended parents from Spain filed a suite for the European court of Human rights, this only fact resolved the issue and they got the documents the next day.

Of course any delays in issuing travel documents for new born children are against children's best interests, against a number of international conventions. It's a discrimination against children's rights and can't be tolerated. Children should not suffer from laws that are not perfect and from incompetence of consular officers, can't get caught in limbo. Intended parents should be informed about their rights, international conventions and existing law-applying practice.

When choosing a destination for surrogacy, intended parents should get to know whether this country signed the Hague convention of Oct. 05th, 1961. A consultation of a lawyer specialized in reproductive and family law is strongly recommended.

P-308 Socio-ethical considerations in the recruitment of volunteers when acquiring eggs for stem cell research

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Introduction: This paper presents some initial findings from our socio-ethical evaluation of a unique scheme that provides human eggs for somatic cell nuclear transfer (SCNT) research. SCNT research has provoked controversy and criticism since its inception, a discourse compounded by the Hwang scandal and given further impetus by the development of induced pluripotent stem cells. During this phase a research group in Newcastle, UK, has continued work on SCNT. In late 2007 they obtained licensing and funding for a scheme they hoped would reduce the perceived bottle-neck in their research, the shortage of human eggs. The Newcastle 'egg sharing for research' scheme mirrors the established practice of egg sharing for treatment in offering women a half price IVF cycle in exchange for half the eggs in that cycle.
Methods: Our qualitative study uses both documentary data and semi-structured interviews with women who have been accepted onto the egg sharing scheme, some of whom went on to provide eggs for research, others of whom did not. We have also interviewed women who volunteered but were not accepted onto the scheme, as well as women who have provided eggs for the treatment of others. Finally, interviews with fertility centre staff will give us insight into the views of those professionally involved in the scheme.

We aim to identify the major themes arising from interviews and documents through the hermeneutic analysis of transcripts and texts, using constant comparison and category building procedures. This will be followed by category mapping and deviant case analysis.
Results: We have completed an analysis of the unusual strategy the researchers adopted in order to recruit women for the scheme. The clinic hoped to avoid legitimate ethical concerns about directly recruiting women to provide eggs, by adopting a 'passive recruitment' strategy. That is, the existence of the scheme was drawn to the attention of potential volunteers through media coverage (newspapers and radio / television programmes) in the hope that women would come forward to volunteer for the scheme. Our analysis had a dual focus; the way in which the media reported the scheme and the way in which the media were used to recruit volunteers to provide eggs.

Our analysis focused on a series of press releases issued over nine months which formed the basis of many stories in the UK media. This exposure kept the scheme in the public domain over the first year of its operation. In general the stories were framed in a similar way to the press releases, although most also included some critical voices. The stories initially focussed on how the scheme could offer a reduction in the cost of IVF treatment and later reported positive aspects of the scheme, such as the number of women coming forward and the number of successful pregnancies. However, a clear omission from the reporting (and the criticism) was the views of women seeking IVF treatment.
Conclusions: It is premature to discuss any findings from the interview analysis as this is not yet complete. However, analysis of the media reporting suggests that the researchers chose a successful strategy to bring the scheme to the attention of the public they wished to recruit from.

In contrast to the findings of previous research, this particular human cloning story was not framed only in terms of controversy but was generally reported positively. This was achieved by focussing on the women volunteers and minimising attention on the research. Further work on our analysis will help to understand whether the ethical concerns about direct recruitment of providers of reproductive tissue to stem cell research were adequately addressed by adopting this 'passive recruitment' strategy.

P-309 A descriptive study of oocyte, blood, and organ/tissue donation features among fertility patients in Ireland

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Introduction: A landmark December 2009 Supreme Court decision addressing the advanced reproductive technologies in Ireland has focused needed attention on the need for legislation to regulate fertility services in Ireland. To inform this public policy challenge, the current investigation examined features of anonymous oocyte donation and participation in organ and blood/tissue donation programmes among fertility patients in Ireland.
Material and Mehtods: Demographic and clinical information was prospectively collected from 337 female infertility patients by anonymous questionnaire to determine their status as a registered organ/tissue donor. Data from patients who themselves had been blood donors (or who had ever received an anonymous blood transfusion) were recorded; patient perceptions about anonymous donor oocyte compensation were also tabulated.
Results: At study entry, 56.7% of patients had no children, and none had participated in a donor oocyte programme either as donor or recipient. Before initial consult, 19.6% had previous in vitro fertilisation (IVF) experience (range of prior cycle number = 1-12). In our sample, more than one third (35.9%) of patients had donated blood anonymously, 19.9% were organ/tissue donors, and 52.2% indicated that anonymous oocyte donors should receive some compensation. Average recommended compensation for anonymous oocyte donors was €2177 (range €200-€9500), with most patients (77.2%) supporting confidential protections for recipient and donor identity.
Conclusions: This is the first study to assess blood and organ/tissue donation features among fertility patients in Ireland, and frame such findings in the context of anonymous oocyte donation. We found the rate of blood donation among fertility patients to be more than ten times higher than the rate measured in the general Irish population. Prior blood donor experience was more common than self-designated status as an organ/tissue donor, but neither donation type correlated with age, education or other characteristics. Protection of anonymity for both donors and recipients was favoured by most patients, even those antagonistic to compensated anonymous donation. These observations, if corroborated by future studies in Ireland, will be crucial as regulations on anonymous donor gamete treatments are crafted here. Further studies should clarify patient perceptions about oocyte donation as a function of their involvement in organ/tissue procurement programmes and blood banks.

POSTERS

SAFETY & QUALITY (I.E. GUIDELINES, MULTIPLE PREGNANCY, OUTCOME, FOLLOW-UP ETC.)

P-310 Serum anti-müllerian hormone and inhibin B levels as predictive markers of ovarian hyperstimulation syndrome (OHSS) in IVF patients

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Introduction: Ovarian Hyperstimulation Syndrome (OHSS) is a severe health complication observed in some patients undergoing controlled ovarian stimulation (COS) during IVF.

However prediction of OHSS prior to controlled ovarian stimulation in an individual IVF treatment cycle using only age and body mass index(BMI) remains a difficult task Monitoring the serum E2 level and number of follicles heve been effective in reducing the incidence of OHSS but these are determined near the completion of COS.

The aim of this study was to find whether serum concentration of anti- müllerian (AMH) and inhibin B in patients undergoing IVF treatment may serve as a predictor of OHSS.
Material and Methods: A cohort of 106 women undertaking the IVF program was investigated prospectively,to evaluate the predictive value for OHSS by means of certain risk factors,including age,body mass index(BMI),day 3 serum E2 FSH,LH,AMH,inhibin B and antral follicles count (AFC) at Istanbul University Cerrahpasa Medical Faculty,IVF unit.Patients were included in the study if they presented moderate or severe OHSS criteria descripted by Navot.

Women participating in this study followed a long or short GnRH agonist protocol that began with daily s.c. injections of 0.1 mg leuprolide acetate,on day 21 of the prestimulated cycles(long protocol) or on day 1 of the stimulation