

TURNER SYNDROME & EP 1690

REPRODUCTIVE COUNSELING

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CENTRO DE PRESERVAÇÃO DA FERTILIDADE

CHUC
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INTRODUCTION

Spontaneous fertility in Turner syndrome (TS) is rare, due to low or absent ovarian reserve. A greater number of ovarian follicles is present in the cases of gonadal mosaicism, although the accelerated pace of apoptosis remains. Thus, the early referral to reproductive counseling is advisable, ideally soon after diagnosis. The cryopreservation of oocytes is one of the options for fertility preservation. The authors present a series of 7 patients with TS admitted in Reproductive Medicine Department between 2012 and 2015.

CASE REPORTS

PATIEN

33 years

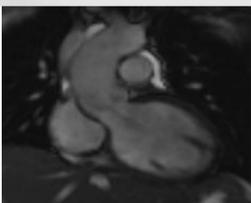
Karyotype 45,X (previous follow-up in Primary Care only)

Amenorrhea + Primary infertility

Low ovarian reserve (FSH 84; Estradiol 19; atrophic uterus and ovaries)

AngioMR:

Insufficient bycuspid aortic valve. Morphology of the aortic arch suggests coarctation, with post-stenotic dilation.



Counseling about **oocyte donation**
Counseling about the cardiovascular risks of pregnancy
Endocrinology referral.

PATIEN

24 years

Karyotype 45,X

Admitted for fertility preservation

AMH: 0,32 ng/mL

After the 2nd oocyte stimulation cycle (OSC)

Corifolitropin alfa 150µg D1
Ganirelix 0,25 mg D6-D8

Has 1 cryopreserved MII oocyte

PATIEN

37 years

Karyotype 45,X/46,XX

Secondary infertility (in vitro fertilization with pregnancy 3 years)

AMH: 0,74 ng/mL

After 2 OSC **without success**

3rd OSC

ICSI after short protocol with Flare up

Triptorelin 0,1 mg D1-D8 + hMG 300 UI D1-D8

3 MII oocytes → 1 embryo

(not transferred due to lack of development to blastocyst phase)

PATIEN

16 years

Karyotype 45,X/46,XX

Admitted for fertility preservation

AMH: 4,5 ng/mL; AngioMR: normal

After the 1st OSC

Short Protocol with antagonist

FSH 150 UI id D1-D9

Cetrorelix 0,25 mg id D6-D9

Has 11 cryopreserved MII oocytes

PATIEN

33 years

Primary infertility

Karyotype 45,X/46,XX

AMH: 1,9 ng/mL

After 1st OSC

FSH 200 UI D1-D6; 300 UI

D7-12

Ganirelix 0,25 mg D9-D12

3 MII oocytes → 2 embryos

Not transferred due to lack of development to blastocyst phase)

PATIEN

24 years

Karyotype 45,X

Admitted for fertility preservation

Low ovarian reserve (FSH 84; Estradiol 19; atrophic uterus and ovaries)

Pregnancy was contra-indicated

AngioMR:

Insufficient bycuspid aortic valve. Morphology of the aortic arch suggests coarctation, with post-stenotic dilation.



PATIEN

33 years

Karyotype 45,X

Primary Infertility

Ovarian atrophy + Mild aneurism of ascending aorta

Counseling about **oocyte donation**
Counseling about the cardiovascular risks of pregnancy

CONCLUSION

These 7 cases illustrate the **complexity** of reproductive counseling in these patients. **Early referral** increases the probability of success in oocyte preservation. The **ovarian reserve**, **structural cardiovascular disease** and **ethical problems** condition the therapeutic options.

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