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.

**INTRODUCTION**

**CASE REPORTS**

**PATIENT 1**
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)

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

**PATIENT 2**
24 years
Karyotype 45,X
Admitted for fertility preservation

AMH: 0.32 ng/mL

After the 2nd oocyte stimulation cycle (OSC)

Corifollitropin alfa 150µg D1
Ganirelix 0.25 mg D6-D8

Has 1 cryopreserved MII oocyte

**PATIENT 3**
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)

**PATIENT 4**
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

**PATIENT 5**
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)

**PATIENT 6**
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 bicuspid aortic valve. Morphology of the aortic arch suggests coarctation, with post-stenotic dilation.

**PATIENT 7**
33 years
Primary infertility
Karyotype 45,X

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.