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DOES PREIMPLANTATION GENETIC TESTING FOR ANEUPLOIDY (PGT-A) IN DONOR EGG RECIPIENTS ALTER TIME TO LIVE BIRTH?

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Title:
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All Other Categories

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Abstract Text:
OBJECTIVE: PGT-A augments embryo selection in the IVF setting. Clinical opinion remains divided on the benefit of PGT-A for patients using donor oocytes. To date, studies have not demonstrated that using PGT-A to screen embryos derived from donor oocytes is beneficial for pregnancy outcomes, including live birth rate. This study aims to examine whether PGT-A is associated with the number of embryo transfers (ETs) required or time to live birth in patients using donor oocytes.

MATERIALS AND METHODS: This retrospective cohort study, performed at a large academic-affiliated practice, compared patients who used or did not use PGT-A during donor oocyte IVF from 2016 to 2024. Patients were included if they achieved at least one live birth (LB). Fresh or frozen donor oocytes and fresh or frozen single ETs were included. Patients who used gestational carriers or had a diagnosis of recurrent pregnancy loss or intracavitary abnormality were excluded. The primary outcome was number of ETs to achieve first LB. Secondary outcomes were days from first ET to first LB, number of clinical pregnancies and clinical pregnancy losses (SABs) per patient and per ET. Wilcoxon rank sum test, chi-square test, and multivariate logistic regression were used to compare outcomes between PGT-A and no-PGT-A groups.

RESULTS: The study included 312 patients (n = 479 ETs) who used PGT-A and 317 patients (n = 448 ETs) who did not use PGT-A. Mean oocyte age was 26.9 ± 3.2 for the PGT-A group and 27.0 ± 3.1 for the no-PGT-A group ($p = 0.50$). The number of ETs required to achieve LB was 1.48 ± 0.89 for the PGT-A group and 1.45 ± 0.85 for the no-PGT-A group ($p = 0.77$). The number of days between first ET and first LB was 315.5 ± 175.8 for the PGT-A group and 307.7 ± 170.1 for the no-PGT-A group ($p = 0.38$). The number of SABs per patient was 0.1 ± 0.3 for both groups ($p = 0.74$) and the number of clinical pregnancies per patient was 1.1 ± 0.3 for both groups ($p = 0.74$).

After adjusting for oocyte age, recipient age and BMI, endometrial thickness at ET, embryo quality, and fresh vs. frozen oocytes, there was no association between PGT-A and number of ETs required to achieve LB ($p = 0.17$). Logistic regression fitted with generalized estimating equation and adjusting for the same variables also found no association between PGT-A and odds of SAB per ET (OR = 0.96 for no-PGT-A compared to PGT-A; 95% CI [0.53-1.75]) or clinical pregnancy per ET (OR = 0.78 for no-PGT-A compared to PGT-A; 95% CI [0.50-1.21]).

CONCLUSIONS: PGT-A in donor oocyte IVF was not associated with number of transfers or time to live birth. Larger studies may reveal smaller differences, and the use of PGT-A as an embryo selection tool should be considered in discussions between patients and healthcare providers.

IMPACT STATEMENT: Patients utilizing donor oocytes can be reassured that the decision to use or forgo PGT-A does not appear to be associated with the number of transfers required to achieve a live birth.

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Biographical Sketch Early success, marked by his first publication in CELL at Harvard Medical School, inspired Joseph to continue his research endeavors in reproductive endocrinology and infertility. Joseph has been with Reproductive Medicine Associates of New York since 2011. Joseph has authored over 400 peer-reviewed abstracts & manuscripts. Passionate about development, he cultivates relationship with investors & entrepreneurs to advance reproductive endocrinology & infertility care.
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