TABLE 2. Clinical Pregnancy Rate by diagnosis and LP-P as % (N)

	Group 1 LP-P (N=94)	Group 2 No LP-P (N=92)	p value
Anovulation	15.4 (5/24)	20.8 (2/13)	NS
Unexplained	8.2 (4/49)	12.5 (6/48)	NS
Endometriosis	12.5 (1/8)	20.0 (2/10)	NS
Uterine fibroids	0.0 (0/2)	16.7 (1/6)	NS
Tubal occlusion	0.0 (0/3)	33.3 (1/3)	NS
Pelvic adhesions	0.0 (0/1)	0.0 (0/1)	NS
Male factor	0.0 (0/0)	22.2 (2/9)	NS
Habitual aborter	0.0 (0/6)	50.0 (1/2)	NS
Hyperprolactinemia	100 (1/1)	0.0 (0/0)	NS

CONCLUSIONS: LP-P failed to improve clinical pregnancy rates and may be unnecessary in the setting of CC/IUI.

Supported by: None.

A-85

ADOLESENCE TO ADULTHOOD: LESSONS LEARNED IN AN ETHICS COMMITTEE'S FOUR YEAR JOURNEY TO SUPPORT FAIR & EFFECTIVE ORGANIZATIONAL AND CLINICAL DECISION-MAKING AT A PRIVATE ART CLINIC. S. Winsor, S. Dale, C. Laskin. Ethics Committee, LifeQuest Centre for Reproductive Medicine, Toronto, ON, Canada.

OBJECTIVE: Ethics committees are highly uncommon enterprises in private ART clinics in Canada. Perceived cost, lack of specialty expertise in ART ethics, and clinicians' unfamiliarity with the model all contribute to historically negligible utilization. After a two-year development phase, one of Canada's largest private ART clinics established an Ethics Committee in January 2004 to support clinical and organizational decision-making by staff and physicians. Clinic-wide surveys conducted to determine best uses of the committee guided the committee's mandate in the first year. Surveys of Ethics Committee members and informal interviews with clinic staff, together with an audit of committee activities, were conducted in 2005 to determine the committee's continued effectiveness at achieving its mandate and if any course corrections were required. In 2008, after two years working to address the results of research, the committee and clinic staff were surveyed again.

DESIGN: Survey of Ethics Committee members and informal interviews with clinic staff, together with an audit of committee activities.

MATERIALS AND METHODS: Data comparison of 2004 and 2005 results with gap analysis.

RESULTS: It was revealed that the committee's consultation work continued to be the dominant activity and contributed to the education of committee members in ethical reasoning and analysis and to their clinical practice. Policy development that had seen as slow to develop initially was now identified as better established with policies effective; challenges in operationalizing and monitoring policies were also identified. Education of all clinic staff around committee activities and the publicizing of committee operations continued to be characterized as poor. However, the committee's work in educating the North American ART community via peer-reviewed presentations and symposium development was seen as a strength.

CONCLUSIONS: It is evident that while the committee's direction has not remained wholly consistent with the original course it had plotted, it is seen overall to be effective and innnovative in three of its key areas: consultation, education, and policy development. Committee members hypothesized that the task-load weight given to certain committee responsibilities had over time become more reflective of clinic priorities and that evidence of the committee's maturation and development could be seen in its assumption of tasks and commitments (e.g., research review, symposia) previously seen as too advanced.

Supported by: None.

A-87

ANY NEED OF LUTEAL PHASE SUPPORT IN IUI CYCLES? M. H. Öz örnek, A. Özay, E. Ergin, M. Atay, K. Elter. EUROFERTIL IVF Center, Istanbul, Turkey; EUROFERTIL, Istanbul, Turkey.

OBJECTIVE: The aim of this study was to proof the effect of progesteron support on the success of IUI cycles, which used a GnRH antagonist protocol.

DESIGN: Retrospective study.

MATERIALS AND METHODS: 63 patients with unexplained infertility or mild male factor infertility undergoing IUI treatment from January 2007 to May 2008 were included in this study. All patients received 75-150 U rFSH or hpFSH starting on day 2-4 of menses. The antagonist was started, when the leading follicle reached a diameter of $\geq$ 14 mm. FSH and antagonist treatment continued until hCG administration day. When the leading follicle reached $\geq$ 17mm in diameter, hCG was administered and IUI performed at 34-36 hrs after hCG injection. 24 patients received progesterone capsule (3x1, vaginally) from IUI until pregnancy test; 39 patients didn't have progesterone. The pregnancy test performed after fifteen days from IUI. All results were analyzed by using the Chi-square and student t-tests and $P < 0.05$ was considered statistically significant.

RESULTS: The results are summerized in table 1.

	Progesterone	No Progesterone	P value
No. of IUI cycles	24	39	
Patients age	29.12	28.95	NS
Total FSH given	1148.1	1060.4	NS
Estradiol levels on HCG day (pg/ml)	428.8	368.8	NS
No. of follicle	1.35	1.29	NS
No. of stimulation day	10.1	9.8	NS
No. of days antagonist used	3.5	3.5	NS
Conception rate (%)	17.9	20.8	NS

NS: Not significant.

CONCLUSIONS: This study shows there is no benefit of luteal phase support in patients who undergo IUI in an antagonist used ovarian stimulation.

Supported by: None.

A-88

GONADOTROPIN-INDUCED CONTROLLED OVARIAN HYPERSTIMULATION AND INTRAUTERINE INSEMMINATION FOR OLDER WOMEN. I. D. Harris, S. A. Missmer, M. D. Hornstein. Obstetrics, Gynecology, and Reproductive Biology, Brigham and Women's Hospital, Boston, MA.

OBJECTIVE: To determine the success rates of gonadotropin-induced controlled ovarian hyperstimulation with intrauterine insemination (COH/IUI) cycles in women $\geq$38.

DESIGN: Retrospective cohort study of patients in a tertiary academic center.

MATERIALS AND METHODS: Eligible patients were infertile couples who underwent at least one COH/IUI cycle from 2005-2007. Inclusion criteria were: 1) $\geq$12 months of infertility; 2) female age >38 at the start of the treatment cycle. Up to three treatment cycles were included per patient. Exclusion criteria were: 1) cycle cancellation due to ovarian hyperstimulation syndrome or inadequate sperm sample; 2) failed stimulation. Multivariable logistic regression quantified the association between female age and the clinical pregnancy or livebirth rates. Wald p-values are two-sided.

RESULTS: 262 treatment cycles from 130 women met the inclusion requirements. There were 57 women (42.6%) aged 38-39 who underwent 110 treatment cycles and 73 women (57.4%) aged $\geq$40 who underwent 147 treatment cycles. Among women aged 38-39, the cumulative clinical pregnancy = 15.7%, with rates of 9.6%, 6.1%, and 5.6% for the first three cycles, respectively. The cumulative clinical pregnancy rate for the women $\geq$40 =12.9%, with cycle-specific rates of 8.6%, 4.4%, and 4.1%, respectively. Women aged 38-39 had a cumulative livebirth rate of 5.8%, while the livebirth rate was 2.2% for women $\geq$40. However, the livebirth rate for cycle two was 0% among women $\geq$40 and was 0% for cycle three regardless of the woman's age.