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1 Oocyte accumulation for Fertility Preservation in women with benign ovarian tumors (BOT)
2 with history of previous surgery or multiple/large cysts.

3

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1 **ABSTRACT**

2 **Research Question:** The study aimed to evaluate the relevance and the acceptance of an
3 oocyte accumulation program in young women with benign ovarian tumor.

4 **Design:** This is a retrospective cohort study carried out in the Academic ART and Fertility
5 Preservation Centre of the Lille University Hospital from January 2016 to December 2019.
6 We evaluate the number of metaphase II oocytes per cycle and per patient after accumulation.
7 We distinguished two groups for the analysis: endometrioma (“endometrioma”) and dermoid,
8 mucinous or serous cyst (« other cysts »).

9 **Result(s):** 113 FP cycles were analysed in 70 women aged 27.9 ± 4.8 years. Almost all women
10 had previous ovarian surgery before FP (89%). Mean AMH levels before COH was 12.5 ± 8.7
11 pmol/L. 6.4 ± 3.4 total oocytes were retrieved and 4.3 ± 3.4 MII oocytes were vitrified per
12 cycle. All agreed in to the oocyte accumulation program and all underwent at least 1 cycle. To
13 date, 36 (51%) patients achieved 2 or 3 FP cycles. After accumulation, 7.0 ± 5.23 MII oocytes
14 were vitrified per patient. No difference was found in terms of ovarian response and oocytes
15 cohort between “endometrioma” and “other cysts” groups. Questionnaires after oocyte
16 retrieval revealed abdominal bloating and mild pelvic pain in most patients with no difference
17 according to the type of cyst. No serious adverse events occurred.

18 **Conclusion(s):** Oocyte accumulation should be systematically offered in young women with
19 BOT whatever the histological type as it appears to be well-tolerated. Long-term follow-up is
20 needed in order to assess the efficiency in terms of further pregnancy chances.

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22 **Key words:** fertility preservation, oocyte vitrification, endometriomas, benign ovarian
23 tumors.

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Key message: Oocyte accumulation is needed to optimize the number of MII oocytes and further chances of pregnancy. FP procedures should be proposed in case of BOT, whatever the histological type.

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2 INTRODUCTION

3 Ovarian cysts are observed in 10 to 20% of young women (American College of Obstetricians
4 and Gynecologists 2007; Royal College of Obstetricians and Gynaecologists 2011; Raiga et
5 al. 2006). 25% of them are organic cysts of which 25-35% are serous cystadenoma, 10-15%
6 mucinous cystadenoma, 20% dermoid cyst and 20% endometrioma (American College of
7 Obstetricians and Gynecologists 2007; Royal College of Obstetricians and Gynaecologists
8 2011; Raiga et al. 2006). In case of large, symptomatic or progressive cysts, surgery is
9 performed for histological examination and confirmation of benignity. Ovarian sparing
10 surgery has become crucial for the management of ovarian tumors in children, adolescents
11 and young women for fertility concerns. Nevertheless, the size of the tumor can be a limiting
12 factor, as large tumors are more likely to induce oophorectomy (Legendre et al. 2014;
13 Dunselman et al. 2014; Borghese et al. 2013; Roman et al. 2010). In addition, all these
14 tumors, especially endometriomas (Guo 2009), are at high risk of recurrence with consequent
15 repeat surgeries (Harada et al. 2013; Rogers, Allen, et Kives 2014; Ben-Ami et al. 2010)
16 leading to the risk of ovarian reserve damages and further fertility impairments.

17 It is now well-established that AMH is the most reliable indicator to the ovarian follicular
18 content (Dewailly et al. 2014). Studies of the consequences of ovarian surgery on the ovarian
19 reserve are almost all performed in case of endometriomas. They highlighted a significant
20 decrease of AMH levels as high as 30 to 50% after cystectomy for endometriomas (Edgardo
21 Somigliana et al. 2012; Uncu et al. 2013; Streuli et al. 2012; Goodman et al. 2016). This
22 decrease is maximal in cases of large tumors, bilateral tumors whatever the size, and low
23 ovarian reserve before surgery (Goodman et al. 2016; Younis et al. 2019; Muzii et al. 2015;
24 Coccia et al. 2011). Ovarian damages are related to the excision of healthy ovarian cortex and

1 potential vascular injury when cystectomy is performed (Alborzi et al. 2009; Matsuzaki et al.
2 2009). In case of endometriomas, it has been shown that folliculogenesis can also be impaired
3 due to ovarian tissue inflammation with premature follicle recruitment, higher rate of
4 follicular atresia and alteration of the number and quality of growing follicles (Kitajima et al.
5 2014). The impact of cystectomy in cases of cystadenomas or dermoid cysts is less obvious,
6 except if oophorectomy is needed due to large tumor size (Rustamov et al. 2016; Mohamed et
7 al. 2016).

8 Fertility preservation (FP) techniques are developing rapidly and must be systematically
9 offered to women with high risk of ovarian reserve depletion. Oocyte vitrification is the first
10 line option in the case of non-oncologic and non-emergency situations, according to the
11 ESHRE-ASRM 2015 committee opinion (Martinez et al. 2017; Martinez 2017). It is now well
12 established that oocyte cryopreservation is safe and efficient, with healthy babies born, thanks
13 to the vitrification techniques (A Cobo et al. 2018; Ana Cobo et Diaz 2011; Glujovsky et al.
14 2014; Argyle, Harper, et Davies 2016; Noyes, Porcu, et Borini 2009; Ana Cobo et al. 2014;
15 De Munck et Vajta 2017).

16 Debates are still ongoing about FP strategies especially in endometriosis (E. Somigliana et al.
17 2015; Donnez, García-Solares, et Dolmans 2018) and French guidelines have been recently
18 published on this topic (C. Decanter et al. 2018). To date, there is no published data regarding
19 oocyte vitrification for FP in case of dermoid, serous or mucinous cysts; and only three cohort
20 studies have been published exclusively in patients with endometrioma (Ana Cobo et al.
21 2020; Raad et al. 2018; Kim et al. 2020).

22 Because of the paucity of literature, we aimed to evaluate the relevance of an oocyte
23 accumulation program in young women with BOT at high risk of ovarian reserve depletion
24 due to previous surgery or presence of multiple or large cysts. The primary endpoint was to

1 evaluate the number of metaphase II (MII) oocytes eligible for vitrification after controlled
2 ovarian hyperstimulation (COH) per cycle and after accumulation. The second endpoint was
3 to examine the tolerance and the acceptability of the procedures in this specific population.

4 **MATERIALS and METHODS**

5 **Study design**

6 This is a retrospective analysis of collected data in the French ART registry (JFIV). This
7 observational study was monocentric carried out in the Academic ART and Fertility
8 Preservation Centre of the Lille University Hospital from January 2016 to December 2019.
9 Written informed consents for both oocyte retrieval and oocyte vitrification were obtained
10 before each procedure. The study was approved by the local ethic committee (DEC20150715-
11 0002).

12 **Population**

13 Seventy patients with BOT, of which 89% had previous ovarian surgery. Large number of
14 women have had first surgeries in other centres and sometimes years before, during childhood
15 or adolescence. They were referred to our FP centre, because of a cyst recurrence, and/or
16 before surgery by surgeons from the Lille University Hospital Centre.

17 Inclusion criteria were age 18 to 35, history of BOT (endometrioma, dermoid, serous or
18 mucinous cysts) with high risk of ovarian depletion: multiple ovarian cysts, ovarian cyst
19 larger than 5 cm of diameter, history of oophorectomy or recurrent surgeries, baseline reduced
20 ovarian reserve. Patients had to have a social insurance and be able to give an informed
21 consent.

22 Exclusion criteria were a diagnosis of borderline or malignant ovarian tumor, personal history
23 of thrombo-embolic events, or undetectable AMH levels.

1 An ovarian reserve assessment was systematically carried out before COH by measuring the
2 serum AMH level and determining the antral follicle count (AFC). AMH was measured using
3 an automated AMH assay, Access Dxi (Beckman Coulter Immunotech®, Villepinte France).
4 The baseline AFC was measured with a Voluson E8 Expert (General Electric
5 Systems, VELIZY, France) with a 5–9 MHz transvaginal transducer by counting all the 2–
6 9mm diameter follicles.

7 Up to three vitrification cycles were offered to optimize the number of MII oocytes and
8 further chances of pregnancy (A Cobo et al. 2018).

9 **Controlled Ovarian Hyperstimulation (COH) protocol**

10 Agonist or antagonist protocols were used for COH. Starting r-FSH dose was determined
11 according to patient age, body mass index (BMI) and baseline AFC and AMH, and varied
12 from 112.5 to 450 IU/day.

13 In 88,5 % of cases, we used the fixed day 6 antagonist protocol. COH was initiated on Day 2
14 of a spontaneous bleed. Recombinant FSH (Follitropin alpha, Gonal F®, Merck-Serono, or
15 Follitropin beta, Puregon®, Merck USA) was administered daily until triggering and GnRh
16 antagonist (Ganirelix, Orgalutran® 0.25mg/0.5ml MSD) was added daily on day 6.
17 Transvaginal ultrasound examination combined with estradiol and LH measurements were
18 performed to monitor the follicles development on day 6 of r-FSH treatment and every 2 or 3
19 days after.

20 For the long GnRH agonist protocol, the GnRH agonist (Nafaréline, Synarel® 0.2mg/dose,
21 pfizer) was initiated during the luteal phase of the previous cycle for pituitary down-
22 regulation. After ultrasound examination and hormone levels measurement, r-FSH and GnRH
23 agonist were administrated daily following the instructions previously described.

24 Triggering was achieved as soon as three follicles reached 18 mm of diameter or larger by

1 administering hCG (250 µg, Ovitrelle ®, Merck Serono) or by 0.2mg triptorelin (Decapeptyl
2 ® Ipsen Pharma) for patients with high risk of ovarian hyperstimulation syndrome in case of
3 antagonist protocol (Youssef et al. 2014).

4 **Oocyte retrieval**

5 Oocyte retrieval was scheduled 36 to 38 hours after triggering and was performed by
6 transvaginal ultra-sound guided needle aspiration. Two hours after oocyte retrieval, cumulus
7 oophorus was denuded by a brief exposure to 80 IU/mL of hyaluronidase solution
8 (Hyaluronidase Fertipro™, Belgium) followed by mechanical removal of the corona radiata
9 with denudation pipette (Flexipet, Cook, USA) in a controlled CO₂ and temperature
10 environment. Oocyte vitrification procedure was carried out after nuclear maturity assessment
11 under stereomicroscop. Only MII oocytes were eligible for vitrification procedure.

12 **Vitrification protocol**

13 We used the RapidVit Kit® (Vitrolife®, Sweden) and the closed system device RapidI®
14 (Vitrolife®, Sweden). Vitrification procedure was performed as previously described
15 (Christine Decanter et al. 2018). Briefly, oocytes were exposed to progressive concentrations
16 of propanediol and ethylene glycol. Oocytes were loaded on the RapidI device in a minimum
17 volume drop and immediately plunged into liquid nitrogen to induce vitrification and then
18 stored at -196°C in liquid nitrogen

19 **Questionnaire**

20 In accordance with our ART center policy, each patient was called back after the oocyte
21 retrieval to answer a questionnaire regarding tolerance. They were also asked about symptoms
22 of pelvic pain, abdominal bloating and fever. Pain intensity was assessed using a self-report
23 scale from 0 to 10 (Numerical Scale, Echelle Numérique: EN). We have classified them into 3
24 categories: low intensity pain ($EN \leq 3$), medium intensity pain ($4 \leq EN \leq 6$) and high intensity

1 pain ($EN \geq 7$).

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3 **Statistical analysis**

4 Categorical parameters were described as frequencies and percentages. Continuous
5 parameters were described as means and standard deviations.

6 A generalized estimating equation (GEE) model (Poisson distribution and logit link function)
7 taking into account the correlation between the cycles of a same patient was used to assess the
8 associated factors with the number of MII oocytes. In the case of p-value lower than 0.10 in
9 univariate analysis, the parameter was introduced in a multivariate model.

10 The comparison between « endometrioma » vs « other cysts » groups were performed using
11 Chi-square test for « patient level » categorical variables, using Student t-test for « patient
12 level » continuous variables. For « cycle level » variables, a linear mixed model with
13 « patient » as random effect was used for dependent continuous variables; a GEE model like
14 previously quoted for dependent count variables.

15 Data were analyzed using the SAS software (SAS Institute Inc, Cary, NC, USA) and all
16 statistical tests were performed with a 2-tailed alpha risk of 0.05.

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RESULTS

Population characteristics

70 patients were referred to the Fertility Preservation Centre of the Lille University Hospital. All agreed in to the oocyte accumulation program and all underwent at least 1 cycle. 51,4% of them underwent 2 cycles and only 10,0% underwent 3 cycles.

Distribution of the different histological types of BOT in the study population is represented in Figure 1: endometrioma (n=39, [56%]), dermoid cyst (n=22, [31%]), mucinous cyst (n=5, [7%]), and serous cyst (n=4, [6%]). We distinguished 2 groups in the overall population so-called “endometrioma” (n= 39) and”other cysts” (n= 31) including dermoid, serous and mucinous cysts.

89% (n=62) of patients had a history of ovarian surgery prior to FP: cystectomy (n=36 [58%]), plasma energy ablation (n=1 [2%]), drainage (n=7 [11%]), unilateral oophorectomy (n=18 [29%]). Among these patients, 33 had a cyst recurrence of which 15 underwent a second surgery: 8 had a cystectomy on the contralateral ovary after oophorectomy, 3 had a second cystectomy and 4 had drainage secondary to a cystectomy (supplemental figure 1). 8 patients (11%) were included prior to surgical management. 32 patients (45.7 %) had a cyst during the stimulation period.

Characteristics of the patients are reported in Table 1. Mean age at accumulation program proposal was 27.9 ± 4.8 years. The average diameter of largest cyst was 7.4 ± 4.2 cm (7.9 ± 4.2 cm in women with previous surgery and 3.8 ± 2.0 cm in women with no history of surgery). Mean AMH levels was 12.5 ± 8.7 pmol/L and AFC was 13.1 ± 7.9 follicles. Twenty-nine patients (41.4%) had already low AMH levels, between 3 and 8 pmol/L, the latter being

1 our in-house threshold for predicting poor ovarian response. Thirty-six patients (51.4%) were
2 taking oral contraceptive pill (n=32) or long agonist GnRH (n=4) before COH.

3 **COH outcomes and oocyte cohort**

4 Main COH outcomes are detailed in Table 2. A mean of 6.4 ± 3.4 total oocytes was retrieved
5 per cycle. The mean number of MII oocytes was 4.3 ± 3.4 per cycle and of immature oocytes
6 was 0.6 ± 1.0 (germinal vesicle and immature metaphase I oocyte). Maturation rate was of
7 66%. In 41.5% of cycles, four or fewer total oocytes were retrieved.

8 In the overall population the mean number of MII oocytes was 7.0 ± 5.2 per patients after
9 accumulation. 44.3% of them (n=31) had more than eight MII oocytes vitrified. A mean
10 number of 4.2 ± 3.4 MII oocytes was vitrified at the end of the first cycle, 8.0 ± 5.4 after two
11 cycles and 9.4 ± 5.6 after three cycles (Table 2). After 1 cycle, only 15.7% of patients had 8 or
12 more MII oocytes eligible for vitrification. After 2 or 3 cycles, 52.8% to 57.1% had more than
13 8 MII oocytes eligible for vitrification. In 5 patients, no oocyte was eligible for vitrification
14 after one (n=3) or two cycles (n=2). 3 of them had endometriomas, the others had dermoid
15 and mucinous cysts. They did not have any particular characteristics at baseline and during
16 COH. Their AMH levels were 3 pmol/L to 17.7 pmol/L.

17 **Associated factors with the number of MII oocytes**

18 Univariate analysis showed that AMH level (RR 1.38, 95%CI [1.17-1.62]), AFC (RR 1.40,
19 95%CI [1.23-1.59]), estradiol level at triggering day (RR 1.19, 95%CI [1.08-1.33]) and the
20 number of mature follicles ≥ 15 mm (RR 1.09, 95%CI [1.05-1.14]), had a significant positive
21 impact on the number of MII oocytes ($p < 0.05$). Conversely, BMI (RR 0.96, 95%CI [0.93-
22 0.98]), history of oophorectomy (RR 0.65, 95%CI [0.47-0.88]), r-FSH starting dose (RR 0.72,
23 95%CI [0.60-0.83]) and r-FSH total dose (RR 0.87, 95%CI [0.79-0.96]) were negatively
24 associated with the number of MII oocytes ($p < 0.05$). There was no effect of smoking,

1 histological type, age, taking oral contraceptive pill (OCP) before COH on the number of MII
2 oocytes.

3 In the multivariate analysis, only the r-FSH starting dose, estradiol level and number of
4 mature follicles ≥ 15 mm at triggering day remained significantly associated with the number
5 of MII oocytes (respectively, RR[95%CI], 0.80 [0.67-0.95], $p=0.012$; 1.10 [1.01-1.21],
6 $p=0.032$; 1.06 [1.01-1.11], $p=0.009$).

7 « Endometrioma » versus « other cysts »

8 We compared the two subgroups “Endometrioma” and “other cysts” (table 3). Patients with
9 dermoid or sero-mucinous cysts were significantly younger and had a higher incidence of
10 unilateral oophorectomy. There was no difference between the 2 groups at baseline regarding
11 ovarian reserve indicators, smoking, BMI and taking OCP. No difference was found regarding
12 the follicular growth under COH, neither total and MII oocytes number between the 2 groups.

13 Follow-up

14 Only one case of moderate ovarian hyperstimulation syndrome was reported. No infection,
15 hemorrhagic or thromboembolic complications occurred. 100% of patients completed the
16 questionnaire after each cycle. Questionnaires after oocyte retrieval ($n=113$) revealed
17 abdominal bloating and mild pelvic pain in most patients (figure 2). There was no difference
18 according to the type of cyst.

19 To date, 3 patients asked for reutilization. A total of 8 MII oocytes were thawed and resulted
20 in one live birth of a healthy baby.

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DISCUSSION

4 To date, this is the first cohort study interested in a systematic proposal of oocyte
5 accumulation for FP in case of BOT whatever the histological type. These results confirmed
6 those we previously showed in a short series of patients (Dadoun et al. 2017). Only three
7 retrospective cohort studies have been published since on this topic but exclusively in women
8 with endometriosis (Raad et al. 2018; Ana Cobo et al. 2020; Kim et al. 2020). Cobo *et al.*
9 reported the results of 840 cycles performed in 485 women in their thirties, Raad *et al.* 70
10 cycles in 49 women of same age, and Kim et al 50 cycles in 34 women before surgery with a
11 mean number of MII oocytes per cycle of 7.2, 5.5 and 4.8 respectively (Ana Cobo et al. 2020;
12 Raad et al. 2018; Kim et al. 2020). We reported in our overall population a mean number of
13 4.3 MII oocytes eligible for vitrification per cycle and a mean number of 7.0 MII oocytes per
14 patients after accumulation. These results are slightly lower than those found by Cobo *et al*
15 and Raad *et al* despite a younger population. It must be stressed that in these two series, every
16 types and stages of endometriosis were eligible for FP, including women with superficial
17 lesions, absence of endometrioma or previous surgery. However, our results were similar to
18 those of Kim et al. in patients without history of surgery. In the current study, we voluntarily
19 focused on young patients under 35 years with high risk of ovarian function impairment due
20 to history of repeated surgeries and/or presence of multiple or large ovarian tumors. Indeed, in
21 our population, 89% had at least one previous ovarian surgery of which 26% had an
22 oophorectomy, in comparison with 47% and 38% in Cobo and Raad Serie (Ana Cobo et al.
23 2020; Raad et al. 2018). The latter reported fewer retrieved oocytes in these “post-surgery”
24 patients, which is in agreement with our results. This is in accordance with the literature
25 reporting ovarian damage after cystectomy for endometrioma (Edgardo Somigliana et al.
26 2012; Uncu et al. 2013; Streuli et al. 2012; Goodman et al. 2016), but also for serous,

1 mucinous and dermoid cysts (Rustamov et al. 2016; Mohamed et al. 2016). Unfortunately, lot
2 of patients, especially in this cohort, had their first surgeries in other centres and sometimes
3 years before, explaining the high proportion of patients with a history of cystectomy or
4 oophorectomy in our cohort. Surgery withhold in cases with endometrioma should be
5 discussed and excision should be cautiously considered. Conservative treatment should be
6 counselled as the first line of treatment, until the patient's reproductive aspirations are
7 realized.

8 In keeping with the high incidence of previous surgery, our patients already had an
9 impairment of their ovarian reserve: they indeed exhibited lower AMH levels than expected
10 with a mean of 12.5 ± 8.7 pmol/L, i-e, < -1 Standard Deviation for age (Kelsey et al. 2011).
11 41.4% of them had an AMH level lower to 8 pmol/l that represents our in-house cut-off
12 threshold for predicting poor ovarian response. This indicates that these patients should have
13 been referred to a FP centre earlier, ideally before surgery, to have more MII oocytes. Half of
14 the population had been using OCP for at least 6 months which may have influenced the basal
15 AMH levels (Kallio et al. 2013; Hagen et al. 2012). Nevertheless, COH while using OCP did
16 not impact the ovarian response nor the number of MII oocytes. Interestingly, AMH levels in
17 the multivariate analysis was no longer associated with the number of MII oocytes. In
18 addition, if we consider results in terms of oocyte number patient by patient, a significant part
19 (47%) with low or very low AMH levels had more than 4 total oocytes retrieved. This
20 confirms that low AMH levels should not be an exclusion criterion before COH for FP in
21 young patients. Maturation rate in our population of BOT was lower than expected in
22 comparison with maturation rate in women undergoing FP for social reasons (A Cobo et al.
23 2018; Garcia-Velasco et al. 2013; Rodriguez-Wallberg et al. 2019), and in ICSI patients in our
24 centre (Christine Decanter et al. 2018). It has to be noted that 45,7 % of our patients had an
25 ovarian tumor during the ovarian stimulation. One can hypothesize the existence of follicular

1 micro-environment alterations impacting the oocyte development and maturation, as it was
2 described in case of endometriomas due to chronic inflammation (Singh et al. 2016; Sanchez
3 et al. 2017) and in oncologic indications (Christine Decanter et al. 2018).

4 Patients from “other cysts” group were younger and had a higher incidence of oophorectomy
5 than those in “endometrioma” group. Nevertheless, there was no statistical difference between
6 the 2 groups regarding the follicular growth under COH and the oocyte cohort in terms of
7 number and quality. Early referral of these young patients is recommended in order to prevent
8 a possible risk of recurrence which would have a greater impact on their future fertility.
9 Nevertheless, whether FP strategies should be the same in these two groups, this remains to be
10 established in larger prospective series.

11 Rienzi *et al.* and Cobo *et al.* showed in different populations, i.e ICSI, oocyte donation or
12 oocyte vitrification for social reasons, that the best chances of pregnancy are observed when
13 oocyte collection is performed under 35 years old (A Cobo et al. 2018; Rienzi et al. 2012; Ana
14 Cobo et al. 2016). They indeed reported in this age range that 8 MII oocytes may provide 30
15 to 45% of cumulative live birth rate (A Cobo et al. 2018; Rienzi et al. 2012; Ana Cobo et al.
16 2016). The younger the patient, the better her chances of being pregnant. In our subgroup
17 patients with a history of recurrent surgery, the mean number of MII oocytes was too low
18 after one cycle. Oocyte accumulation concept was primarily proposed by Cobo *et al.* in
19 patient with low ovarian reserve in IVF procedure to increase pregnancy chances (A. Cobo et
20 al. 2012) and is now routinely proposed in case of FP. Only 4.3 ± 3.4 MII oocytes were
21 vitrified per cycle in this study which clearly does not insure pregnancy achievement
22 justifying the accumulation program. We indeed observed in our population a clear increase
23 in the number of MII oocytes after accumulation, as also suggested in the cohort of Kim et al
24 (Kim et al. 2020). Hence, if we extrapolate the recent results of Cobo *et al.* to our patients ,
25 aged of 28, with a mean number of 7.0 MII oocytes after accumulation, they may have 30%

1 chances of live birth rate (A Cobo et al. 2018). But, it has to be stressed that these results
2 concerned patients in an elective FP program. In the FP series in women with endometriosis,
3 Cobo *et al* showed a cumulative live birth rate of 46,4% with an average of 9 MII oocytes per
4 patient (Ana Cobo et al. 2020).

5 The acceptability of FP by oocyte vitrification was high as all patients agreed the procedure at
6 the time of offer. But it is interesting to note that only 51.4% of them returned for a second
7 cycle and 10.0% for a third one, even though in France, FP for medical reasons is completely
8 supported by social insurance without any advance of costs. In addition, no severe adverse
9 event occurred, and the functional tolerance was good. Logistical difficulties, and
10 disappointment regarding the oocyte number at the first cycle were the main reasons for not
11 coming back.

12 The retrospective design of this study with a limited number of patients does not allow us to
13 preclude firm conclusions. Nevertheless, we analysed data prospectively collected extracted
14 from our ART national registry, allowing us to have exhaustive and precise population
15 description.

16 It is now too soon to evaluate the efficiency of these procedure on further fertility as only 3
17 patients asked for re-utilization. Large prospective studies with a long-term follow-up are
18 clearly needed to estimate the re-utilization rate, the oocyte quality through fertilization and
19 further pregnancy rates.

20 To summarize, the results of this study highlighted that in this population of patients with
21 history of surgeries and/or multiple or large cysts, oocyte accumulation is needed to optimize
22 the number of MII oocytes and further chances of pregnancy. FP procedures should be offered
23 in case of BOT, whatever the histological type, ideally before the ovarian surgery if it is
24 technically feasible. Fertility sparing surgery remains the most challenging option in these
25 young women until the patient's reproductive aspirations are realized.

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LEGENDS of FIGURES

Figure 1: histological types of BOT

Figure 2: Tolerance questionnaire result

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Table 1 : Population characteristics	
Characteristics	Values (n = 70)
Age (years)	27.9±4.8 28.0 [18.0-35.0]
Smoking ^a	23/70 (33.3)
Ovaries number	
1	18/70 (25.7)
2	52/70 (74.3)
Mean number of surgeries	1.2±0.75 1.0 [0-2.0]
Diameter of largest cyst (cm)	7.4 ± 4.2 6.8 [2.0-20.0]
Contraception	
No	34/70 (48.6)
Yes	36/70 (51.4)
Number of FP cycles	
1	34/70 (48.6)
2	29/70 (41.4)
3	7/70 (10.0)
Body Mass Index (kg/m ²)	24.3±5.6 22.9 [17.0-42.7]
Total AFC	13.1±7.9 12.0 [4.0-36.0]
AMH (pmol/L)	12.5±8.7 9.6 [3.0-43.0]
AMH ≤ 8 pmol/L	29/70 (41.4)

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Values are expressed as mean ± standard deviation and median [mini-maxi], or number (percentage).

^a 1 missing data

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Table 2 : COH outcomes	
Parameters per cycle (n=113)	Value
Protocol	
antagonist	100/113 (88.5)
agonist	13/113 (11.5)
Recombinant FSH starting dose (UI)	306.5±101.6 300.0 [112.5-450.0]
Recombinant FSH cumulative dose (UI)	3319±1441 3000 [675.0-9000]
Duration of ovarian stimulation (days)	10.6±2.1 10.0 [5.0-18.0]
Oestradiol level at triggering day (ng/ml)	1270±1088 874.0 [173.0-6654]
Triggering	
hCG (250 µg, Ovitrelle)	101/113 (89.4)
0.2 mg triptorelin	12/113 (10.6)
Number of follicles ≥15mm	6.4±3.4 6.0 [1.0-19.0]
Number of MII oocytes	4.3 ± 3.4 6.0 [0-19.0]
Number of MII oocytes/ Total oocytes : maturation rate	482/724 (66.6)
Number of MII oocytes/ Number of follicles ≥ 15mm	0.7 ± 0.6 0.7 [0-2.5]
Low ovarian response ≤ 4 total oocytes	47/113 (41.5)
Parameters per patient (n=70)	
Number of MII oocytes / patient after accumulation	7.0 ± 5.2 6.0 [0-22.0]
Number of MII oocytes after 1 cycle	4.2 ± 3.4 3.0 [0-16.0]
Number of MII oocytes after 2 cycles	8.0 ± 5.4 9.0 [0-22.0]
Number of MII oocytes after 3 cycles	9.4 ± 5.6 9.0 [3.0-18.0]
≥ 8 MII oocytes	31/70 (44.3)

Values are expressed as mean \pm standard deviation and median [mini-maxi], or number (percentage)

Table 3 : Comparison « endometrioma » versus « other cysts »			
	Other N=31	Endometrioma N=39	p value
Age (years)	25.8 \pm 4.4	29.5 \pm 4.6	0,001
Smoking	12 (40)	11 (28.2)	0.30
Ovaries number :			
1	16 (51.6)	2 (5.1)	0.001
2	15 (48.4)	37 (94.9)	
BMI (kg/m ²)	24.6 \pm 6	24.2 \pm 5.5	0.77
AMH (pmol/L)	12.7 \pm 9	12.3 \pm 8.5	0.85
AFC	13.6 \pm 7.6	12.8 \pm 8.2	0.73
Contraception :			
Yes	13 (41.9)	23 (59.0)	0.16
No	18 (58.1)	16 (41.0)	
r-FSH starting dose ^a	309.2 \pm 97.7	304.5 \pm 105.3	0.78
r-FSH cumulative dose ^a	3597 \pm 1725	3105 \pm 1149	0,097
Duration of ovarian stimulation ^a	10.9 \pm 2.3	10.3 \pm 1.9	0.17
E2 level at triggering day ^a	1139 \pm 1167	1369 \pm 1021	0.18
Number of follicle \geq 15mm ^a	6.8 \pm 4,0	6.0 \pm 2.8	0.25
Total oocytes ^a	7.3 \pm 4.9	5.8 \pm 3.8	0.11
MII oocytes ^a	4.8 \pm 3.9	3.9 \pm 3.1	0.18
Maturation rate ^a	233/356 (65.4)	249/368 (67.7)	0.58

Values are expressed as mean \pm standard deviation or number (percentage)

^a Values are calculated over all cycles (n=49 cycles for « other » group, n=64 cycles for « endometrioma »).

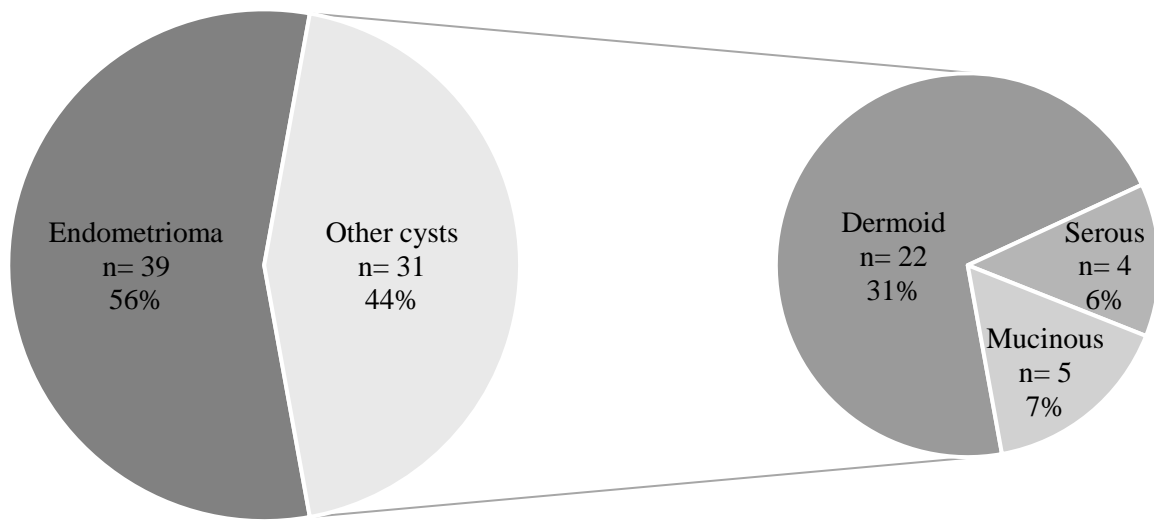
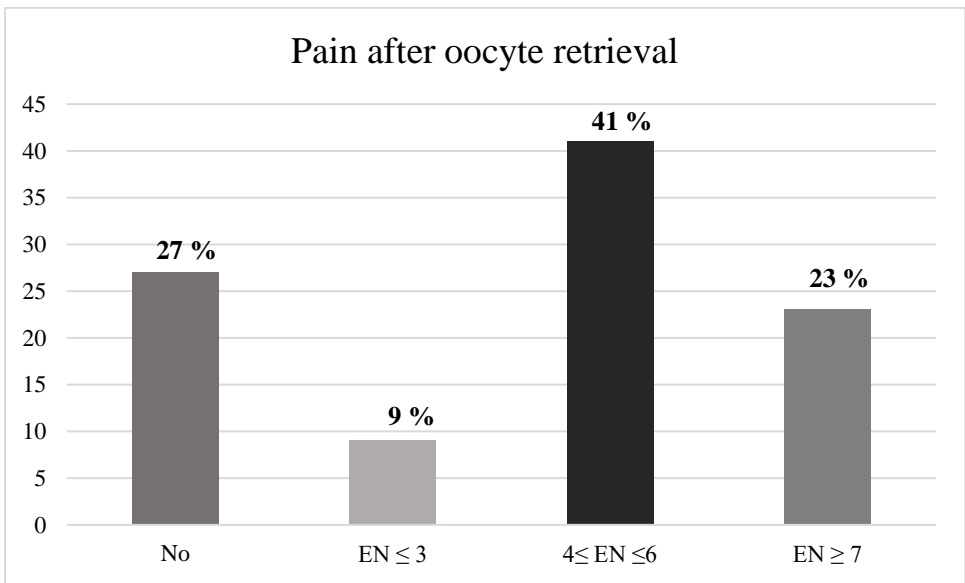
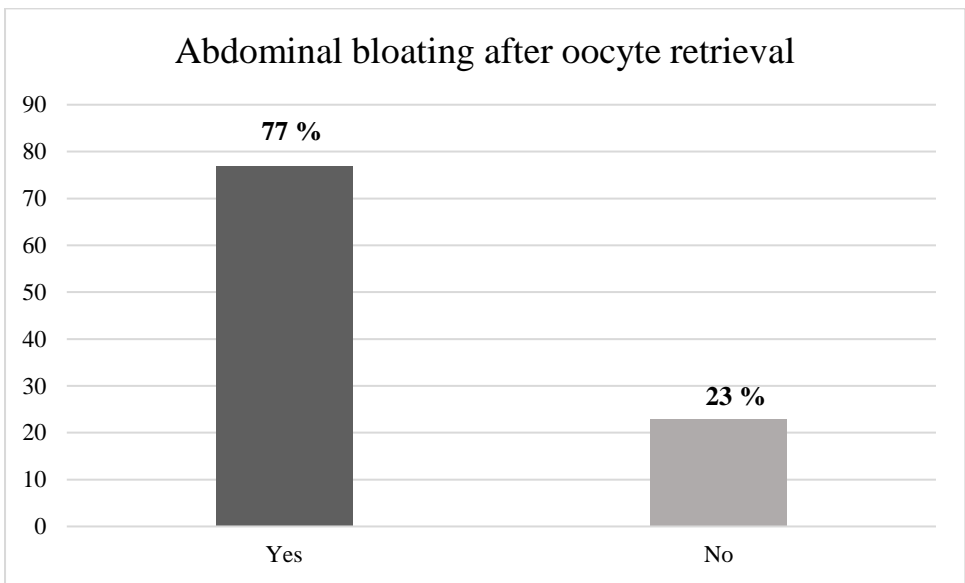
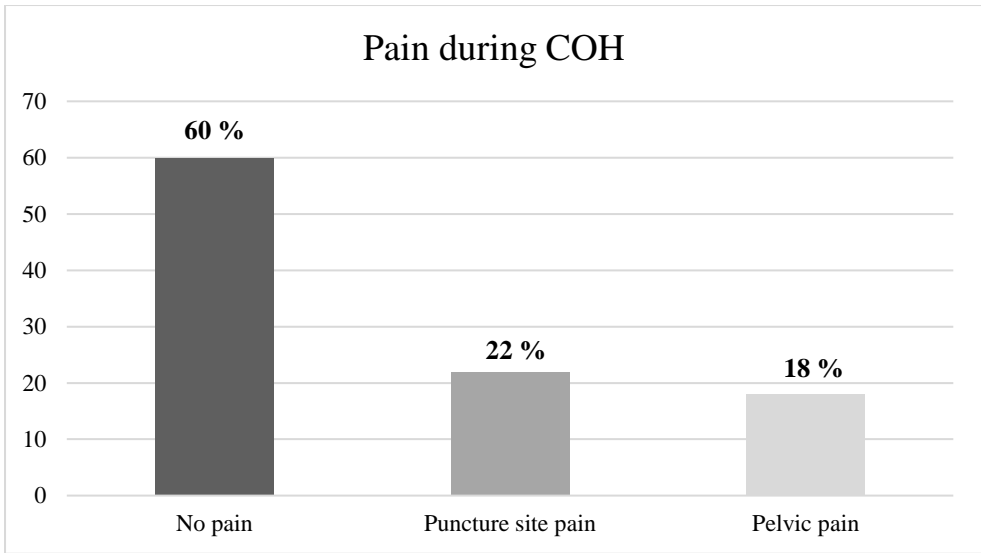


Figure 1



EN ≤ 3: low intensity pain,
 4 ≤ EN ≤ 6: medium intensity pain,
 EN ≥ 7: high intensity pain

Figure 2