Live Births from Frozen Embryo Transfer Cycles in Patients with Malformed Uterus – Case Series

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ABSTRACT

Müllerian duct malformations are rare congenital defects of the female reproductive tract, which affects 3% to 5% of women in the general population. These congenital uterine malformations are caused by abnormal fusion of Müllerian duct during embryonic life. These malformations include septate uterus, unicornuate uterus and bicornuate uterus. Pregnancies are usually associated with increased risk of recurrent miscarriages, preterm labours, malpresentations and intrauterine growth restrictions. There had been some studies which suggest that these women should receive corrective surgery before embryo transfer to achieve successful pregnancies. However, we are presenting two patients who were diagnosed with uterine malformation and yet resulted with successful pregnancies from frozen embryo transfer cycles without corrective surgery.

Pregnancies following Treatment in Hypogonadotrophic Hypogonadism

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ABSTRACT

Introduction: Hypogonadotropic hypogonadism causes ovulatory disorders resulting in primary amenorrhoea and primary infertility. The incidence of congenital hypogonadotropic hypogonadism is approximately 1-10:100,000 live births. It can be congenital or acquired. **Case Reports:** *Case 1:* A 27 year old lady was referred for primary infertility of 3 years duration. She was diagnosed as a case of Mullerian Duct Agenesis when she presented with primary amenorrhoea at the age of 18. Her secondary sexual characteristics were well developed with normal external genitalia. Serum levels of LH, FSH, Prolactin, Estradiol and Progesterone (Day 21) were 0.1 mIU/ml, 0.7 mIU/ml, 66.3 mIU/mL, < 5.0 pmol/ml and 0.4 ng/ml respectively. Thyroid function and Karyotyping were normal (46XX). Diagnostic laparoscopy & dye revealed an infantile uterus with no spillage and both ovaries were normal. She was commenced on Progyluton which was followed by a FET IVF cycle. This resulted in a DCDA twin pregnancy. *Case 2:* A 23 year nulliparous lady (married for 2 years) was referred for primary amenorrhoea. Her secondary sexual characteristics were well developed with normal external genitalia. Serum levels of LH, FSH, Prolactin, Estradiol, and Testosterone were 0.4 mIU/ml, 0.6 mIU/ml, 83 mIU/ml, 66.5 pmol/ml and 0.37 nmol/ml respectively. Thyroid function and Karyotyping were normal (46XX). Diagnostic laparoscopy & dye revealed an infantile uterus with bilateral spillage. Both ovaries were small. She was started on a 3 month course of Progyluton for uterine priming. She underwent one cycle of IVF with an antagonist protocol which was successful. **Results:** Both these patients had delivered live babies. **Conclusion:** Women with hypogonadotrophic hypogonadism are obvious candidates for ovulation induction with exogenous gonadotrophins. When an unassisted pregnancy is not achieved, assisted reproductive techniques ranging from intrauterine insemination to in vitro fertilization should be considered.