

early as 60 days after reimplantation compared 3-6 months to cases in which vascular transplantation of ovarian tissue was performed. Furthermore OTC should be considered prior to administration of gonadotoxic drugs are administered.

## HEALTH DISPARITIES

O-323 Wednesday, October 24, 2012 03:45 PM

**EFFICACY OF ULIPRISTAL ACETATE FOR THE TREATMENT OF SYMPTOMATIC UTERINE LEIOMYOMAS IN AFRICAN AMERICANS.** L. J. Green,<sup>a</sup> G. Levy,<sup>b</sup> R. Wesley,<sup>b</sup> L. Nieman,<sup>b</sup> A. Armstrong.<sup>b</sup> <sup>a</sup>Obstetrics and Gynecology, Howard University Hospital, Washington, DC; <sup>b</sup>Program in Reproductive and Adult Endocrinology, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institute of Health, Bethesda, MD.

**OBJECTIVE:** There are considerable ethnic differences in the molecular characteristics, prevalence, and symptomatology of uterine leiomyomas. Prior studies have demonstrated that the selective progesterone receptor modulator, ulipristal acetate (UPA), effectively controlled bleeding and reduced leiomyoma volume. Studies of pharmacologic therapies for leiomyomas are limited by small numbers of African American (AA) patients and medical therapies have been shown to have different efficacy in AA women, thereby limiting the applicability of results. This study aims to determine if UPA is an effective pharmacologic therapy in AA women with symptomatic uterine leiomyomas.

**DESIGN:** Subgroup analysis of a prospective, randomized, placebo-controlled trial.

**MATERIALS AND METHODS:** This study is a subgroup analysis from a randomized, placebo-controlled, double blind study, evaluating the efficacy of UPA for the treatment of uterine leiomyomas. AA patients receiving UPA or placebo were compared to non-AA patients. The primary outcome was change in leiomyoma volume. Secondary outcomes included duration of amenorrhea and presence of ovulation.

**RESULTS:** Forty-five AA and eleven non-AA premenopausal women were treated with UPA at 10 mg, 20 mg or placebo. AA women receiving UPA demonstrated a (-23%±19.1) reduction in leiomyoma volume compared to (+8.2% ± 24.8) in AA women receiving placebo ( $P<0.05$ ). After 3 months, no patients receiving placebo were amenorrheic compared to (73.9%) receiving UPA ( $P<0.05$ ). Patients receiving UPA exhibited a decrease in the number of ovulatory cycles and a decrease in vaginal bleeding. When compared to non-AA women, changes in leiomyoma volume in AA women (-22.7%) were not statistically different (-6.6%),  $P=0.29$ .

**CONCLUSION:** UPA is an effective pharmacologic therapy in African American women for decreasing leiomyoma volume and vaginal bleeding.

*Supported by:* In part, by the Intramural Program in Reproductive and Adult Endocrinology, NICHD, NIH and a Cooperative Research and Development Agreement with HRA Pharma.

O-324 Wednesday, October 24, 2012 04:00 PM

**HOW MUCH DOES AN IVF BABY COST? THE BOSTON IVF EXPERIENCE.** V. A. Moragianni,<sup>a,b</sup> K. N. Aronis,<sup>c</sup> D. Sakkas,<sup>b</sup> A. S. Penzias,<sup>a,b</sup> M. M. Alper.<sup>a,b</sup> <sup>a</sup>Obstetrics & Gynecology, Division of Reproductive Endocrinology & Infertility, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA; <sup>b</sup>Boston IVF, Waltham, MA; <sup>c</sup>Internal Medicine, Boston Medical Center, Boston University, Boston, MA.

**OBJECTIVE:** Numerous models have been proposed to assess the efficiency of IVF. One question that arises consistently is the cost effectiveness of continually pursuing routine IVF treatment or adding a more complex technology to a routine treatment. As an initial step to answer these questions we have determined the cumulative cost of achieving live birth from IVF.

**DESIGN:** Retrospective time to event analysis.

**MATERIALS AND METHODS:** We analyzed a total of 49,530 autologous fresh or frozen IVF cycles from 21,155 patients that were treated in our clinic between 01/1995 and 12/2011. The cost per cycle was as follows: (a) fresh=\$8300, and (b) frozen=\$3000+\$65 per month since last fresh IVF cycle (storage fee). We calculated the total amount each patient spent to

achieve a live birth. We performed a Cox proportional hazard analysis to evaluate the hazard ratio (HR) across different age strata: <30, 30-35, 35-40, and ≥40yo. We also performed accelerated time ratio parametric survival models to evaluate the effect of age on the cost required to achieve the same success rate.

**RESULTS:** When compared with patients <30yo, the HR (95%CI) of the 30-35 age group was 0.91 (0.86-0.97), of 35-40: 0.70 (0.66-0.75) and of >40: 0.33 (0.30-0.35). Similarly, the cost ratio of 30-35 was +6%, of 35-40 +27% and of >40 +107%. For instance, after spending \$12K (one fresh and the ensuing frozen cycle), a <30 patient had a 32% chance of live birth, in 30-35 30%, in 35-40 25%, and in >40 13%.

**CONCLUSION:** Our models demonstrate that patients over 40yo who spend the same amount as their younger cohorts for IVF treatment have a 77% lower chance of achieving a live birth. Moreover, to achieve similar success rates as younger patients they need to spend 107% more. Our results will be further utilized to evaluate the cost effectiveness of treatment or novel adjuvant technologies, such as aneuploidy screening, utilized in ART.

O-325 Wednesday, October 24, 2012 04:15 PM

**"I WAS KIND OF TAKEN ABACK BECAUSE IN MY MIND IT HAD ALWAYS BEEN A PERSONAL AND NOT A PUBLIC HEALTH ISSUE" – HOW PHYSICIAN EXPERIENCE AND FRAMING IMPACTS ADVOCACY FOR INFERTILITY CARE.** G. L. Ryan,<sup>a</sup> A. M. Lewis,<sup>b</sup> L. A. Shinkunas,<sup>c</sup> W. S. Lester,<sup>b</sup> S. P. Stuart.<sup>d</sup> <sup>a</sup>Obstetrics and Gynecology, University of Iowa Carver College of Medicine, Iowa City, IA; <sup>b</sup>Department of Psychological and Quantitative Foundations, University of Iowa, Iowa City, IA; <sup>c</sup>Program in Bioethics and Humanities, University of Iowa Carver College of Medicine, Iowa City, IA; <sup>d</sup>Psychiatry, University of Iowa Carver College of Medicine, Iowa City, IA.

**OBJECTIVE:** Physicians are often the only source of information and advocacy for the infertile; it is vital they identify and address issues at the individual, professional, and societal levels. Our goal was to explore physicians' conceptualizations of infertility and consider how this impacts patient care and advocacy.

**DESIGN:** Qualitative interview study using inductive content analysis.

**MATERIALS AND METHODS:** 18 infertility physicians and 16 non-infertility physicians (19 men, 15 women) with 2-45 years practice were interviewed; age range 33-76. Semi-structured phone interviews (16-58 minutes) were recorded, transcribed verbatim, and verified. Codebook was modified 11 times based on emerging themes. Transcripts were coded independently then by consensus by 2 research assistants and the principal investigator using basic inductive content analysis. Nvivo 8.0 software (QSR International, 2008) was used for data management.

**RESULTS:** 15 themes and 29 subthemes emerged, with more richness in the infertility provider interviews. Neither group was comfortable defining infertility in a language of disease, disability, public health, or rights. Infertility providers tended to feel that a disease definition is valuable for improving infertility insurance coverage and patient suffering. Non-infertility providers were more comfortable positioning their specialty-specific issues in a disease model and had more personal than professional experience with infertility. They regarded infertility as low priority and were less supportive of federal coverage for infertility treatments, more often citing the dangers of growth in low income populations.

**CONCLUSION:** Infertility providers work to fit infertility into a biomedical model, despite conceptual tensions, due to a common desire to alleviate suffering. Non-infertility providers may be a poor advocacy group since they do not generally recognize infertility as disease, nor have experience with the impact of infertility outside of a high-income personal reality.

*Supported by:* U of Iowa WRHR: K12-NIH-HD063117.

O-326 Wednesday, October 24, 2012 04:30 PM

**ASSOCIATIONS BETWEEN IN VITRO FERTILIZATION (IVF) INSURANCE COVERAGE AND CUMULATIVE NUMBER OF CHILDREN.** E. S. Jungheim,<sup>a</sup> L. Pollack,<sup>b</sup> G. A. Macones,<sup>a</sup> R. R. Odem,<sup>a</sup> K. Omurtag,<sup>a</sup> B. Hamilton.<sup>b</sup> <sup>a</sup>Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, MO; <sup>b</sup>Washington University Olin School of Business, St. Louis, MO.

**OBJECTIVE:** Our clinic is located between a state with an infertility insurance mandate that includes IVF and a state without any mandate. Our