

embryo transfer number or eSET was directly correlated with choosing eSET, with higher numbers of channels being associated with higher rates of eSET ( $p < 0.001$ ).

**CONCLUSIONS:** In our digital age, information about IVF and embryo transfer practices is often acquired through multiple information channels. These data suggest that patients who receive more education and utilize more channels for information acquisition may be more likely to choose eSET. Clinics should consider offering and encouraging patients to access multiple information channels to encourage the use of eSET; this information should also be accessible on a smartphone browser.

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**PHYSICIAN INFLUENCE AND IVF: HOW MUCH DO PATIENTS RELY ON PHYSICIAN OPINION WHEN CHOOSING ELECTIVE SINGLE EMBRYO TRANSFER?** E. M. Munch,<sup>a</sup> K. M. Summers,<sup>a</sup> G. Ryan,<sup>a</sup> J. D. Kapfhamer,<sup>a</sup> B. Collura,<sup>b</sup> G. D. Adamson.<sup>c</sup> <sup>a</sup>Reproductive Endocrinology and Infertility, University of Iowa Hospitals and Clinics, Iowa City, IA; <sup>b</sup>RESOLVE, McLean, VA; <sup>c</sup>PAMF Fertility Physicians of Northern California, Saratoga, CA.

**OBJECTIVE:** While some patients desire twins from IVF, most are interested in their physician's opinion regarding the optimal number of embryos to transfer. Our objective was to determine how physician influence relates to the likelihood of a patient undergoing elective single embryo transfer (eSET) or multifetal reduction.

**DESIGN:** Descriptive analysis of online survey results from a cross-sectional sample of U.S. community women.

**MATERIALS AND METHODS:** An online survey advertised through RESOLVE, the National Infertility Association, was conducted over 5 weeks in 2014. Interested respondents were screened for gender and cycle eligibility and gave consent by acknowledging an online privacy statement. Inclusion criteria for this study were age  $< 40$  and the completion of at least one IVF cycle with embryo transfer. The outcomes of interest were elective single embryo transfer (eSET) versus multiple embryo transfer (MET) in 1st cycle, as well as attitudes related to multifetal reduction as queried on a Likert scale. Responses were analyzed using descriptive statistics, with  $X^2$  used to compare proportions among groups.

**RESULTS:** Of 888 participants, 654 met age and cycle criteria. Compared to those receiving MET, participants who underwent eSET were more likely to report that the decision was made between her and her partner and less likely to report it was solely the doctor's decision ( $p < 0.001$ ). There was no association between perceived physician opinion on number of embryos to transfer and whether a patient actually received MET vs eSET ( $p = 0.402$ ). Forty-two percent of participants who underwent eSET stated the most important reason for doing so was potential health risks to offspring, while 23% stated the doctor's opinion was most important. Compared to those undergoing MET, participants who underwent eSET reported being more likely to consider selective reduction if ever recommended by their physician ( $p = 0.001$ ).

**CONCLUSIONS:** Physician opinion may not be a highly critical factor when patients are deciding on eSET, as more study participants reported making this decision on their own and influenced mostly by risks to offspring. This suggests that efforts should be focused on educating patients on the risks of multiple gestations as a means of improving eSET rates and reducing the need to consider selective reduction.

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**CLINICAL OUTCOMES FOR PATIENTS WHO FAILED IN THE FRESH SINGLE EMBRYO TRANSFER AND RECEIVED A SECOND ELECTIVE FROZEN SINGLE OR DOUBLE EMBRYO TRANSFER.** P. A. Monteleone,<sup>a,b</sup> J. Miorin,<sup>c</sup> D. Rodrigues,<sup>b</sup> A. Gomes,<sup>b</sup> M. G. Fujii,<sup>d</sup> r. mirisol,<sup>b</sup> P. Petersen,<sup>b</sup> S. P. Goncalves.<sup>c</sup> <sup>a</sup>Disciplina de Ginecologia, Hospital das Clinicas, Universidade de Sao Paulo, Sao Paulo, Brazil; <sup>b</sup>Monteleone Centro de Reproducao Humana, Sao Paulo, Brazil; <sup>c</sup>Clênica Monteleone, São Paulo, Brazil; <sup>d</sup>Monteleone Human Reproduction Center, Sao Paulo, Brazil; <sup>e</sup>Centro de Reproducao Humana Monteleone, Sao Paulo, Brazil.

**OBJECTIVE:** Patients that fails in a fresh single embryo transfer (SET) cycles tend to ask for two embryos transfer in a second attempt, aiming to increase the success chance. The objective of this study was to evaluate the pregnancy rates in good prognosis patients who failed in fresh elective-SET and had a second cycle with elective double frozen embryo transfer (eD-FET) compared with elective single frozen embryo transfer (eSFET).

**DESIGN:** Retrospective observational study.

**MATERIALS AND METHODS:** This study evaluated 123 ICSI cycles using standard conventional protocol, at a private Assisted Reproduction Center between 2007 and 2014. Good prognosis patients were designated for elective SET in a fresh cycle and pregnancy failed. Patients underwent a second frozen embryo transfer: eDFET ( $n = 84$ ) and eSFET ( $n = 39$ ). It was defined as eSET and eDET patients who transferred one or two top quality embryos, respectively, and had at least two spared top quality embryos cryopreserved.

**RESULTS:** Patients demographics for eDFET and eSFET were: age ( $34.0 \pm 3.1$  x  $34.6 \pm 2.5$ ;  $p = 0.330$ ), basal-FSH ( $7.1 \pm 10.6$  x  $5.7 \pm 1.9$ ;  $p = 0.467$ ), FSH dose administered ( $1708.2 \pm 238.9$  x  $1682.8 \pm 246.1$ ;  $p = 0.595$ ), oocytes collected ( $10.7 \pm 5.3$  x  $14.4 \pm 6.4$ ;  $p = 0.001$ ) and number of embryos cryopreserved ( $5.6 \pm 3.0$  x  $7.6 \pm 4.5$ ;  $p = 0.01$ ). Patients who received eDFET presented lower implantation (16.1%) than eSFET (35.9%;  $p = 0.007$ ) but pregnancy rates were similar (eDFET: 34.6% x eSFET: 41.0%;  $p = 0.492$ ). Patients at eSFET had 1 monozygotic twin pregnancy (6.60%) and eDFET presented 25% of multiple pregnancy ( $p = 0.126$ ). The multiple logistic linear regression demonstrated that transfer of two embryos (eDFET) did not influence the pregnancy rate (OR: 0.87,  $p = 0.738$ ), adjusted for patients age and number of oocytes collected.

**CONCLUSIONS:** Pregnancy rates after eDFET or eSFET in patients that failed at fresh-eSET are similar, while 25% of multiple pregnancy is observed only in eDFET. Hence, patients with good prognosis that failed in the first fresh eSET do not have advantages if receive eDFET in a second cycle compared with eSFET.

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**SALARY TRENDS OF REPRODUCTIVE LABORATORY PROFESSIONALS 2001-2014 AND COMPARISON TO RELEVANT BENCHMARKS.** T. Chang,<sup>a</sup> C. Chang,<sup>b</sup> M. A. Israel,<sup>c</sup> Y. Su.<sup>d</sup> <sup>a</sup>Obstetrics and Gynecology, University of Texas Health Science Center, San Antonio, TX; <sup>b</sup>Reproductive Biology Associates, Atlanta, GA; <sup>c</sup>Progyny, Menlo Park, CA; <sup>d</sup>Research Consultant, San Antonio, TX.

**OBJECTIVE:** To investigate trends in salary and status among reproductive lab professionals in the United States.

**DESIGN:** Retrospective analysis of Society of Reproductive Biologists & Technologists Salary Survey data, and comparable publications and benchmarks.

**MATERIALS AND METHODS:** SRBT biennial survey data 2001-2014 were analyzed to determine longitudinal trends of salary among reproductive lab personnel. Patterns of salary changes in various lab positions, clinic settings, and gender, workload and off-site lab directing were analyzed. In addition, salary data were compared with national average earnings data from U.S. Bureau of Labor Statistics and two other clinical lab wage surveys.

**RESULTS:** A total of 1,436 responses were included in this study. Overall, salaries of reproductive lab professionals have steadily increased, 2.8-8.8% annually, better than the national average of 2.2-2.4% for college/advanced degree workers during the same period. The actual earnings of reproductive lab staff were higher than the national average of BA/BS/advanced degrees (Labor Statistics data) and most clinical lab science specialties except pathologists' assistants (PA) (two other surveys). Director salary increases trended slightly higher to others with advanced degrees nationwide (3.2% vs. 2.3% during 2001-2014, 7.9% vs. 2.1% in 2014), and non-director staff categories saw faster and more significant salary growth (2.3-8.8% vs. 2.2-2.3% nationwide college/advanced degrees during 2001-2014, and -0.6-23.1% vs. 2.1-3.1% in 2014). Lab staff serving a dual embryologist/andrologist role showed the fastest pace of increase, which may reflect the current demand of experienced embryologists. We observed gender-related differences in compensation, with females receiving 10-18% lower salaries in various categories in 2014. This gender gap is similar to other clinical lab science specialties and better than the gap in college/advanced degree workers nationwide. Female director and supervisor salaries have increased faster than their male counterparts in the past decade. The most common benefits received were health/dental insurance, paid time-off, retirement plan, and matching retirement contributions. The average lab staff member processed 114 fresh IVF cycles/year, and off-site directors earned 20% of their total compensation