In vitro maturation of immature oocytes for fertility preservation in cancer patients compared to control patients with fertility problems in an in vitro fertilization program

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Background. The aim of this study was to determine whether in vitro maturation (IVM) of immature oocytes after controlled hormonal stimulation of the ovaries could be important in cancer patients to improve their chances of conception in the future.

Patients and methods. After ovarian stimulation in cancer patients, the number of oocytes and their quality and maturity were compared to control patients with fertility problems in the in vitro fertilization (IVF) program. In both groups of patients, immature oocytes at the developmental stage of germinal vesicle were matured in vitro and the proportion of oocytes that matured in vitro was compared between groups. In a subset of women with fertility problems, intracytoplasmic sperm injection (ICSI) was performed on IVM oocytes to assess their ability to be fertilized and develop into an embryo compared to vivo matured oocytes in the same cycles and consider the procedure in cancer patients.

Results. In patients with different cancers, the disease did not affect the number and quality of retrieved oocytes. In cancer patients, there was even a significantly lower proportion of immature oocytes than in patients with fertility problems (30.0% vs 43.6%; P < 0.05). However, in patients with cancer, fewer oocytes per patient matured in vitro than in patients with fertility problems (1.39 ± 1.04 vs. 2.48 ± 1.83; P < 0.05). After ICSI, the proportions of fertilized oocytes and fertilized oocytes developing into an embryo did not differ between oocytes matured in vitro and in vivo in the same cycles.

Conclusions. Oocyte IVM is proving to be a reliable procedure for resolving immature oocytes after controlled ovarian stimulation in cancer patients.

Key words: cancer; fertility preservation; oocyte; in vitro maturation; vitrification

Introduction

Many young women in the reproductive period of life who do not yet have children or would like to have another child suffer from cancer. Today, cancer therapies are successful, but unfortunately, they can negatively affect the ovarian function (including oocyte quality) and fertility. At a median of 5.0 years from initial breast cancer diagnosis, 49% patients after adjuvant chemotherapy with anthracyclines and taxanes and 11% after therapy with tamoxifen had become post- and peri-menopausal. Decreased ovarian follicle reserve occurs in more than one-third of patients after breast can-
cancer treatment resulting in permanent infertility. In long-term female survivors of pediatric hematologic malignancies 26.7% experienced premature ovarian insufficiency and face infertility after cancer treatment. The situation is similar with other cancers; cancer therapy is the cause of premature ovarian failure in 25% of women with this diagnosis. Therefore, it is very important to consider the preservation of female fertility before oncotherapy. An improvement in the survival rates of cancer patients and recent advances in assisted reproductive technologies have led to significant progress in fertility preservation treatments.

One option is vitrification and long-term storage of the patient’s oocytes for later in vitro fertilization (IVF) with partner’s sperm and transfer of embryos into the uterus. This program is established in many health care institutions around the world for a variety of cancers, including breast cancer. Oocyte cryopreservation is an effective approach, but it is still thought that further studies are needed in cancer patients to ensure the excellent outcomes obtained in women without cancer. After controlled hormonal stimulation of the ovaries, in vitro maturation (IVM) of immature oocytes before vitrification is recommended and not after vitrification/devitrification procedure. Even if there are no differences in survival rates between oocytes vitrified before or after IVM procedure, decreased maturation rates of immature oocytes vitrified before IVM may be explained by underlying ultrastructural and biomolecular alterations.

Human oocyte cryopreservation may offer some advantages compared to embryo freezing in cancer patients and also eliminates some ethical, legal, and moral concerns of embryo freezing, and is an option in young cancer patients who are single. However, the chance of success depends primarily on the number of oocytes that have been vitrified in the patient and some breast cancer patients may have contraindications to exogenous gonadotropin administration for controlled ovarian stimulation. Some recent data show that ovarian stimulation for oocyte vitrification does not modify disease-free survival and overall survival rates in patients with early breast cancer and the safety of pregnancy after an established diagnosis of breast cancer has been confirmed in numerous studies.

In the case of vitrification and storage of oocytes, controlled hormonal stimulation of the ovaries is required to obtain oocytes. Despite careful hormonal stimulation of the ovaries, the significant proportion of oocytes obtained by ultrasound-guided aspiration of ovarian follicles is immature as metaphase I (MI) oocytes or prophase I oocytes with germinal vesicle (GV). Immature MI oocytes mostly mature spontaneously in vitro and are vitrified, while immature GV oocytes do not mature spontaneously and are incapable of fertilization. Therefore, GV oocytes are not vitrified and stored in liquid nitrogen in clinical practice and are discarded and lost to the patient. The important question is whether the maturation of these oocytes in vitro makes sense. There is a lack of data regarding the outcome of in vitro matured oocytes cryopreserved in cancer patients. Recently, the first birth achieved after fertility preservation using vitrification of in vitro matured oocytes in a patient with breast cancer has been reported.

The purpose of this study was to investigate the effectiveness of maturation of immature GV oocytes of cancer patients in laboratory conditions (in maturation medium and co-culture with cumulus cells from mature oocytes of the same patients) compared to control women involved in the IVF program due to fertility problems. Because all oocytes of cancer patients are still frozen, we tried to elucidate the success of IVF procedure, actually intracytoplasmic sperm injection (ICSI), on the in vitro matured oocytes of patients with fertility problems as a model for cancer patients.

Patients and methods

This research was approved by the Slovenian National Medical Ethical Committee (No. 0120-222/2016-2; KME 115/04/16). In this prospective research the immature (germinal vesicle-GV, prophase I) oocytes of two groups of patients were included: i) 45 oocytes of 18 cancer patients with predominating breast cancer (Figure 1) and ii) 74 oocytes of 21 healthy (non-cancer) patients (control) with fertility problems (partners of infertile men with impaired semen quality: oligozoospermia with less than 15 million spermatozoa/ml or teratozoospermia with less than 4% morphologically normal spermatozoa according to the World Health Organization (WHO) Criteria 2010 who were included in the IVF program. All patients were in the reproductive period of life, aged 18 to 43 years.

Oocytes after controlled hormonal stimulation of the ovaries

In both groups of patients, both immature and mature oocytes were together retrieved after controlled hormonal stimulation of the ovaries using
the same, antagonist protocol and ultrasound-guided aspiration of ovarian follicles. In patients with fertility problems, the stimulation was started on day 2 of the menstrual cycle with 150 to 300 I.U. of recombinant follicle-stimulating hormone (rFSH) daily. In cancer patients, the stimulation was initiated immediately after they have been sent to our department, no matter of the cycle phase. The ovarian stimulation was started with 225 to 300 I.U. of rFSH. In breast cancer patients, an aromatase inhibitor – letrozole (2.5 mg every 12 hours) was added to prevent estradiol rise and its possible detrimental effect on breast cancer. In all patients, the gonadotropin-releasing hormone (GnRH) antagonist was added, when dominant follicle measured 14 mm in a diameter. In patients with fertility problems, the oocyte maturation was triggered with choriogonadotropin alfa – Ovitrelle, when follicles measured 18 mm or more. If there were more than 15 follicles in both ovaries, the maturation triggering was performed with GnRH agonist. In majority of cancer patients, GnRH agonist was used for oocyte maturation to prevent ovarian hyperstimulation (ovarian hyperstimulation syndrome; OHSS), but some of them, if there were less than 10 follicles in both ovaries, were also treated by Ovitrelle. All follicles with a diameter of 16 mm or more were aspirated in all patients. A constant aspiration pressure of 180 mm Hg was used to aspirate the oocytes from the follicles.

Mature oocytes with expressed polar body were immediately vitrified by soaking in a mixture of cryoprotectants, direct plunging into liquid nitrogen (-196°C), and stored in it, as described elsewhere.25

In vitro maturation of immature oocytes

Immature GV oocytes were exposed to the procedure of IVM in a seria of media of the IVM Maturation System (MediCult IVM® System, Origio/CooperSurgical, Denmark).

For IVM, each GV oocyte was first exposed for two hours in the LAG Medium for conditioning and then for 24 to 28 hours to the maturation medium of this system containing the reproductive hormones: follicle stimulating hormone (FSH; 75 mIU/ml) and human chorionic gonadotropin (HCG; 100 mIU/ml) and in a co-culture with cumulus cells denuded from mature oocytes of the same patient, as described elsewhere (Figure 2).26 During incubation in these media, oocytes were cultured in a CO₂ incubator at 37°C and 6% CO₂ in air. Oocytes were supposed to be mature (in a metaphase II) when they extruded a polar body. All oocytes of cancer patients and the majority of oocytes of women with fertility problems that matured in vitro were vitrified and stored in liquid nitrogen for later clinical use (IVF). Patients with ≥ 31% GV oocytes had increased oocyte immaturity. A subset of in vitro matured oocytes of women with fertility problems was fertilized in vitro.

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In vitro fertilization by ICSI

In a subgroup of 17 in vitro matured oocytes from 17 patients (1 oocyte per patient) with fertility problems (female partners of infertile men with oligozoospermia or teratozoospermia) ICSI was performed with partner’s sperm one day later after oocyte and sperm retrieval from a couple. Oocytes were denuded by hyaluronidase to remove the cumulus cells and microinjection of one spermatozoon per oocyte was performed, as described elsewhere.27 Only motile spermatozoa were used for ICSI. The next day, fertilization (presence of two pronuclei and extruded second polar body) was checked and embryo cleavage one day later. Good quality embryos were vitrified and stored in liquid nitrogen (-196°C) for later clinical use (transfer to the uterus). The rates of fertilization and embryo cleavage were compared between oocytes that matured in vitro and in vivo (in the ovaries; aspirated as mature) in the same patients after controlled ovarian hormonal stimulation.

Statistics

Both groups of patients, cancer and infertile patients, were compared in terms of the number of oocytes obtained after controlled hormonal stimulation of their ovaries, the proportion of immature and degenerated oocytes, and the proportion of immature (GV) oocytes that matured in vitro. Due to the relatively small number of patients/oocytes included and the abnormal distribution of data, tested by Shapiro-Wilk normality test, non-parametric tests (Fisher’s exact and Mann-Whitney U tests) were performed; statistical significance was set at P < 0.05. After ICSI, the fertilization and embryo cleavage rates of oocytes that matured in vitro were compared with oocytes of the same patients that matured in vivo and were aspirated from the ovaries as mature oocytes in the same cycle of controlled ovarian hormonal stimulation using Fisher’s exact and Wilcoxon tests; statistical significance was set at P < 0.05.

Results

Cancer patients had different types of cancer, but breast cancer was predominant (Figure 1). The average age of cancer patients was 30.3 ± 6.3 years and of women with fertility problems 33.4 ± 5.0 years. The two groups of women did not differ significantly in their age. There was also no significant difference in the age of patients with breast cancer and patients with other cancers (32.0 ± 6.2 vs. 29.0 ± 6.0 years).

Numbers, quality and immaturity of oocytes after controlled hormonal stimulation of the ovaries

After controlled hormonal stimulation of the ovaries, 198 oocytes were retrieved in cancer patients and 259 oocytes in infertile women. Cancer patients and patients with fertility problems did not differ significantly in the number of retrieved oocytes (11.0 ± 9.0 oocytes/patient vs. 12.3 ± 9.2 oocytes/patient), as revealed by Mann-Whitney U test. In cancer patients, the proportion of immature GV and MI oocytes was significantly lower than in patients with fertility problems (30.0% vs. 43.6%; P < 0.05), as revealed by Fisher’s exact test (Table 1). The groups did not differ significantly in the proportion of GV oocytes (23.0% vs. 28.6%) (Table 1); among patients with immature oocytes, 50% of cancer patients and 48.0% of patients with fertility problems had a proportion (≥31%) of GV oocytes with a germinal vesicle, which did not differ significantly. There was also no difference in the proportion of degenerated oocytes between cancer patients and patients with fertility problems (8.6 vs. 6.5%) (Table 1).

If we considered the type of cancer, we found that there was no significant difference in the number of all immature (MI and GV) oocytes in patients with breast cancer compared to patients with fertility problems or patients with other cancers (4.17 ± 3.25 vs. 5.29 ± 3.76 and 2.92 ± 2.47 immature oocytes/patient, respectively), as revealed by Mann-Whitney U test. There was also no statistically significant difference in the proportion of all immature (GV and MI) oocytes in breast cancer patients compared to patients with other cancers (36.0% vs. 27.0% and 43.6%), as found using the Fisher’s exact test. Nevertheless, there was a tendency for a significantly higher proportion of immature, GV oocytes in breast cancer patients compared to patients with other cancers (31.43% vs. 18.75%; P = 0.0531, Fisher’s exact test).

In vitro matured oocytes

Forty-five GV oocytes in cancer patients and 74 GV oocytes in patients with fertility problems underwent IVM procedure (Table 2); the proportion of oocytes (15.5% in cancer patients and 12.2% in
In cancer patients, there was also a lower proportion of oocytes that matured in vitro in patients with breast cancer than in patients with other cancers and patients with fertility problems (54.5% vs. 81.2% and 80.0%) (Table 2). The difference between patients with breast cancer and women with fertility problems tended to be statistically significant (P = 0.0862; Fisher’s exact test) and was probably not significant due to the relatively low number of oocytes included.

Overall, 198 oocytes were retrieved in cancer patients, of which 139 were mature. Following IVM, the number of total mature oocytes increased to 164 (13.0% increase in mature oocyte yield). In patients with fertility problems, 259 oocytes were retrieved, of which 146 were mature. After IVM, the number of total mature oocytes increased to 198, which means 20.1% increase in mature oocyte yield. Thus, there was no significant difference in the yield of mature oocytes after IVM between cancer patients and patients with fertility problems. 15.5% (7/45) GV oocytes in cancer patients and 12.2% (9/74) GV oocytes in patients with fertility problems degenerated before in vitro maturation procedure.

Results of ICSI of in vitro matured oocytes in patients with fertility problems

In vitro fertilization of 49 oocytes in 17 patients with fertility problems (average age 34.3 ± 4.4 years) was performed by ICSI with partner’s semen (in 2 men oligozoospermia and 15 men teratozoospermia). After performing this method, 27 (55.1%) oocytes were fertilized (expressing two pronuclei and two polar bodies) and 23 (85.2%) fertilized oocytes (zygotes) further developed into an embryo, as shown in Table 3; four zygotes did not cleave further. Good quality embryos were vitrified and stored in liquid nitrogen for future clinical use in patients (transfer into the uterus).

After ICSI, the fertilization and cleavage rates of 49 oocytes that matured in vitro were compared with 121 oocytes of the same patients that matured in vivo and were aspirated from their ovaries as mature oocytes (metaphase II [MII] oocyte meiosis) in the same cycle of controlled ovarian hormonal stimulation. Of the 121 oocytes obtained as mature oocytes, 69 oocytes were fertilized, representing a fertilization rate of 57.0%. Sixty-one fertilized oocytes further developed into an embryo (Table 3). Fisher’s exact test revealed no statistical differences in the proportions of fertilized oocytes, noncleaved zygotes, and embryos obtained by ICSI on in vitro and in vivo matured oocytes (Table 3).
In patients with an increased proportion of immature (GV) oocytes (≥31%), there was a tendency for a lower proportion of fertilized oocytes and a higher proportion of non-cleaved zygotes, but the differences were not statistically significant (Table 4).

**TABLE 3.** Non-significant differences in fertilized oocytes, non-cleaved zygotes, and cleavage embryos obtained by intracytoplasmic sperm injection (ICSI) on in vitro matured and in vivo matured oocytes of patients with fertility problems (in the same cycles)

| ICSI cycles (n = 17) | In vitro matured oocytes | In vivo matured oocytes* |
|---------------------|--------------------------|-------------------------|
| Number of microinjected oocytes | 49 | 121 |
| Fertilized oocytes | 27 (55.1%) | 69 (57.0%) |
| Non-cleaved zygotes | 4 (15.0%) | 8 (11.6%) |
| Cleavage embryos | 23 (85.2%) | 61 (88.4%) |

* = non-significant differences, as revealed by Fisher’s exact test

**TABLE 4.** Non-significant differences in results of intracytoplasmic sperm injection (ICSI) cycles (fertilized oocytes, non-cleaved zygotes, cleavage embryos) on in vitro matured oocytes of patients with fertility problems regarding the number of immature (germinal vesicle [GV]) oocytes

| ICSI cycles (n = 17) | ≤ 30% GV oocytes | ≥ 31% GV oocytes |
|---------------------|-----------------|-----------------|
| Female age (years) | 34.4 ± 3.0 | 34.3 ± 5.6 |
| Number of microinjected oocytes | 16 | 33 |
| Fertilized oocytes | 11 (69.0%) | 16 (48.5%) |
| Non-cleaved zygotes | 0 (0%) | 4 (25.0%) |
| Cleavage embryos | 11 (100%) | 12 (75%) |

Non-significant differences, as revealed by Fisher's exact test

**Discussion**

The results of this research show that cancer and control healthy patients with fertility problems did not differ in the number and quality of oocytes after controlled hormonal stimulation of their ovaries, which is positive. In cancer patients, there was even a significantly lower proportion of immature oocytes than in patients with fertility problems. However, in patients with cancer, fewer oocytes per patient matured in vitro than in patients with fertility problems (1.39 ± 1.04 vs. 2.48 ± 1.83, P < 0.05). Following ICSI of oocytes in patients with fertility problems, the fertilization and embryo cleavage rates were approximately the same in oocytes that matured in vitro and in vivo in the same patients, in the same cycles of controlled hormonal stimulation of the ovaries. This is also to be expected in cancer patients.

The proportion of mature, MII oocytes in the patients with fertility problems included in this research was relatively low (56.4%) compared to the internationally accepted reference value of 70-80%, because we included mainly patients with a higher proportion of immature oocytes which did not reflect the average condition; in cancer patients, the proportion of mature oocytes was higher (70%) and within the reference value.28 The number and quality of oocytes in cancer patients did not differ between different cancers and from control patients with fertility problems. The same has been found in other studies for different types of cancer such as breast cancer, lymphoma, gliomas and other cancers.29,30 For breast cancer, the results of various studies are otherwise contradictory. In a study by Malacarne et al., as in our study, the average number of oocytes obtained per breast cancer patient after ovarian stimulation did not differ significantly from healthy control women including oocyte donors, women with fertility preservation for non-medical reasons, and female partners of infertile men in an IVF program31; it was concluded that patients with breast cancer undergoing controlled ovarian hormonal stimulation for fertility preservation can expect the ovarian response predicted for their age. The results obtained by different studies do not support the notion of a negative impact of the breast cancer gene 1/2 (BRCA1/2) mutation on the ovarian response of women with breast cancer.31-33 Nevertheless, the results of some other studies suggest the reduced number and maturity of oocytes obtained for cryostorage in patients with breast cancer35, which may be attributed to the higher grade of cancer36 or different expression of hormonal receptors.36

There is little data in the literature on how different cancers affect the oocyte IVM in cancer patients. The oocyte IVM rate in breast cancer patients was found to be approximately 53.2 to 64.2% in the...
study of Shalom Paz et al., which is very similar to our study (54.5%), or slightly higher - 62.0%, 66.0% or 66.7% in some other studies. In this study, the proportion of immature oocytes matured in vitro tended to be lower in breast cancer patients (54.5%) than in patients with fertility problems (80.0%), while this was not observed in patients with other cancers (81.2%). Although, the difference was not significant, possibly due to relatively low number of patients and oocytes included. In a study conducted by Liu et al., 811 genes were identified that were expressed differently in malignant breast tissue compared to healthy breast tissue; among the up-regulated genes was also a group of genes involved in the cell cycle and progesterone-mediated oocyte maturation. For cancer patients, Cohen et al. found that the mean oocyte maturation rate in stimulated IVF cycles was 38%, which is significantly lower than in our study (66.0%; 54.5% in breast cancer and 81.0% in other cancers). In our study, IVM of oocytes in coculture with cumulus cells from mature oocytes in the same patients may have been beneficial, at least in part providing an ovarian niche. Also Chatroudi et al. have been beneficial, at least in part providing an ovarian niche. Thus, we also had to take certain safety precautions in cancer patients. In these patients, the ovarian hormonal stimulation was initiated by GnRH analogue to prevent hyperstimulation, but more patients with less than 10 follicles were also treated with Ovitrelle similar to patients with fertility problems. Therefore, in most patients, oocyte maturation was triggered by Ovitrelle. If we used exactly the same method of hormonal ovarian stimulation and triggering oocyte maturation in cancer patients and patients with fertility problems, there might be more immature oocytes in cancer patients, but this was not possible for cancer-related safety reasons.

In addition, for safety reasons, breast cancer patients were also treated with an aromatase inhibitor, letrozole, to prevent an increase in estradiol and worsening of the disease. Thus, based on our own experience and literature, we believe that both random start of hormonal stimulation in cancer patients and use of aromatase inhibitor in patients with breast cancer do not affect the number, maturity and in vitro maturation of oocytes obtained in these patients.

Letrozole treatment may also increase the intraovarian androgen levels, which have a negative impact on granulosa cells (apoptosis) in the late antral and pre-ovulatory follicles. In this research, granulosa (cumulus) cells were used in co-culture for oocyte maturation, which may lower the maturation rate. However, we performed in vitro maturation of oocytes with cumulus cells of mature oocytes because our previous work showed that coculture with cumulus cells does not affect the proportion of in vitro matured oocytes, but improves the molecular status of oocytes (gene expression profile) compared to oocytes matured in vivo.

In patients with fertility problems, we determined the FSH, LH and AMH levels in early follicular phase of the cycle as well as the number of antral follicles. For cancer patients, we have no such data. Only informative ovarian scan with antral follicle estimation was performed at the beginning of ovarian stimulation.

In our study, approximately the same proportion of oocytes were matured in vitro and in vivo matured oocytes. Some studies have shown poorer embryo development and live birth rates with in vitro matured oocytes, which could be linked to structural and morphologic differences in human oocytes after IVM due to suboptimal maturation medium and lack of ovarian niche. It needs to be point out that in our study, oocyte IVM was performed in coculture with cumulus cells from ma-
titure oocytes of the same patients thus providing a degree of ovarian niche. In spite of a lower rate of good-quality embryos and different developmental dynamics of embryos, pregnancy rates as well as live births did not necessarily differ after oocyte IVM, as found by Roesner et al. Moreover, in a matched setting between IVM and IVF babies born from women with polycystic ovaries, no significant increased risk associated with IVM has been identified in 2-year-old singletons born after IVM and after a mean follow-up up to 7.5 years. In general, more studies are urgently required to improve IVM—vitrification method to successfully preserve oocytes collected from cancer patients.

Conclusions

We may conclude that ‘rescue’ of immature oocytes with IVM is a useful strategy to improve the mature oocyte yield of fertility preservation cycles in cancer patients. Immature oocytes retrieved during oocyte and also embryo cryopreservation cycles in cancer patients should not be discarded in order to improve the future potential of pregnancy in these patients. Their immature oocytes can mature in vitro comparable to healthy controls. After ICSI, approximately the same proportion of in vitro matured oocytes could be fertilized and developed into an embryo as in oocytes matured in vivo.

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