functional sperm parameters). Stepwise multiple regression analysis on all of the parameters (male and female) yielded two estimation curves only related to non sperm parameters: PIRCSI=1.608412-0.036848*AGE-0.046633*DURA*(AGE=years of age of the female; DURA=duration of infertility in years) PIRCSI=0.609082-0.017673*AGE

Conclusion: individualization of expected pregnancy rates and implantation rates for IVF and ICSI is possible; the estimation curves should be made for each centre; ICSI curves are not related to any sperm parameter.

45. Y-deletions and ICSI: from gene to clinic.


46. Vasectomy, vasovasostomy and MESA/ICSI: is it the future triad of vasectomised man who regrets vasectomy?


47. Testis-specific histone 2B in human spermatozoa

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48. Identification of pro-nerve growth factor in rat round spermatids: potential role as a trophic factor in the maintenance of Sertoli cell viability.

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Results: Nine men didn’t cooperate to examine the semen. The potency of the vas was reversed at 75% (56/75) of the cases. Six patients lost their child wish. The number of 69 patients were divided in three groups: group A; (fertile group) n=21 (30%) with average spermatozoa counts (ASC) of 37±19 (12-82) X10^6/ml, group B; (subfertile group) n=29 (42%) with ASC of 20±21 (1-79) X10^6/ml and an azoospermic group C, n= 19 (28%). Ten couples from group C were treated by MESA/ICSI. Seven healthy children have been already born. Since 1-4-1996 MESA-treatments were stopped in the Netherlands. There was a significant difference between group A and B (only) in the sperm counts (P<0.05). A, B and C were not statistically significant different concerning the hormonal state and the testis biopsies score. The interval between the vasectomy and the vasovasostomy was 10.8±4.1 and 6.7±2.5 years in azoospermic respectively fertile group (p=0.001).

Conclusions: MESA/ ICSI (efficacy 70%) is a powerful tool in case of vasectomy and then vasovasostomized men when azoospermia persists.