**Prevalência de anomalias citogenéticas e da pré-mutação do gene *FMR1* numa população Portuguesa com insuficiência ovárica prematura**

Ana Raquel Neves1,2, Ana Sofia Pais1,2, Susana Isabel Ferreira3, Vera Ramos1, Maria João Carvalho1,2, Alexandra Estevinho4, Eunice Matoso4, Fernanda Geraldes1, Isabel Marques Carreira3, Fernanda Águas1

1 Department of Gynecology, Centro Hospitalar e Universitário de Coimbra, Coimbra, Portugal

2University Clinic of Gynecology, Faculty of Medicine, University of Coimbra, Clinical Academic Center of Coimbra, CACC, Coimbra, Portugal

3 Cytogenetics and Genomics Laboratory, Faculty of Medicine, University of Coimbra, Polo Ciências da Saúde, Coimbra

4 Cytogenetics Laboratory, Department of Medical Genetics – Pediatric Hospital, Centro Hospitalar e Universitário de Coimbra

Corresponding author:

Ana Raquel Neves

Address: Rua Augusta, 3000-045 Coimbra

E-mail address: anaraquel.lneves@gmail.com

Tel: +351915227816

**Prevalência de anomalias citogenéticas e da pré-mutação do gene *FMR1* numa população Portuguesa com insuficiência ovárica prematura**

**Abstract**

**Introduction**

Chromosome abnormalities contribute to 10% of cases of premature ovarian insufficiency. Most are associated with X chromosome. *Fragile Mental Retardation 1* (*FMR1)* gene premutation has an estimated prevalence of 1-7% in sporadic cases and up to 13% in familial cases.

Our aim was to describe the clinical characteristics, cytogenetic and *FMR1* geneanalysisof a Portuguese population with premature ovarian insufficiency.

**Material and Methods**

Women diagnosed with premature ovarian insufficiency in a Portuguese tertiary centre were retrospectively analysed. Data was retrieved from electronic medical records including clinical characteristics, cytogenetic and *FMR1* analysis. Main outcome measures were the prevalence of chromosome abnormalities and *FMR1* premutation in a Portuguese population with premature ovarian insufficiency.

**Results**

Ninety-four patients were included, with a median age at menopause of 36 years. The prevalence of chromosome abnormalities was 16.5% (14/85) and most were X chromosome related (78.6%). The prevalence of *FMR1* premutation was 6.7% (6/90). The prevalence of karyotypic abnormalities or *FMR1* premutation did not differ significantly between familial and sporadic cases. Neither chromosome abnormalities nor *FMR1* premutation influenced age at menopause or FSH levels at diagnosis in premature ovarian insufficiency patients.

**Discussion**

This is the first study describing the clinical characteristics and both cytogenetic and *FMR1* analysis in a Portuguese population with premature ovarian insufficiency. The rate of chromosome abnormalities in our sample was higher than in other populations, while the prevalence of *FMR1* premutation was similar to previous reports.

**Conclusions**

Our results underline the importance of genetic screening in premature ovarian insufficiency patients in both etiological study and genetic counselling.

*Fragile Mental Retardation 1* (*)*

de insuficiência ovárica prematura

insuficiência ovárica prematuramédicoclínicasdesfechosinsuficiência ovárica prematura

(14/85) , n=11a pré-mutação (6/90) pré-mutação pré-mutação na população com insuficiência ovárica prematura

insuficiência ovárica prematura pré-mutação

doentesinsuficiência ovárica prematura

**Keywords:** Premature ovarian insufficiency, *FMR1* premutation, chromosome abnormalities, cytogenetic analysis

**Introduction**

Premature ovarian insufficiency (POI) is defined as the loss of ovarian function before the age of 40 and affects approximately 1% of women 1. Clinically, patients may present with primary or secondary amenorrhea, or with olygomenorrhea 1. Several factors have been recognized as causes of POI, such as genetic factors, previous chemo- or radiotherapy, bilateral ovarian surgery, autoimmune or infectious diseases 1–3. In most cases, however, the underlying cause will remain unknown.

In the last decades, an increasing interest has been drawn to the genetic causes of POI 4–6. Chromosome abnormalities are known to be present in 10-13% of patients with POI and most are associated with X chromosome 4,7,8. Numerous karyotypic abnormalities have been reported, ranging from X chromosome deletions, X-autosome translocations or X-isochromosomes to numerical defects 4,9. X-monosomy, both with and without mosaicism, has been associated with an accelerated follicular atresia 4. 47,XXX patients are also at risk for POI, with a reported prevalence varying between 1.5% and 3.8%. The exact mechanism is still unclear but an association with autoimmune diseases or a meiotic disturbance caused by an extra X chromosome have been proposed 4,7,10. In 1973, Sarto et al defined a X chromosome critical region from Xq13-Xq21 to Xq23-q27 11. The implication of this region in translocations or deletions was associated with POI. Multiple studies have corroborated this finding 4.

*Fragile Mental Retardation 1* (*FMR1*) gene is the strongest genetic association with POI 6. The *FMR1* premutation (*FMR1*-PM) has a prevalence of 1:130-250 in the female population 5,12. Carriers of premutated alleles, with 55-200 CGG repeats, are known to have a risk of developing POI as high as 34% 13,14. A relation between the number of CGG repeats and the development of POI has been reported, although the number of repeats associated with the highest risk is still a matter of debate 15–17. Contrary to what has been reported in the past, intermediate alleles (45-54 CGG repeats) do not seem to be associated with POI 18.

Carriers of FMR1-PM are not only at risk of developping POI, but also have an increased risk of fragile-X-associated tremor/ataxia syndrome (FXTAS) 1,19. This is a late onset neurodegenerative disorder, characterized by gait ataxia, dementia and intention tremor, which occurs in male carriers of FMR1-PM. The penetrance of symptoms increases with age, affecting more than one third of patients with 50 years and exceeding 50% for men aged 70-90 years. Females are also affected although to a lesser extent 19.

Another reason to test for *FMR1*-PM is the increased risk of expanding to the full length mutation (>200 CGG repeats) in the offspring, leading to the Fragile X Syndrome (FXS). This risk is directly associated with the number of the premutation carrier CGG repeats, increasing significantly with more than 65-70 repeats 20.

These figures highlight the importance of the genetic characterization of these patients, both at the chromosomal and molecular level. This will contribute to a better understanding of the biological mechanisms associated with POI. Also, this knowledge will allow for an evaluation of their family risk of developing POI or having a fragile X or FXTAS descendent, identifying family members candidates to genetic evaluation, genetic counseling or prenatal diagnosis. In this regard, a multidisciplinary approach envolving gynecologists, obstetricians, geneticists and neurologists is of paramount importance in the correct counselling of these patients.

It is known that population characteristics, such as ethnicity, may affect POI prevalence and its genetic contribution 1. Therefore, our aim was to describe, for the first time, both cytogenetic abnormalities and *FMR1* analysis in a Portuguese population with POI.

**Methods**

*Study design*

Our group carried out a retrospective study regarding patients with the diagnosis of POI who attended their first visit in a tertiary university-affiliated hospital between January 2010 and December 2018. The study was performed in accordance with the Helsinki Declaration. Since the study involved completely anonymous data extraction from electronic medical records, patient consent was not required. Inclusion criteria were: primary or secondary idiopathic amenorrhea for at least 4 months in women < 40 years and two serum FSH measurements > 25mUI/mL obtained at least 1 month apart. Patients with conditions known to induce POI (previous chemo- or radiotherapy, ovarian surgery and autoimmune diseases) were excluded. Patients with typical Turner syndrome stigmata were also ruled out. Family history of POI was considered when a history of first or second-degree relatives with POI was present. Family history of Fragile X syndrome was validated when a medical report confirming the diagnosis was available.

Electronic medical files were reviewed for gynecological and obstetric history (age at menarche and menopause, gravidity and parity, previous miscarriages and menstrual pattern), family history of POI and Fragile X Syndrome and laboratorial results (plasma serum FSH and estradiol levels at diagnosis, cytogenetic analysis and FMR1 analysis).

*FSH and estradiol measurements*

Plasma serum levels of estradiol and FSH were measured using a commercial chemiluminiscence array (CMIA) using the Architect analyser (Abbot Diagnostics, Spain).

*Cytogenetic analysis*

Chromosomal analysis was performed on metaphases obtained from 72 h phytohemagglutinin (PHA) stimulated peripheral blood lymphocyte cultures according to standard procedures. Analysis of GTG-banded chromosomes was done at a resolution of 700 bands per haploid genome, according to the International System for Human Cytogenetic Nomenclature (ISCN) 2016 21. A minimum of 30 cells were counted to rule out mosaicism, the common occurrence of age related sex chromosome losses and/or gains was considered before reporting sex chromosome mosaicism 22,23.

*FMR1 analysis*

Genomic DNA was extracted from peripheral blood lymphocytes using Jetquick blood and cell culture DNA Midi Spin kit (Genomed, Löhne, Germany) and DNA concentration and purity were evaluated using a NanoDrop1000 Spectrophotometer (Thermo Scientific, Waltham, USA). *FMR1* gene CGG repeat number was determined by conventional PCR using primers C and F described by Fu et al. and by Triplet Repeat Primed PCR (TP PCR) using Asuragen AmplideX® *FMR1* PCR Kit (Asuragen, Austin, USA), as previously described by Ferreira *et al* 24,25.

*Statistical analysis*

Statistical analysis was performed using SPSS Statistics, Version 23.0 (IBM Corp., Armonk, NY, USA). Categorical variables were compared using the Fisher’s exact test according to the Cochrane rules. Quantitative non-normal variables were expressed as median (interquartile range) and the non-parametric Mann-Whitney U test was used for distribution comparisons. All tests were 2 tailed, and p < .05 was considered statistically significant.

**Results**

*3.1 Clinical characteristics*

A total of 94 patients enrolled the study. Patients’ gynecological and family history is shown in Table 1. Median age at menopause was 36.0 (6.0) years. The majority of patients reported secondary amenorrhea (95.7%, n=90).

Obstetric history was unavailable in 4 patients. Overall, the nulliparity rate was 40.0% (36/90) and 18.9% (17/90) of the patients had a history of previous spontaneous miscarriage.

Twenty-three patients presented a family history of POI. The prevalence of primary amenorrhea was 4.3% (1/23) in familial cases and 4.2% (3/71) in sporadic POI patients. A family history of Fragile X Syndrome was present in 2 patients. None of the cases with family history of Fragile X Syndrome presented with primary amenorrhea.

No statistically significant difference was found between the median FSH at diagnosis in patients with primary vs. secondary amenorrhea [64.9 (56.0) vs 80.0 (39.0) IU/l, p=0.392, Mann Whitney test].

*3.2 Chromosomal abnormalities*

Due to missing data, the karyotype was analysed in 85 patients (Table 2).

An abnormal karyotype was observed in 16.5% (n=14), of which 78.6% (n=11) involved the X chromosome. The most common abnormality was X chromosome mosaicism, which was found in 50.0% of our cohort (7/14). The 4 patients with primary amenorrhea presented a normal karyotype.

No significant difference was found regarding age at menopause [35.5 (7.8) vs 36.0 (6.0) years, p=0.691, Mann Whitney test] or FSH at diagnosis [83.0 (62.0) vs 78.1 (32.0) IU/l, p=0.415, Mann Whitney test] between patients with (n=14) or without (n=71) an abnormal karyotype.

Also, no statistically significant difference was found regarding the prevalence of karyotypic abnormalities between the 23 patients with a family history of POI (8.7%, n=2) and those without (19.4%, n=12) ( p=0.333, Fisher’s exact test).

*3.3 FMR1 analysis*

Due to missing data, *FMR1* analysis was performed in 90 patients (Table 3). *FMR1*-PM was present in 6.7% (n=6). The most frequent CGG number of repeats was 30 (n=53), followed by 31 (n=19) and 29 (n=18).

None of the 4 patients with primary amenorrhea presented the *FMR1*-PM.

No significant difference was found between patients with and without *FMR1*-PM concerning age at menopause [38.0 (1.8) vs 36.0 (6.0) years, p=0.092, Mann Whitney test] or FSH levels at diagnosis [84.7 (63.0.) vs 77.7 (40.0) IU/L, p=0.340, Mann Whitney test].

There was a higher prevalence of *FMR1*-PM in patients with a family history of POI but this difference was not statistically significant [13.0% (3/23), vs 4.5% (3/67), p=0.176, Fisher’s exact test].

Both patients with a family history of X Fragile Syndrome carried premutated alleles [(30,60) and (35,58)].

**Discussion**

This is the first study describing the clinical characteristics and both cytogenetic and *FMR1* analysis in a Portuguese population with POI.

The median age at menopause in our population was 36 years, similar to the results published by Murray *et al* in a UK population 26. In an Italian study, Baronchelli *et al* also reported a mean age at menopause of 34 years 27. However, in this study the authors considered patients with menopause before the age of 45 years 27. Janse *et al* described a median age at menopause of 32 years in a POI Dutch population 28. Lower ages at menopause have been reported in POI non-European populations, varying between 24 and 30 years 7,8,29–31. Although more studies are needed to consolidate this data, the available evidence seems to point towards a higher age at menopause in European populations with POI. This is in line with previous reports which suggest differences regarding age of natural menopause in different ethnic groups 32. Despite the controversy regarding race/ethnicity *per se* as a factor that influences age at menopause, a higher educational level, the prolonged used of oral contraceptives and a higher baseline weight seem to be associated with a higher age at natural menopause 32,33. The exact mechanism behind these associations is not completely understood. Although no epidemiological studies have been performed in POI populations, we hypothesize that these factors may also contribute to our results.

The prevalence of primary amenorrhea in our population was 4.3% (95%CI 1.6-11.0%), which is lower than in previously analysed populations (13.2%-51.0%) 7,8,28,29,31,34. We hypothesized that the fact that our department assists predominantly adult patients might have contributed to this bias.

The rate of previous spontaneous miscarriage was 18.9% (95%CI 12.0-28.5%), higher than reported by Allen *et al* and Jansel *et al* in a POI population (5.0-13.9%), but similar to the expected rate in the general population 15,28,35.

The prevalence of chromosomal abnormalities in our population was 16.5% (95%CI 9.9-26.1%). Most studies report a prevalence of karyotypic abnormalities varying between 9% and 14% 7,8,27,28,31,34. However, a higher prevalence, between 21% and 32%, has also been reported in Tunisian, American, Chilean and Turkish populations 29,36–38. Similarly to what has been previously published, most karyotypic abnormalities were X chromosome related 7,8,28,29. In accordance with the results of Lakahl *et al* and Janse *et al*, in our population, the most frequent were mosaic numerical X chromosome abnormalities 28,31. Other authors reported X chromosome structural abnormalities as the most frequent 7,8,27,29. Regarding X chromosome structural abnormalities, in our sample, all cases involved the Xq, which is in agreement with previous studies and with the critical regions previously defined for the development of POI (Xq13-Xq21 and Xq23-Xq27) 4,7,11. Two patients presented robertsonian translocations, which have also been previously reported in POI patients, although the autosomal role in POI remains unexplained 4,7 Finally, one patient, who was referred to our department due to secondary amenorrhea, presented one autosomal mosaic involving a trisomy 21 in two different cell lines (47,XX,+21[2]/46,XX[38]). Being a mosaic, we cannot predict the presence of the trisomy in other tissues and a causal effect with POI cannot be disregarded, since women with Down syndrome have a higher chance to suffer from POI 39,40.

Despite the fact that previous studies found a higher prevalence of chromosome abnormalities in patients with primary amenorrhea than in patients with secondary amenorrhea 8,29,31, in our study none of the cases with primary amenorrhea presented karyotypic abnormalities. Most certainly, the small size of the primary amenorrhea subgroup (n=4) was underpowered to provide these differences. Similarly to what has been previously described, no difference was found regarding the prevalence of karyotypic abnormalities in familial and sporadic cases 8,31.

The prevalence of *FMR1*-PM in our sample was 6.7% (96%CI 3.0-14.2%), similar to what has been previously described in non-Asian populations 1,29. In Asian populations, the prevalence seems to be lower (0.5-1.5%) 30. This is in line with a previous study involving almost 135.000 women from an unselected pan-ethnic cohort, which also reported a lower incidence of *FMR1*-PM in Asian patients 41. In accordance with other studies, the prevalence was higher in familial cases of POI (13.6% vs. 4.5%)5,14,26. The fact that this difference was not statistically significant in our sample may also be attributed to the small sample size. The number of CGG repeats has emerged as a possible predictor of risk and severity of *FMR1*-related POI. Despite still being a matter of debate, 80-100 repeats alleles seem to confer the highest risk 15,16. In our sample, among the 6 patients with *FMR1*-PM, only 2 presented alleles in the high-risk zone (respectively, 80 and 82).

The most frequent number of CGG repeats has been reported as 32 4, while in our sample the most frequent allele was 30. This probably reflects population related variations, which account for the importance of the genetic characterization of these patients on a population based level. Considering that Fragile X Syndrome is the result of the expansion of the number of CGG repeats when transmitted from mother to offspring, the fact that both patients with family history of Fragile X Syndrome presented *FMR1*-PM [(30,60) and (35,58)] was an expected finding. In accordance with the findings by Bouali *et al*, all patients with *FMR1*-PM presented with secondary amenorrhea 29.

Taking into account the prevalence of chromosomal abnormalities and *FMR1*-PM in our cohort, these results demonstrate the importance of a genetic screening for patients with POI and add new data on the different phenotypic and genotypic patterns of this disorder in different populations. We highlight the higher prevalence of chromosome abnormalities in the Portuguese cohort studied. Chromosomal studies and *FMR1* analysis not only provide an etiologic explanation for the POI patient, but they also bear important information for both reproductive and genetic counselling, not only for the couple but also for other relatives. Taking into account the extra-reproductive risks conferred by *FMR1-*PM, namely FXS and FXTAS, the importance of a multidisciplinary approach for these patients, involving gynaecologists, obstetricians, neurologists and medical geneticists should not be disregarded.

*Funding sources*

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

**References**

1. European Society for Human Reproduction and Embryology (ESHRE) Guideline Group on POI, Webber L, Davies M, Anderson R, Bartlett J, Braat D, Cartwright B, et al. ESHRE Guideline: management of women with premature ovarian insufficiency. *Hum Reprod*. 2016;31(5):926-937. doi:10.1093/humrep/dew027

2. Coccia ME, Rizzello F, Mariani G, Bulletti C, Palagiano A, Scarselli G. Ovarian surgery for bilateral endometriomas influences age at menopause. *Hum Reprod*. 2011;26(11):3000-3007. doi:10.1093/humrep/der286

3. Silva C, Yamakami L, Aikawa N, Araujo D, Carvalho J, Bonfá E. Autoimmune primary ovarian insufficiency. *Autoimmun Rev*. 2014;13(4-5):427–430. doi:10.1684/mte.2017.0645

4. Qin Y, Jiao X, Simpson JL, Chen ZJ. Genetics of primary ovarian insufficiency: New developments and opportunities. *Hum Reprod Update*. 2015;21(6):787-808. doi:10.1093/humupd/dmv036

5. Rossetti R, Ferrari I, Bonomi M, Persani L. Genetics of primary ovarian insufficiency. *Clin Genet*. 2017;91(2):183-198.

6. Greene AD, Patounakis G, Segars JH. Genetic associations with diminished ovarian reserve: A systematic review of the literature. *J Assist Reprod Genet*. 2014;31(8):935-946. doi:10.1007/s10815-014-0257-5

7. Jiao X, Qin C, Li J, Qin Y, Gao X, Zhang B, et al. Cytogenetic analysis of 531 Chinese women with premature ovarian failure. *Hum Reprod*. 2012;27(7):2201-2207. doi:10.1093/humrep/des104

8. Kalantari H, Madani T, Zari Moradi S, Mansouri Z, Almadani N, Gourabi H, et al. Cytogenetic analysis of 179 Iranian women with premature ovarian failure. *Gynecol Endocrinol*. 2013;29(6):588-591. doi:10.3109/09513590.2013.788625

9. Liu J, Cox L. Primary ovarian insufficiency: an update. *Int J Womens Health*. 2014;6:235. doi:10.2147/IJWH.S37636

10. Goswami R, Goswami D, Kabra M, Gupta N, Dubey S, Dadhwal V. Prevalence of the triple X syndrome in phenotypically normal women with premature ovarian failure and its association with autoimmune thyroid disorders. *Fertil Steril*. 2003;4:1052–1054.

11. Sarto G, Therman E, Patau K. X inactivation in man: a woman with t(Xq--;12q+). *Am J Hum Genet*. 1973;3:262–270.

12. Hagerman P. The fragile X prevalence paradox. *J Med Genet*. 2008;45(8):498-499. doi:10.1016/j.dcn.2011.01.002.The

13. Utine GE, Şimşek-Kiper PÖ, Akgün-Doğan Ö, Ürel-Demir G, Alanay Y, Aktaş D, et al. Fragile x-associated premature ovarian failure in a large Turkish cohort: Findings of Hacettepe Fragile X Registry. *Eur J Obstet Gynecol Reprod Biol*. 2018;221:76-80. doi:10.1016/j.ejogrb.2017.12.028

14. Wittenberger MD, Hagerman RJ, Sherman SL, McConckie-Rosell A, Welt C, Rebar RW, et al. The FMR1 premutation and reproduction. *Fertil Steril*. 2007;87(3):456-465. doi:10.1016/j.fertnstert.2006.09.004

15. Allen E, Sullivan A, Marcus M, Small C, Dominguez C, Epstein MP, et al. Examination of reproductive aging milestones among women who carry the FMR1 premutation. *Hum Reprod*. 2007;22(8):2142-2152. doi:10.1093/humrep/dem148

16. Sullivan AK, Marcus M, Epstein MP, Allen EG, Anido AE, Paquin JJ, et al. Association of FMR1 repeat size with ovarian dysfunction. *Hum Reprod*. 2005;20(2):402-412. doi:10.1093/humrep/deh635

17. Spath M, Feuth T, Smits A, Yntema HG, Braat DDM, Thomas CMG, et al. Predictors and risk model development for menopausal age in fragile x premutation carriers. *Genet Med*. 2011;13(7):643-650. doi:10.1016/j.dcn.2011.01.002.The

18. Schufreider A, McQueen DB, Lee SM, Allen R, Uhler M, Davie J, et al. Diminished ovarian reserve is not observed in infertility patients with high normal CGG repeats on the fragile X mental retardation 1 (FMR1) gene. *Hum Reprod*. 2015;30(11):2686-2692. doi:10.1093/humrep/dev220

19. Jacquemont S, Hagerman RJ, Hagerman PJ, Leehey MA. Fragile-X syndrome and fragile X-associated tremor / ataxia syndrome : two faces of FMR1. *Lancet Neurol*. 2007;6:45-55.

20. Yrigollen C, Durbin-Johnson B, Gane L, Nelson DL, Hagerman R, Hagerman PJ, et al. AGG interruptions within the maternal FMR1 gene reduce the risk of offspring with fragile X syndrome. *Genet Med*. 2012;14(8):729-736. doi:10.1038/gim.2012.34.AGG

21. McGowan-Jordan J, Simons A, Schmid M (eds). *An International System for Human Cytogenomic Nomenclature.* Basel: S. Karger; 2016.

22. Gardner R, Sutherland G, Shaffer L. *Chromosome Abnormalities and Genetic Counselling.* Fourth Ed. Oxford University Press; 2012.

23. Guttenbach M, Koschorz B, Bernthaler U, Grimm T, Schmid M. Sex chromosome loss and aging: in situ hybridisation studies on human interphase nuclei. *Am J Hum Genet*. 1995;57:1143-1150.

24. Fu Y, Kuhl D, Pizzuti A, Pieretti M, Sutcliffe JS, Richards S, et al. Variation of the CGG repeat at the fragile X site results in genetic instability: resolution of the Sherman paradox. *Cell*. 1991;67(6):1047-1058.

25. Ferreira SI, Pires LM, Ferrão J, Sá J, Serra A, Carreira IM. Mosaicism for FMR1 gene full mutation and intermediate allele in a female foetus: A postzygotic retraction event. *Gene*. 2013;527(1):421-425. doi:10.1016/j.gene.2013.05.079

26. Murray A, Schoemaker MJ, Bennett CE, Ennis S, MacPherson JN, Jones M, et al. Population-based estimates of the prevalence of FMR1 expansion mutations in women with early menopause and primary ovarian insufficiency. *Genet Med*. 2014;16(1):19-24. doi:10.1038/gim.2013.64

27. Baronchelli S, Conconi D, Panzeri E, Bentivegna A, Redaelli S, Lissoni S, et al. Cytogenetics of premature ovarian failure: An investigation on 269 affected women. *J Biomed Biotechnol*. 2011;2011:20-22. doi:10.1155/2011/370195

28. Janse F, Knauff E, Niermeijer M, Eijkemans MJ, Laven JS, Lambalk CB, et al. Similar phenotype characteristics comparing familial and sporadic premature ovarian failure. *Menopause*. 2010;17(4):758-765.

29. Bouali N, Hmida D, Mougou S, Bouligand J, Lakhal B, Dimessi S, et al. Analysis of FMR1 gene premutation and X chromosome cytogenetic abnormalities in 100 Tunisian patients presenting premature ovarian failure. *Ann Endocrinol (Paris)*. 2015;76(6):671-678. doi:10.1016/j.ando.2015.10.001

30. Guo T, Qin Y, Jiao X, Li G, Simpson JL, Chen ZJ. FMR1 premutation is an uncommon explanation for premature ovarian failure in Han Chinese. *PLoS One*. 2014;9(7):6-10. doi:10.1371/journal.pone.0103316

31. Lakhal B, Braham R, Berguigua R, Bouali N, Zaouali M, Chaieb M, et al. Cytogenetic analyses of premature ovarian failure using karyotyping and interphase fluorescence in situ hybridization (FISH) in a group of 1000 patients. *Clin Genet*. 2010;78(2):181-185. doi:10.1111/j.1399-0004.2009.01359.x

32. Gold EB. The Timing of the Age at Which Natural Menopause Occurs. *Obs Gynecol Clin N Am*. 2011;38(3):425-440. doi:10.1016/j.ogc.2011.05.002

33. Gold EB, Crawford SL, Avis NE, Crandall CJ, Matthews KA, Waetjen LE, et al. Original Contribution Factors Related to Age at Natural Menopause : Longitudinal Analyses From SWAN. *Am J Epidemiol*. 2013;178(1):70-83. doi:10.1093/aje/kws421

34. Portnoï MF, Aboura A, Tachdjian G, Bouchard P, Dewailly D, Bourcigaux N, et al. Molecular cytogenetic studies of Xq critical regions in premature ovarian failure patients. *Hum Reprod*. 2006;21(9):2329-2334. doi:10.1093/humrep/del174

35. National Collaborating Centre for Women’s and Children’s Health (UK). Ectopic pregnancy and miscarriage: Ectopic Pregnancy and Miscarriage: Diagnosis and Initial Management in Early Pregnancy of Ectopic Pregnancy and Miscarriage. https://www.nice.org.uk/guidance/cg154/. Published 2012. Accessed January 15, 2019.

36. Ceylaner G, Altinkaya S, Mollamahmutoglu L, Ceylaner S. Genetic abnormalities in Turkish women with premature ovarian failure. *Int J Gynaecol Obs*. 2010;110(2):122-124.

37. Castillo S, López F, Tobella L, Salazar S, Daher V. The cytogenetics of premature ovarian failure. *Rev Chil Obs Ginecol*. 1992;57(5):341-345.

38. Rebar R, Connolly H. Clinical features of young women with hypergonadotropic amenorrhea. *Fertil Steril*. 1990;53(5):804-810.

39. Romualdi D, Proto C, De Cicco S, Immediata V, Barone C, Romano C, et al. Low AMH levels as a marker of reduced ovarian reserve in young women affected by Down’s syndrome. *Menopause*. 2016;23(11):1247-1251. doi:10.1097/GME.0000000000000695

40. Parizot E, Dard R, Janel N, Vialard F. Down syndrome and infertility: what support should we provide? *J Assist Reprod Genet*. 2019;36(6):1063-1067. doi:10.1007/s10815-019-01457-2

41. Owens KM, Dohany L, Holland C, DaRe J, Mann T, Settler C, et al. FMR1 premutation frequency in a large, ethnically diverse population referred for carrier testing. *Am J Med Genet Part A*. 2018;176(6):1304-1308. doi:10.1002/ajmg.a.38692

Table 1. Patients’ baseline characteristics

|  |
| --- |
| Obstetric and Gynecological history |
| Age at menarche (years)  | 12.0 (3.0) |
| Primary amenorrhea | 4/94 (4.3%) |
| Nulligravida | 31/90 (34.4%) |
| Nullipara | 36/90 (40.0%) |
| Previous miscarriage | 17/90 (18.9%) |
| Age at menopause (years) | 36.0 (6.0) |
| FSH at diagnosis (IU/L) | 79.0 (43.9) |
| Estradiol at diagnosis (pg/mL) | 20.0 (10.0) |
| Family history |  |
| POI | 23/94 (24.4%) |
| Fragile X Syndrome | 2/94 (2.1%) |

Values are median (interquartile range) deviation or n(%).

Table 2. Karyotype analysis

|  |  |
| --- | --- |
| Normal (46, XX) | 71/85 (83.5%) |
| Abnormal  | **14/85 (16.5%)** |
|  X Chromosome related |  |
|  - 46,X,del(X)(q25~q26).ish del(X)(DXYS61-)- 46,X,del(X).ish del(X)(pter-q22.2)(DXS28-)- 46,X,t(X;8)(q24;q24.22)- 47,XXX- mos 45,X[2]/46,XX[28].nuc ish(DXZ1x1)[4/110]- mos 45,X[1]/47,XXX[1]/48,XXXX[1]/46,XX[47]- mos 45,X[3]/47,XXX[1]/46,XX[26]- mos 45,X[3]/47,XXX[1]/46,XX[26]- mos 45,X[3]/47,XXX[1]/46,XX[16]- mos 47,XXX[3]/45,X[1]/46,XX[26]- mos 47,XXX[2]/45,X[1]/46,XX[32] |
| N Non-X Chromosome related |
| - mos 47,XX,+21[2]/46,XX[38] |
| - 45,XXder(13;14)(q10;q10) |
| - 47,XX,+mar.ishder(14/22)(D14Z1/D22Z1+,D22S75-) |

Table 3. Number of CGG repeats in *FMR1* analysis

|  |  |
| --- | --- |
| Normal alleles | 82 patients/90 (91.1%) |
| <29 | 62 |
| 29 | 18 |
| 30 | 53 |
| 31 | 19 |
| 32-44 | 19 |
| Intermediate zone alleles | **2 patients/90 (2.2%)** |
| 53 | 1 |
| 54 | 1 |
| Premutation alleles | **6 patients/90 (6.7%)** |
| 58 | 1 |
| 60 | 2 |
| 69 | 1 |
| 80 | 1 |
| 82 | 1 |