



CREATE HEALTH CLINIC

FERTILITY & ASSISTED CONCEPTION SERVICES



CREATE HEALTH

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for existing IVF patients only

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Disclaimer: All information contained in this document is correct at time of publication.

INTRODUCTION

Create Health Clinic for Fertility and Women's Health provides cost-effective, patient centred care with a holistic approach. We offer comprehensive, out-patient "One-Stop Fertility Diagnosis" and a full range of fertility and assisted conception treatments in a safe, friendly, relaxed environment with skilled, dedicated, sympathetic staff to care for your needs.

We encourage you to consider simple, natural, less invasive and least expensive options in the first instance where appropriate. Our specialist staff are trained in all aspects of infertility and will be able to discuss options and advise you accordingly.

IVF and related techniques are not appropriate to all infertile couples.

A full list of our staff can be found on our web site and in separate leaflet.

Create Health Clinic supports and funds the national charity "HER TRUST" Health Education Research - Women's Health Foundation UK.

We offer fertility care with the following key priorities:



A Natural and Holistic approach



Minimal Ovarian Stimulation



Less Invasive Options



Cost Effective Treatments



Counselling and Continuity of Care

INFERTILITY

The official definition is the failure to conceive after two years of unprotected sexual intercourse in the absence of known reproductive pathology.

There are two types of infertility: Primary infertility, which is infertility without any previous pregnancy and Secondary infertility, when there has been a previous pregnancy.

There are many causes of infertility and therefore many tests to explain these various causes. These include checking the number and quality of your partner's sperm, assessing the level of hormones that control the activity of your ovaries, ultrasound or x-ray examination of the fallopian tubes and other tests to exclude disease or infection.






There are a number of options open to infertile couples. If all tests are normal, you may be advised to try naturally for some more time. Fertility pills or injections are used for ovulation induction if you are not ovulating. If there is a mild sperm problem, introduction of sperm inside the uterine cavity (IUI) could be an option. If the fallopian tubes are damaged or blocked, IVF is usually required. If there are severe male-factor problems, sperm injection into your egg (Intra-Cytoplasmic Sperm Injection or ICSI) could help.

It is important that you discuss all options with your consultant and choose the least invasive and the most cost-effective method of treatment.

ONE-STOP FERTILITY DIAGNOSIS

This unique service allows a couple to visit the Clinic for a range of tests to be carried out in a single visit which enables us to diagnose the probable cause of any infertility problems and to recommend possible treatments without delay. You will receive the results of these tests within an hour.

During your visit to the centre you will receive:

-  A comprehensive 3D scan of the womb and ovaries and a tubal patency test
-  Doppler scan to assess the blood flow to the womb and ovaries to estimate your ovarian reserve
-  A detailed semen analysis to assess the sperm count and quality
-  A full report and explanation of the results of these tests
-  An expert opinion on which treatments could be the most suitable for you




These tests have to take place at a particular time in the female partner's menstrual cycle - between days 7-12.

In preparation for the test, a course of antibiotics 2 days prior to the appointment is required.








(An additional blood test may be required)

ASSISTED CONCEPTION TREATMENTS

The following treatments are classified as assisted conception treatments:

-  Ovulation Induction
-  Intrauterine Insemination
-  In Vitro Fertilisation and related techniques

In Vitro Fertilisation and Embryo Transfer

-  Natural Cycle (Unstimulated)
-  Stimulated Cycle
-  Assisted Hatching
-  In Vitro Fertilisation and Intracytoplasmic Sperm injection (ICSI)
-  Surgical Sperm aspiration
-  Donor Insemination
-  Egg Donation and Egg Sharing Cycle

This section has been prepared to help you to understand the purpose and techniques of IVF treatment. Please read it carefully before you decide to attend for your first consultation.

If you require further clarification or have any comments or suggestions please do not hesitate to ask at the time of consultation.

Please refer to separate information booklets for other treatments.

IN VITRO FERTILISATION (IVF)

What is In Vitro Fertilisation?

Fertilisation is a term that is used for a series of events that take place at the penetration of the egg by the sperm. The egg ripens within a growing follicle, which is a small fluid containing sac within the ovary. In a natural cycle usually only one follicle grows fully and one egg is released. Under normal circumstances fertilisation occurs in one of the woman's fallopian tubes and thereafter the fertilised egg enters the womb where it grows. IVF means fertilisation in a glass dish in the laboratory. It is alternatively called "test tube baby treatment".

Your First Consultation

You should allow about an hour for your first consultation with the Consultant. During the consultation your medical history will be taken and you will have an examination. Your husband/partner may be asked to produce a semen sample for analysis. This can be organised locally on the day of your consultation. You will be asked to abstain from sexual intercourse for approximately two to three days before your initial consultation so that a satisfactory sperm sample can be obtained for analysis. The result of the semen analysis will be available during consultation.

Please remember that everything you tell your consultant is confidential. The purpose of this consultation is to obtain background information and find out if there are any health problems that might affect a pregnancy. If you have any information you do not wish to disclose to your partner or GP please let the consultant know. This visit is an important visit to discuss the role of the Human Fertilisation and Embryology Authority (HFEA), the consent forms, the welfare of the child, ethical issues and the rights of the unborn child.

Human Fertilisation and Embryology Authority (HFEA)

The Human Fertilisation and Embryology Authority Act 1990, and the related Disclosure of Information Act 1992, introduced some major regulatory changes to clinical practice involving IVF and/or the use of donor eggs and sperm. All licensed centres must be registered with the HFEA. Each cycle of treatment is registered and a fee is charged by the HFEA. We will not be allowed to pass on information about your treatment to any one not covered by the licence without your written permission. You are required to sign a “Disclosure of Identifying Information” to enable us to pass on any information about your fertility treatment to your doctor.

Welfare of Child Questionnaires

We are obliged by the Human Fertilisation and Embryology Act to take all necessary steps to ensure that account has been taken of the welfare of any children who may be born as a result of treatment or of any existing children who may be affected by the birth. In order to help us to fulfil this obligation, you will be asked to complete a questionnaire prior to starting treatment. Your doctor will be asked to complete a questionnaire and inform us of any concerns he/she may have.

Use and Storage of Gametes and Embryos

The Human Fertilisation and Embryology Authority publishes detailed information on use and storage of human gametes and embryos. Our centre provides you with these booklets.

Please make sure that you have read this information before you sign the consent forms.

Blood Tests

It is our policy to test all couples for HIV, Hepatitis B and Hepatitis C before they undergo treatment. Blood tests to assess ovarian reserve may be required. If there is severe male factor infertility, blood tests are required to assess the male partner's hormones and chromosomes.

Consent Forms

When your sub-fertility has been fully assessed you will be advised by the consultant, as to the various treatment options.

INTRACYTOPLASMIC SPERM INJECTION (ICSI)

What is ICSI?

In conventional IVF treatment, specially prepared sperm are added to the petri-dish in which eggs are cultured and allowed to fertilise. ICSI is a specialised laboratory technique used to facilitate fertilisation in male factor infertility. The ICSI technique involves injection of a single sperm into the fluid contents of the egg cell called cytoplasm. A glass pipette (like a needle) which is finer than a human hair is used to pick up a single sperm and inject it into the egg.

Couples undergoing ICSI treatment have exactly the same treatment as in conventional IVF. The laboratory procedure for fertilisation is different as described above.

WHO MIGHT BENEFIT FROM ICSI?

- 🌿 Couples where the male partner has a very low sperm count
- 🌿 Low sperm motility (movement)
- 🌿 Anti sperm antibodies
- 🌿 High number of abnormal sperm
- 🌿 Couples who previously had a failed fertilisation of eggs in a conventional IVF attempt
- 🌿 In men where there is no sperm found in ejaculate (azoospermic) but sperm can be collected surgically from testes (TESE/TESA) or epididymis (PESA)

Will it Work?

Although results are encouraging, we cannot guarantee fertilisation.



RISKS ASSOCIATED WITH ICSI TREATMENT

Concerns have been raised about the potential risks of ICSI to children born as a result of this technique. It is an invasive procedure and involves using sperm that may not be selected to fertilise an egg in a natural conception. There are several studies published with information on children conceived as a result of ICSI but the numbers are relatively small. We need further studies with large numbers.

The following genetic and developmental risks are documented:

Increased Incidence of Cystic Fibrosis Gene Mutations in Azoospermic Men

It appears that 5-10% of azoospermic men selected for ICSI have congenital bilateral absence of the vas deferens (CBAVD), a condition associated with certain cases of cystic fibrosis (CF). Two thirds of men with this condition appear to be carriers of CF mutations. CF testing may therefore be indicated for azoospermic men and with CBAVD.

Genetic counselling is strongly recommended for CBAVD azoospermic men and their partners. Those involved in counselling should understand the issues relating to CBAVD and its association with incidence of CF mutation.

Male Infertility Relating to Y Chromosome Deletions

Small percentages of men with very low sperm counts have parts of their male (Y) chromosome missing (deleted).

Sub-fertile men with Y chromosome deletions may pass the same type of sub-fertility onto their sons. It is therefore necessary to test this chromosome if there are concerns.

Sex Chromosomal Anomalies

Where ICSI is used in the treatment of men with severe azoospermia or oligospermia there is a risk of an increased frequency of sex chromosome disorders. Research has shown that up to 3.3% of fathers of children conceived through ICSI have abnormal chromosomes compared to 2.4% in wider population. Abnormal numbers or structure of sex chromosomes (X and Y) may be associated with infertility in men and women. Children born from ICSI treatment may have slightly increased risk of inheriting these abnormalities.

New Chromosomal Abnormalities

Although individuals possess a normal set of chromosomes, their eggs and sperm may potentially contain abnormal number of chromosomes. It is not possible to detect this abnormality in sperm used for fertilisation in ICSI procedure. This means that sperm that would not have fertilised an egg naturally might be used for ICSI. Children conceived with ICSI treatment have been found to have new(novel) chromosome abnormalities in up to 3% of cases compared to around 0.6% in normal population.

Birth Defects

There is no clear evidence whether ICSI results in increased birth defects. Studies show that minor abnormalities occur in up to 20% of ICSI children, compared to up to 15% in the general population. The number of children reported to have major birth defects such as cleft palate, is between 1 and 5% in both general population and children conceived with ICSI treatment.

Developmental Delays

Recent research papers concerning follow up of relatively small numbers of ICSI children has given an indication of possible developmental delay in some children conceived using the ICSI technique.

Miscarriages






It is known that many abnormal embryos fail to implant and fail to lead to conception. But some abnormal embryos might implant and lead to miscarriages.

It has been reported that there is an increased risk of miscarriage if there is severe male factor infertility. This could be due to increased number of DNA damage in sperm, which causes infertility. We might inject a sperm in ICSI that would not be normally capable of fertilising an egg. It is therefore possible that we create more viable but abnormal embryos that result in pregnancy but tend to miscarry.

Further studies are needed to understand the risks of ICSI procedure.

WHO NEEDS IVF?

IVF is indicated in the following conditions:

-  Damaged or blocked fallopian tubes
-  Unexplained infertility
-  Low sperm count or reduced sperm activity
-  Endometriosis
-  Sub-fertility caused by antibody problems

NATURAL CYCLE (UNSTIMULATED) IVF

IVF can be carried out in natural cycles without hormonal stimulation. Natural cycle IVF involves collection of a naturally produced egg, fertilisation in a laboratory and placement of an embryo in the uterus, which has not been stimulated by medication. The success rates are low compared to stimulated cycles. But this treatment is less expensive, less invasive and can be repeated in subsequent cycles as there are no drugs involved for ovarian stimulation. This treatment is offered to women who do not wish to take fertility medicines or where fertility medicines are contraindicated.

Women who are ovulating and have damaged tubes may try Natural Cycle IVF before moving on to Stimulated IVF.

(Please ask for separate Information on Natural Cycle IVF)

WHAT IS A TYPICAL STIMULATED IVF OR ICSI TREATMENT CYCLE?

Ovarian Stimulation in Long Protocol (Agonist) or Short (Antagonist) Cycle. Ovarian Stimulation takes place in two phases.

Suppression of Ovaries (Agonist Cycle) - Phase 1 of Ovarian Stimulation

You will have an ultrasound scan during the cycle before you commence treatment. The treatment starts on the first day or twenty first day of your menstrual cycle. The aim of this phase is to achieve suppression of the ovaries by using either a daily injection or a nasal spray. The ovary is under the control of the pituitary gland that lies near the front of your brain.

During your IVF cycle the response from your ovaries may vary because of the influence of the pituitary gland. Suppression of the pituitary gland helps us to achieve optimum stimulation, increased number of eggs and embryos and most importantly prevent your ovary from releasing eggs prior to egg collection. We use either Buserelin injection or Naferelin nasal spray to achieve suppression of the pituitary gland.

Buserelin Injections: These injections are taken once a day just under the skin at exactly the same time each day. You or your partner can administer it.

Naferelin Nasal Spray: This nasal spray needs to be taken as one sniff in each nostril twice a day at exactly the same time each day.

As your ovarian suppression is achieved you may notice side effects such as hot flushes or night sweats. Bleeding towards the end of the second week is also noted. It is important that Buserelin injections or Naferelin nasal spray are continued at the same time of day until we advise you to stop.

Stimulation of the Ovary - Phase 2 of Ovarian Stimulation

If you've been through the suppression phase, your second scan will be two weeks after you have started Buserelin or Naferelin. This scan is to check that your ovaries look inactive and the lining of your womb (endometrium) is thin. The usual time taken for the ovaries and endometrium to reach this stage is two weeks but you may need more time. Once ovarian suppression is achieved you will start daily injection to stimulate your ovaries to recruit a number of eggs.

In a natural cycle your ovary recruits several follicles at the beginning of the cycle but usually only one follicle is selected to carry on with further development and one egg released. In a stimulated cycle, several follicles are recruited in ovaries and ripened for fertilisation. Hormones required for the recruitment and ripening of follicles are called Follicle Stimulating Hormone (FSH) and Luteinising Hormone (LH). FSH is responsible for the growth of the follicle and egg and LH triggers ovulation. Different drug regimes are used to stimulate the ovaries. The doctor involved in your management will explain to you which regime is the most appropriate for you. The dosage of injection and the regime would depend on your age, hormone levels, and previous response if any.

You will be given injections of FSH. A separate leaflet outlining your drug regime will be given to you prior to the start of your treatment cycle.

You will have an ultrasound scan around day 8 of your stimulation to assess the growth of follicles. Ultrasound scanning monitors the growth of follicles and the lining of the womb. You may have a blood test on the same day. Ultrasound scans are done transvaginally by inserting a small probe into the vagina. The procedure is painless and the size and number of follicles is closely monitored. You will be shown the response of your ovaries on the screen while you are having the ultrasound scan. You will usually require two or three scans from day 8 of stimulation until you are ready for egg collection.

Antagonist Cycle:

If you are advised to use LH-RH antagonist such as Cetrotide or Orgalutron, you will not go through the suppression phase. Instead, you will start your treatment with ovarian stimulation on Day 2 of your cycle and start antagonist injections on day 6 or 7. These injections are given for 6 or 7 days to block your LH surge and spontaneous ovulation.

The Day of hCG Injection

When your follicles have reached an appropriate size (the leading follicle being around 18mm in size) you will be prepared for egg collection. You will be asked to have the injection HCG (Human Chorionic Gonadotrophin) and stop the Buserelin or Naferelin and FSH injection. HCG mimics the natural process of LH release and triggers ovulation. It also helps in achieving the final ripening (maturity) of eggs and the timing of egg collection. Egg collection is normally planned around 36 hours after the HCG injection. This is a late night injection and is administered in the same way as the FSH injection (under the skin). It is essential that you bring your ampoule of HCG when you come for your last ultrasound scan to assess the follicles. It is important that you have your HCG injection at the time specified and make sure that you dissolve the powder in water completely before you inject the drug.

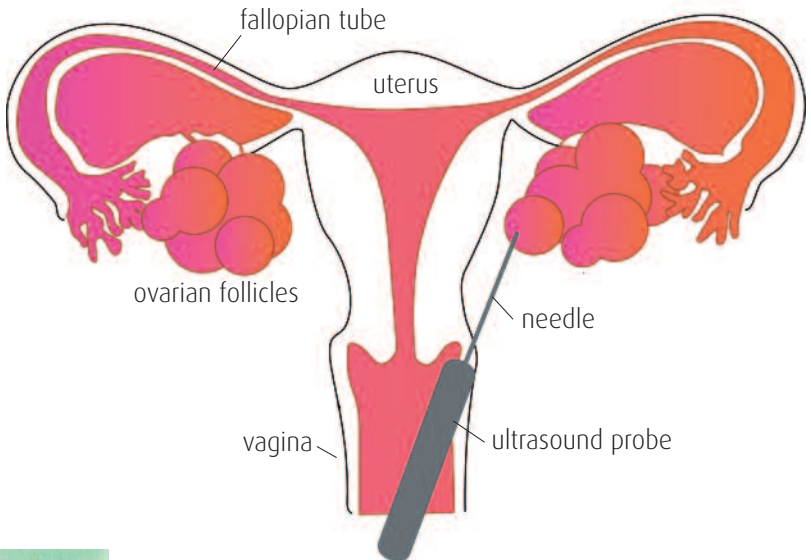
The Day After hCG

This is your "day off ". You will not be having any injections or scans. It is important that you are able to relax and have a good night sleep before the egg collection.

EGG COLLECTION

You will be asked to fast on the morning of egg collection. If your egg collection is in the late morning you may be asked to take an early morning drink. Vaginal egg collection is performed generally under sedation with ultrasound guidance. A needle is passed through the vagina into the ovary where the follicles are present. Your husband or partner can be present at the time of egg collection. The contents of the follicles are removed and examined under the microscope to see if an egg is present. The procedure is an outpatient procedure, which takes normally twenty to thirty minutes. The egg collection is not a totally pain free procedure, but this is usually controlled by the sedation. You will be able to rest for half an hour to an hour after your egg collection before you are ready to go home. You may experience a dull ache or period like cramps in the lower part of your abdomen on the day of egg collection. You may take Paracetamol if required. There should be no sharp pain or bleeding after the egg collection.

ULTRASOUND GUIDED EGG COLLECTION



a human egg

The rule is that you will gradually get better and if you feel that that is not the case, please inform us.

After your egg collection you will be told how many eggs were collected. Occasionally, some eggs may be difficult to identify and the final egg number may be less than that quoted immediately after egg collection

Sperm Collection

Your husband or partner is asked to produce a semen sample by masturbation in a special room at the centre before you are taken into theatre for egg collection. This sample is assessed and if it is found suitable it is washed in preparation and kept ready for fertilisation. Occasionally, the sample may not be adequate and your partner may be asked to produce another sample.

Insemination of Eggs

The semen sample provided by your husband or partner is washed and prepared and progressively motile sperms are selected to inseminate the eggs. The eggs are normally inseminated between 40-42 hours after the hCG injection.

Intracytoplasmic Sperm Injection (ICSI)

This is a technique by which a single sperm is injected directly into the fluid content of an egg (cytoplasm) using a glass pipette. If ICSI is indicated based on previous sperm analysis or on the quality of sperm on the day of egg collection, the embryologist will carry out this procedure.

Make sure that you have signed an informed consent for this.

Fertilisation

The eggs and the sperms are cultured overnight in an incubator. On the day after egg collection the cultured eggs are examined microscopically to check for fertilisation. Under normal circumstances, 70-80% of eggs will fertilise in the laboratory.

Embryo Transfer

Within 24 hours after fertilisation has occurred the embryos will divide into two or four cells. The embryos are examined under the microscope for cell division and grading. Embryos are graded into four grades as 1-4 (depending on quality). The embryo transfer procedure is performed by passing a fine tube through the neck of the womb (cervix). The embryos are injected high into the womb (uterus) in a minute amount of culture fluid. This technique does not normally require analgesia and is pain free. The procedure is quick and you may leave the Centre shortly after.

The Number of Embryos to be Transferred

The number of embryos transferred will depend on the quality of embryos, the quality of the lining of your womb, your age and previous treatment. The HFEA recommends that we transfer a maximum of two embryos at any one time. In exceptional circumstances in women over 40 years of age, we are allowed to transfer three embryos. However, the final decision as to whether to transfer two or three embryos is made with informed consent. The doctor and the embryologist will help and advise you in making this decision. Whilst trying to come to a decision you need to balance your chance of conceiving and of having a multiple pregnancy.

After Embryo Transfer

This is a very difficult time for you as you will be worried as to what you should and should not do in order to increase your chance of conception. There is no need to be confined to bed!

Studies have shown that chances of pregnancy are not influenced by physical activity. There are no restrictions and you can resume normal activities. You may be given hormone pessaries to help implantation of the embryos. One pessary should be inserted into the vagina once or twice a day until you know the outcome of your treatment.

You may wish to freeze any spare embryos of good quality. Frozen embryos can be stored to be transferred at a later stage. This possibility will be discussed with you before you reach the stage of egg collection.

You will be asked to perform a urine pregnancy test 14 days after embryo transfer to check if you are pregnant. If your test is positive an ultrasound scan will be performed a week later to check that the pregnancy is in the womb and also to check the number of gestational sacs.

You will have an ultrasound scan two weeks later to confirm that the pregnancy is ongoing. You will be able to see the fetal heart and take a picture with you!

COMPLICATIONS OF IVF TREATMENT CYCLES

Ovarian Hyperstimulation Syndrome (OHSS)

Ovarian Hyperstimulation is a rare but serious complication of ovarian stimulation which is more common in women with polycystic ovaries. It can be mild, moderate or severe. The mild or moderate forms of OHSS do not require hospitalisation. Severe ovarian hyper-stimulation syndrome is a serious complication and can be fatal. OHSS occurs in women who have developed a large number of follicles (i.e. more than 20) and if you have had a large number of eggs collected then you are at a risk of severe ovarian hyperstimulation syndrome (OHSS). You will know if you have polycystic ovaries after the initial scan and blood tests. At all scans you will be shown on the screen what the doctor is looking at. The doctor will try to avoid the development of OHSS by giving you the minimum dose of stimulation required, monitoring your ovaries closely and emptying all follicles at the time of egg collection.

Despite all precautions, severe OHSS may occur. Symptoms usually start after you have had your hCG (late night complete injection). Symptoms of OHSS include feeling bloated, swelling of the abdomen, nausea, and vomiting. The ovaries are very large and can be surrounded by free fluid in the abdomen. If you start vomiting you may not be able to keep fluids down which may lead to dehydration leading to concentration of blood and clotting problems. This condition can be potentially serious and women have been known to have clotting, strokes and kidney failure.

If not controlled in time OHSS can be fatal.

Severe OHSS is extremely rare (occurs in only 1-2% of women) and the nursing and medical staff are trained in managing women with this condition. This condition can get worse if you conceive and particularly if you have a multiple pregnancy. The development of OHSS is related to either administration of hCG or production of hCG following conception. If you are at risk of developing severe OHSS you would be advised to have a smaller dose of hCG.

Occasionally, you may be advised to have all embryos frozen for transfer at a later date in order to avoid a pregnancy.

If in doubt please do not hesitate to contact the IVF team or on-call doctor at any time.

Risk of Egg Collection Procedure

At the time of egg collection a speculum will be inserted into the vagina and the cervix cleaned with antiseptic solution. The speculum is removed and a vaginal ultrasound probe is inserted to scan your womb and ovarian follicles. A needle is carefully passed through the wall of your vagina into the ovary under ultrasound vision. The needle can inadvertently enter a blood vessel leading to internal bleeding or the loop of the bowel leading to infection. The risk of this complication is highly unlikely. If there is injury to a blood vessel or surrounding structures you may need to have an operation to correct the complication. If there is the introduction of a pelvic infection you may need to take antibiotics. These complications are extremely rare and we have not had any complications relating to the injury to blood vessels or surrounding structures in our experience.

Risk of a Multiple Pregnancy

All assisted conception programmes with ovarian stimulation carry the risk of multiple pregnancy. There is approximately a 1 in 4 chance of having a twin pregnancy and a 3 percent chance of having a triplet pregnancy if you have three embryos transferred. The risk of miscarriage, pre-maturity, fetal growth restriction and pregnancy complications in the mother and the need for operative delivery are all increased in multiple pregnancy. Usually this is more of a problem with triplets rather than twins. A triplet pregnancy carries a 1 in 12 chance of losing each baby and a twin pregnancy a 1 in 21 chance of losing each baby (compared with a 1 in 113 chance in singleton pregnancies). The risk of producing at least one handicapped child is approximately 1 in 13 pairs of twins and 1 in 4-5 sets of triplets. Please refer to the HFEA Annual Report for details.

Risk of an Ectopic Pregnancy

Although the embryos are transferred into your womb there is still a small risk of an ectopic pregnancy (the embryo implanting in your fallopian tube). Occasionally you can have a combined intrauterine (inside the womb) and an ectopic pregnancy. This is called a Heterotopic Pregnancy. You will be monitored closely with transvaginal ultrasound scans and blood tests if we suspect that you have an ectopic pregnancy.

The Risk of Miscarriage

The risk of miscarriage in a singleton pregnancy is no different to normal conception. The risk of miscarriage is slightly higher if you have a multiple pregnancy. Once the pregnancy sac has been established and a fetal heart is identified this risk is small.

Common Causes of Failure of Treatment

Treatment could fail at any stage. It could be because of no response or poor response of ovaries to hormone stimulation. Rarely follicles contain no eggs. Sometimes eggs may fail to fertilise when mixed or injected with sperm. Fertilised eggs may not divide to form embryos. Occasionally, embryo quality is poor and embryos are not suitable for transfer.

However the most common cause of failure of IVF/ICSI treatment seems to be the failure of implantation of embryos in the womb.

Counselling

Provision of independent counselling is an important aspect of providing assisted conception services. There are three types of counselling as described below:

Support Counselling: This type of counselling offers emotional support before, during and after treatment. Our specialist team offers you support at all times. The Nurse Specialist plays a pivotal role in giving you advice during your treatment.

Implications Counselling: Implications counselling means giving accurate factual information to help you choose the most appropriate treatment option and on how to proceed with treatment.

Therapeutic Counselling: Some couples need to be saved from their own unrealistic and overwhelming pursuit of fertility. Some couples need help and support to come to terms with childlessness if treatments fail. This type of counselling is offered by an independent counsellor who is not involved in your treatment.

An independent counsellor who specialises in assisted conception treatment is available at our centre. Please ask for details at any time. There is no fee for counselling.

Costs of Services:

A complete list of up-to-date charges is available for all investigations and treatments. Please refer to the separate leaflet on the cost of different treatments. We aim to offer affordable and cost-effective services at all times. Please do not hesitate to ask our Centre Manager if you have any queries about our costs. Charges are revised annually.

Refunds

When a treatment cycle is abandoned for medical reasons, an appropriate refund will be offered. Please ask for details of our refund policy.

Satisfaction Questionnaires and Suggestions

We aim to offer you the best care because you deserve this. We would like to hear from you about our services and the care you receive at our centre. Please fill in a questionnaire or send us your suggestions. This would help us to improve the service we provide.

Patient Information Sessions and Support Group

We are committed to raising public awareness about fertility and assisted conception and conduct regular Patient Information Evenings. We are setting up a Patient Support Group locally. Please ask the Centre Manager for details of our next patient information evening and whether you would like to join the support group.

COMPLAINTS PROCEDURE

We take your complaints seriously. Your concerns will help us to improve the quality of the care we provide. If you have any complaints, please write to our complaints officer. All complaints will be processed according to Health Care Commission regulations. You can also write to the Healthcare Commission (www.healthcarecommission.org.uk) and/or the Human Fertilisation and Embryology Authority (HFEA) directly.

SUCCESS RATES

Success rates must be interpreted with caution. Rates from different centres cannot be simply quoted and compared for they are greatly affected by selection criteria, the types of cases treated and the definition of a treatment cycle and pregnancy which can vary from centre to centre.

Centres that treat unfavourable cases, patients over 40 years of age or those with complex fertility problems have an overall low success rate. Centres that refuse treatments for women over 40 years of age or couples with unfavourable outcome factors tend to keep their overall success rates high.

Our aim is to estimate your chances of success by natural conception compared with assisted conception and where possible we will try to help you achieve a pregnancy by natural means. If assisted conception is required we believe in using the lowest effective stimulation dose in order to reduce costs and side effects.

All couples are fully counselled about the various treatments and their costs and effectiveness. We help all couples provided the predicted outcome is not extremely unfavourable. Even in these circumstances some couples request and are granted one cycle of treatment despite knowing that the success rate is low, in order to feel that they have done everything they could to have a child. Studies have suggested that there is a “willingness to pay” in order to come to terms with childlessness and then get on with life.

Rarely, there is a zero chance of conceiving naturally. It is important for couples to realise that many will conceive naturally after several failed attempts of IVF. There are no large studies looking at the long-term physical, mental and social health of couples who have had failed fertility treatment.

We feel that we have a responsibility to help couples who have had repeated failures with IVF treatment to come to terms with their infertility and lead a happy and fruitful life. Please remember that counselling and support is available to you at all times.

Our results can be found in a separate leaflet. Please ask for a copy of our latest success rates and discuss the results during consultation with your consultant.

USEFUL ADDRESSES

Human Fertilisation and Embryology Authority (HFEA)

Paxton House, 30 Artillery Lane, London E1 7LS

HER Trust - Women's Health Foundation UK

www.hertrust.org

ISMAAR - The International Society for Mild Approaches in Assisted Reproduction

www.ismaar.org

For a local support group, please contact the nurse coordinator.



CREATE HEALTH

www.createhealth.org

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