MONASH IVF
QUARTERLY REVIEW

Fertility in focus

WINTER
2021

Welcome to our new look newsletter, ‘Fertility in focus’ specifically designed to keep you up to date with the latest science, technology and specialised services on offer at Monash IVF as well as provide you with quality information on fertility treatment within Australia. I know you will find this issue informative as it contains what we believe to be the best medical advice at this time in relation to fertility treatment in Australia that will have a direct and positive impact for many of your patients.

By Professor
Luk Rombauts

Not all IVF providers are created equal.

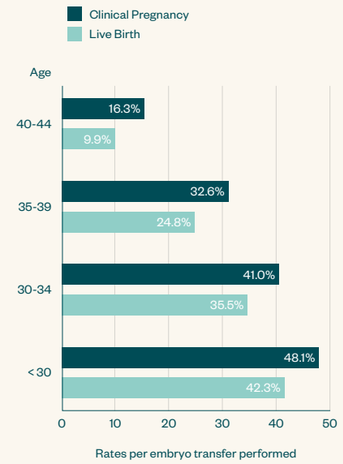
Live Birth Rates.

The Monash IVF team and I are extremely proud of our clinical birth rates. Our success rates position Monash IVF as a true leader in reproductive care and represents a continuation of the standards that have seen us benchmark above the national average for clinical pregnancy rates for Australian IVF.

I encourage you to review, ask questions and compare Monash IVF’s success rates against other IVF units. Our Live Birth Rates and Pregnancy Rates can also be found on our website (monashivf.com) or similarly our live birth rates can be found on the independent website YourIVF Success (a new website launched by the Australian Government).

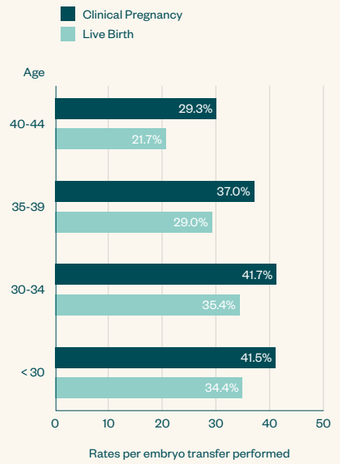
The higher the live birth rates are at an IVF unit, the smaller the number of treatment cycles a patient will have to experience to achieve their desired outcome of having a healthy baby. This has the flow-on effects of reduced cost to Medicare, and less financial cost and emotional toll for your patients.

2019 Clinical Pregnancy and Live Births for Fresh Embryo Transfers



These success rates include data for all clinics within the Monash IVF Group (Monash IVF, Repromed and Reproductive Medicine Albury). The graph shows IVF and ICSI treatments with an embryo transfers that took place at current Monash IVF Group clinics between 1 January and 31 December 2019. This data excludes cycles completed by patients using donated eggs.

2019 Clinical Pregnancy and Live Births for Frozen Embryo Transfers



These success rates include data for all clinics within the Monash IVF Group (Monash IVF, Repromed and Reproductive Medicine Albury). The graph shows treatments using all frozen embryos created via IVF or ICSI. These transfers took place at one of our current Monash IVF Group clinics between 1 January and 31 December 2019. This data includes treatment cycles that incorporated Pre-Implantation Genetic Testing (PGT). However, it excludes cycles completed by patients using donated embryos.

How does Monash IVF achieve such consistently strong success rates?

We consistently achieve high success rates year on year by having world leading Fertility Specialists and Scientists implement the very latest technologies and advancements into our clinical program. We ensure that our patient experience and model of care are cutting edge and our patients experience the best outcomes.

Monash IVF Group introduced a Group Medical Advisory Group and a Best Practice Clinical and Scientific Committee to ensure the implementation of best practice clinical and scientific policies across the group.

This Group Scientific Advisory Committee was integral to implementing The Monash Way across each of our clinics. The Monash Way ensures alignment and improvement of laboratory protocols based on best practice. This group is also responsible for internally benchmarking our clinics, harnessing best practice and rolling out protocols to other clinics across Monash IVF Group.

Monash IVF Group has also made significant investments in state-of-the-art laboratory equipment and laboratory systems across our clinics. This investment reflects our continued focus on quality control and quality assurances. We continue to invest in world-class equipment as part of our commitment to improving success rates and outcomes for patients.

As well we also regularly conduct comprehensive, end-to-end laboratory reviews. These reviews allow us to assess how our laboratories are running, and make improvements as required. As part of our laboratory reviews, we complete education and knowledge assessments for the entire scientific workforce.

Safety of our patients’ gametes and embryos - our highly developed Quality Management Systems and Disaster Planning ensures that Monash IVF is prepared for any adverse possibility. This means that our labs are prepared for cyclones in Queensland, power outages in Victoria and everything else in between. I am also proud to say that Monash IVF has carefully designed workflows to ensure our patients’ eggs, sperm and embryos are exposed to minimal fluctuations in temperature, pH or toxins.

So when considering a fertility clinic for your patient/s I encourage you to consider Monash IVF if you do not already do so. We are one of this country’s leading fertility clinics, we have leading industry voices, leading technologies and leading success rates.

A positive step forward for the IVF industry.

On February 15th 2021 the Federal Minister for Health launched a new initiative; YourIVFSuccess, to better inform patients regarding infertility treatments.

The YourIVFSuccess website contains three key pieces of information that will be useful in assisting patients make informed decisions regarding infertility treatment.

1) An online IVF success (live birth) calculator which takes into account an individual patient's age, past IVF and obstetric history and causes of infertility (if known). This calculator has been developed by the UNSW and is based on actual IVF results in Australia. By entering these key prognostic variables, a prospective IVF patient can be given a reasonably accurate prediction of her chances of having a child from IVF treatment. This information helps set realistic expectations for chances of success, but may also assist some poor prognosis patient to avoid IVF treatment all together.

2) In Australia there are over 80 IVF units. While all IVF clinics provide IVF treatment, other lesser options such as Intra-Uterine Insemination, Ovulation Induction and third-party reproduction (surrogacy, donor sperm, egg and embryo) are only available in a few clinics. The YourIVFSuccess website lists the various treatment options available at each clinic, thereby allowing patients to be fully informed of their options before arriving in the clinic.

3) Clinic success rates. Since 2002 all IVF units have been required to submit their live birth success rates to the National Perinatal Epidemiology and Statistics Unit at the UNSW. The purpose of this mandated database was primarily to monitor for complications (maternal and baby) in the relatively new IVF technology. However, these valuable results were hidden in a report read only by the industry, with individual IVF units success rates not being available due to the data being de-identified at publication.

It was apparent from this report that there was a huge variance in IVF success rates between clinics. Senator Stirling Griff recognised this anomaly and has been instrumental in making this existing data publicly available so patients can compare live birth success rates between IVF units in their home state. In order to account for variations in clinic success rates, the YourIVFSuccess website takes two approaches.

Firstly, it publishes the individual clinic's patient characteristics compared to national averages, allowing informed assessment of the average type of patient treated at that clinic. Secondly, the website publishes an "ideal good prognosis" patient yardstick (first cycle of IVF, age under 38 years) for that clinic, allowing valid comparisons between clinics and the national average for a typical good prognosis patient.

The majority of IVF units in Australia (92%) like Monash IVF, have consented to publication. Monash IVF is proud to have our results included as we are committed to a policy of transparency and honest reporting of our success rates.

By Dr Tristan Hardy,
Medical Director Genetics

Pre-conception genetic carrier screening.

What is genetic carrier screening?

Genetic carrier screening is a test that assesses a reproductive couple's chance of passing on a single gene condition to their child(ren). These conditions occur when each reproductive parent is a carrier of a genetic change which is passed on to their child, or a woman carries a genetic change on the X chromosome which is passed on. Some examples of single gene conditions include cystic fibrosis, fragile X syndrome and spinal muscular atrophy.

Who should consider genetic carrier screening?

Individuals do not need to be IVF patients or be undergoing fertility treatment to have genetic carrier screening. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends that all individuals planning a pregnancy consider genetic carrier screening.

Although genetic carrier screening can be done at any time, it is recommended that this test is done before pregnancy. If already pregnant, patients can still have this testing in addition to other screening tests during pregnancy such as non-invasive prenatal testing (NIPT).

Your patient does not have a family history of genetic conditions. Do they still need the screening?

The majority of children with single gene conditions are born into families with no other affected family members. About 1 in 40 reproductive couples who have genetic carrier screening will find out they have an increased chance of having a child with a single gene condition.

What does the screening entail?

Monash IVF now provides at-home genetic carrier screening. The process for patients is simple:

1. The patient orders the screening kit online at monashivf.com
2. They book a phone consultation with the Monash IVF Genetic Counselling Team.
3. They receive an at-home genetic carrier screening test kit in the mail.
4. They follow the instructions to provide a saliva sample.
5. Mail the sample back using the reply-paid envelope in the kit or drop it off at an eligible clinic.
6. The patient receives a phone call from a member of the Monash IVF genetic counselling team with results (usually within about 4 weeks).

How much does the screening cost?

The Monash IVF genetic carrier screening kit costs $549 for an individual or $749 for a couple. This includes saliva testing kits, support from our genetic counsellors and a pre-paid return envelope. We strongly recommend that testing is performed simultaneously for reproductive couples in order to avoid delays and take advantage of the discounted pricing for couples.

What if the results say your patients are at-risk?

If your patients are one of the 1 in 40 reproductive couples with an increased chance of having a child with a single gene condition, our experienced genetic counselling team will talk to them about their reproductive options and help them decide what may be best for their individual situation. These options may include testing in pregnancy, testing after the birth of a child, considering IVF with a gamete donor or considering IVF with preimplantation genetic testing of embryos. The Monash IVF team are here to support your patients, whichever option they choose.

More information

For more information or to order a genetic carrier screening kit, your patients can visit: monashivf.com/monash-ivf-at-home-genetic-carrier-screening-test/

When speaking about infertility the focus is often on female factors, however a third of infertility is due to male factors alone. After a female's age, male factor infertility is the second most common reason a couple may experience difficulty conceiving.

By Professor Rob McLachlan

Professor McLachlan helps dispel some myths about male infertility.

Q: What is infertility?

A: Infertility is commonly described as the inability to conceive after a year of unprotected intercourse, but couples may seek earlier evaluation especially if they have reasons for concern or the female partner is older.

Q: Do most people fall pregnant within a year?

A: In general, half of all couples will fall pregnant within the first 2-3 months and 85% will fall pregnant within the first 12 months of trying. Approximately 1 in 7 couples will experience difficulties trying to conceive.

Q: What are some of the possible causes of male infertility?

A: Most male factor cases are due to the failure to produce enough motile (swimming) sperm that can fertilise the egg. Sperm production can be damaged by prior surgery, trauma, infection or cancer treatments, or failure of the testis to descend into the scrotum early in life (cryptorchidism).

In a small minority a genetic issue is found such as breaks in the chromosomes, or parts of the male Y chromosome are missing. But many cases are unexplained.

Blockage to sperm tubes is the next common cause due to congenital problems or the result of infection or surgery e.g. vasectomy. A rare cause is pituitary hormone deficiency. Several medications can also negatively impact on sperm production and quality.

Overall, in many cases no obvious cause is found. "Lifestyle issues" such as obesity, stress, excessive consumption of alcohol, smoking or exposure to heat can all have an impact on a man's fertility. There is much emerging evidence that these stresses can damage the sperms genetic material [so-called epigenetic changes] and affect reproductive success including the health of offspring. The key message is for men to be 'as fit and healthy as they can be' when planning to start a family.

Male Fertility Testing

A Semen Analysis is the single most important piece of information needed to assess male fertility and is therefore crucial to obtain an accurate analysis.

The test (which requires a referral) can give accurate information about:

- motility – how many sperm can swim
- morphology – shape of the sperm
- count – how many individual sperm in the sample
- vitality – how healthy the sperm are and their chance of survival

Q: Can heat affect a man's fertility?

A: The testes are located within the scrotum which serves as an 'evaporative air conditioning' role by keeping them 2 degrees cooler than core body temperature as needed for normal sperm production.

Overheating a man's genital region can therefore have a negative impact on his fertility. Saunas, spas and hot baths or occupational exposure to heat (smelters) all result in heating of the testicles and can damage a man's fertility. Even working for long periods with a computer on the lap can overheat a man's genitals. These activities overwhelm the natural cooling process thereby impairing sperm production; happily this is reversible.

Q: It is widely known that a woman's fertility starts to decline in her early to mid 30s, do men have a similar biological clock?

A: We know that male fertility slowly decreases with age, although not to the extent seen in women.

We often hear through the media of men fathering children well into their 'golden years', however on average men who are older than 50 take five times as long to make their young partners pregnant compared to men who are under 25 years of age. So while men can father children in their later life, it certainly becomes more challenging to conceive a healthy child. Even more concerning is that there is now good evidence suggesting the DNA quality of sperm declines with age and this may explain why children conceived by older fathers have a higher risk of health problems such as autism spectrum disorder and schizophrenia.

Q: Will a man know if he is infertile?

A: For many men, the diagnosis of their infertility comes as a complete surprise and they enjoy good health in other regards. Unless he has had children previously then generally speaking, a man will only know his fertility potential after he has had a semen analysis that confirms he has motile sperm. Being in peak physical condition and good health is not a guarantee of fertility. Therefore, we suggest that anyone who has concerns about their fertility status should see a doctor and possibly have testing.

Q: How do you determine a man's fertility?

A: The most effective way to assess a man's fertility is via a semen analysis in an expert laboratory.

Q: If a couple has been trying to conceive for a while without success, what should they do?

A: Firstly they should see a GP who can undertake some inexpensive basic testing. Thereafter a Fertility Specialist will provide guidance into a couple's options including natural fertility prospects, as not all couples will require IVF to fall pregnant.

By Associate Professor
Warren Chan

Managing endometriosis to improve fertility.

Missed our webinar on 'Understanding Endometriosis'?

We recently held a webinar on Endometriosis which was designed specifically for General Practitioners.

Speakers included:

- Prof Luk Rombauts – Medical Director of the Monash IVF Group
- Dr Virochana Kaul – Fertility Specialist, Obstetrician and Gynaecologist with Monash IVF
- Dr Sashi Siva – Doctor and Sonologist at Sydney Ultrasound for Women

If you would like the link to this recording please email the team at seminars@monashivf.com

Incidence & Presentation

Endometriosis is a common, chronic disease with increasing public awareness of its effect on fertility. Treatment to improve subfertility secondary to endometriosis often involves surgery and/or assisted conception.

Endometriosis is defined as endometrial glands or stroma outside the uterus and typically presents in women of child-bearing age with:

1. **Subfertility** - Up to 50% of subfertile women are found to have endometriosis (compared to 5-10% in fertile couples). Women with endometriosis have a reduced monthly fecundity rate (2-10%) compared with fertile couples (15-20%)
2. **Pelvic Pain** – Dysmenorrhea, dyspareunia, dyschezia, dysuria and chronic pelvic pain can all suggest the presence of endometriosis. Women presenting with both pelvic pain and subfertility should raise a high index of suspicion for endometriosis as a contributing cause
3. **Adnexal mass** – Endometriomas can present as adnexal masses which have a significant impact on oocyte quality, ovarian reserve and fertility.
4. **Asymptomatic** – Women who do not experience pelvic pain but are having difficulty conceiving should raise suspicion of occult endometriosis.

Pathophysiology & Diagnosis

Diagnosis of endometriosis is made on histology. Laparoscopic surgery is the gold standard for both diagnosis and surgical treatment of endometriosis.

The most common staging system used is the revised American Society Reproductive Medicine (rASRM) system which classifies endometriosis into Stages 1 to 4 (minimal, mild, moderate & severe endometriosis). The rASRM stage of endometriosis does not always correlate to a patient's pain symptoms, but does correlate to the degree of subfertility.

Minimal/mild endometriosis (rASRM Stage 1-2) results in subfertility via altered cytokine, hormonal and immune pathways leading to reductions in oocyte quality and quantity (reduced ovarian reserve), altered tubal motility and endometrial receptivity.

Moderate/severe endometriosis (rASRM Stage 3-4) causes subfertility via significant anatomical distortion caused by pelvic adhesions and endometriomas in addition to the pathophysiological processes described for minimal/mild endometriosis.

Anti-Mullerian Hormone (AMH) levels often demonstrate reduced ovarian reserve in women with endometriosis. Pelvic Ultrasound can help diagnose endometriomas but will generally not detect mild/moderate peritoneal disease. Deep Infiltrative Endometriosis Ultrasound (patients require a pre-procedure bowel preparation) is increasingly utilised for detection of severe endometriosis (especially endometriosis with rectal involvement). This can help plan a multi-disciplinary approach to surgery, improving outcomes for patients who undergo fertility sparing surgery.

Management Options:

Medical Therapy

Hormonal therapies (eg. combined oral contraceptive pill, progestogen only pill, Mirena IUCD) are often used to treat pelvic pain secondary to endometriosis. However, medical therapy is generally contraceptive and has a limited role in treatment of endometriosis from a fertility perspective. Hormonal suppression of endometriosis does not improve spontaneous pregnancy rates.

Surgery

Laparoscopic surgery remains the gold standard for both diagnosis and surgical treatment of endometriosis. The aims of surgery are to remove all macroscopic endometriosis and restore normal pelvic anatomy.

A Cochrane meta-analysis of laparoscopic excision of minimal/mild endometriosis (rASRM Stage 1-2) demonstrated significant improvement in spontaneous live birth rate by 2 fold (OR 1.94 95%CI 1.20-3.16 p=0.007).

Prospective studies have also shown improvement in pregnancy rates after surgical excision of moderate/severe endometriosis (rASRM Stage 3-4). However, surgical planning and appropriate discussion with the woman regarding additional surgical risks including the possibility of reducing ovarian reserve (especially with excision of endometriomas) is important. A multi-disciplinary surgical approach (Colo-rectal Surgeon and Urologist) working in conjunction with an Advanced Surgical Gynaecologist provides the best results.

Complete excision of endometriosis at the initial operation is an important concept – pregnancy rates from second-line (repeat) surgery are reduced by 50%. Complete excision of endometriosis also has the advantage of concurrently reducing pelvic pain, confirming histological diagnosis, reduced recurrence and adhesion formation.

Assisted Conception

Both Ovulation Induction/Intra-Uterine Insemination (OI/IUI) and In-Vitro Fertilisation (IVF) have demonstrated significant benefits in women with endometriosis.

If assisted conception is required, IVF is generally the treatment of choice because of demonstrated superior pregnancy rates compared with OI/IUI. However, women with endometriosis have reduced IVF outcomes compared to those who do not have endometriosis.

A multi-disciplinary team approach involving a Fertility Specialist, GP and IVF team (nurses, embryologists and counsellors) are vital in providing the best results.

Summary

Couples presenting with subfertility where the female partner has endometriosis is common. Laparoscopic excision of endometriosis and IVF provide the best chance for a successful pregnancy.

Once pregnancy is achieved, pregnancy itself helps reduce symptoms of endometriosis. Because endometriosis is a chronic condition, management of the inter-pregnancy interval is important and should aim to control the woman's symptoms and reduce the recurrence of endometriosis to maximise the success of subsequent pregnancies.

References

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2. Duffy JMN et al. Laparoscopic surgery for endometriosis. *Cochrane Database Sys Rev* 2014; 4: CD011031.
3. The Practice Committee of the American Society for Reproductive Medicine. Endometriosis and infertility: a committee opinion. *Fertil Steril* 2012; 98(3): 591-598.
4. Dunselman GAJ et al. ESHRE guideline: management of women with endometriosis. *Hum Reprod* 2014; 29(3): 400-412.

Government supports genetic screening for embryos.

Genetic experts at Monash IVF have welcomed the Australian Government's move to include preimplantation genetic testing of embryos on the Medicare Benefits Schedule, as part of the 2021 Federal Budget.

On Friday 14 May, 2021 the Government announced it was investing $95.9 million for preimplantation genetic testing as part of an overall package aimed at "improving long-term health outcomes for women and girls" across Australia.

The inclusion is an important step in supporting women's health and providing better health outcomes for families. Preimplantation genetic testing involves the screening of embryos for significant genetic conditions that could affect the health of the child. In the past, individuals and couples who carry genetic conditions have had to pay a significant out-of-pocket cost to screen their embryos if they wished to reduce their chance of passing genetic conditions on to their future children. Unfortunately, this has meant that preimplantation genetic testing has been inaccessible to many families. But this has now changed, with preimplantation screening now covered under the Medical Benefits Scheme.

Dr Tristan Hardy, Medical Director of Genetics at Monash IVF Group and Australia's only dual trained obstetrician-gynaecologist and genetic pathologist, said while the IVF component of this treatment has previously been funded by the MBS, this funding did not include preimplantation genetic testing.

"Preimplantation testing is an exceptionally important medical treatment," Dr Hardy said.

"It allows couples to test embryos for genetic conditions that they may carry, such as Fragile X syndrome or cystic fibrosis, or may personally be affected by, such as hereditary breast and ovarian cancer. In the past people have had to pay for this service themselves and, for many people, this made it inaccessible. Now this crucial barrier has been removed.

"Australia is one of the first countries in the world to have this treatment broadly supported by the Government and the health system. It's extremely forward thinking." Dr Hardy said when people are planning a pregnancy, they need to be aware there is a chance that either one or both might be carriers of a significant genetic condition, even if there is no family history of a genetic condition. By undergoing reproductive genetic carrier screening, they may identify that they have a high chance of having a child with a significant genetic condition. In his experience, around 1 in 40 couples will find out they are in this situation.

"For individuals and couples who find themselves in this situation, the Government funding will make a big difference by supporting their care and keeping this option available.

"Our genetics team have been asking for this for years. Preimplantation embryo testing is a mature technology and it has become obvious that more and more couples could benefit from it.

"This will be a significant help to a lot of people."

For more information on how genetic testing can help your patients talk to one of our team on 1800 754 356 or visit monashivf.com

Monash IVF sperm donor program.

States and territories within Australia are governed by state based ART legislation, regulations and/or guidelines which prevent a person from being refused fertility treatment based on their sexual orientation, gender identity, marital status or religious beliefs.

People no longer require a medical diagnosis of infertility to be considered for fertility treatment. This has given single females wishing to solo parent and same sex couples the opportunity to become parents with the use of donor sperm or eggs.

Monash IVF patients as well as having access to local Australian donors, have access to California Cyrobank, with over 40 years of reproductive experience. Queensland patients can also access Seattle Sperm bank and Victorian patients can access Northwest Cryobank. All international sperm donors accessed through Monash IVF are ID disclosed donors who comply with Australian guidelines.

Monash IVF have a dedicated Donor Team who work closely with potential donors to recruit them to our program as well as working with recipients to allocate them to available donors that they chose.

Monash IVF also offer a known sperm donation program. This program allows recipients to undertake treatment with a sperm donor who is known to them.

All recipients and donors are required to undertake counselling prior to commencing their donations or treatment.

Our donor teams work closely with our Fertility Specialists, nurses, laboratories, counsellors and ultrasound services to ensure we are providing a comprehensive service that is recipient and donor focused.

QUICK FACTS:

- A child born as a result of donation is considered to be a child of the Recipient/s under various state and national legislation. The Donor has no legal parenting rights or responsibility (including financial) for the child.
- Donors are never listed on the birth certificate, only the child's parent/parents (donor recipient) will be listed.
- All donors are required to continue to keep Monash IVF updated with any changes to their contact details, medical and genetic information and any changes to their relationship status.
- All donors must be an identity release donor, which allows a donor conceived person to access the donor's identifying information once they reach mature age. In most states this is considered to be 18 years of age however in some states this could be lower.
- Donors can not be paid for their donations, however they can be reimbursed for verifiable out of pocket expenses associated with their donations.

Monash IVF FAQ's by GP's

Q: Do I need to perform any tests / investigations on my patient before I refer to Monash IVF?

A: No, once a Monash IVF Fertility Specialist receives your referral they will organise any initial tests and investigations which may be required.

Q: Do I need to refer my patient to a particular doctor at Monash IVF?

A: You can if you wish, or you can address the referral to 'Dear Doctor' and our Nurse Enquiry Team will allocate a doctor depending on your patient's clinical requirement, location of work or home. If you are referring a couple, please include both names on your referral.

Q: What is the general waiting time to see a doctor at Monash IVF?

A: Usually 2 - 4 weeks.

Q: Will my patient need to undergo IVF?

A: Not necessarily. Many have fertility counselling or other forms of treatment such as oral medication, intercourse timing or ovulation tracking.

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