

**NAME OF DOCUMENT:**

**Assisted Conception Policy**

**Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) AND  
Intracytoplasmic sperm Injection (ICSI)**

**KEYWORD DESCRIPTOR:**

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## **Assisted Conception Policy – Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) AND Intracytoplasmic sperm Injection (ICSI)**

The management of fertility includes both primary and secondary care support and intervention where appropriate, including advice on lifestyle changes that are likely to improve the probability of conception.

1. In Vitro Fertilisation (IVF) Intra-Uterine Insemination (IUI) and Intracytoplasmic Sperm Injection (ICSI) will normally be funded only in the context of the fertility care pathway recommended by protocol for the clinical management of infertility (Appendix 2).
2. Access to NHS funding for specialist assisted conception treatments will normally be on the recommendation of a local NHS Consultant Gynaecologist and on some occasions from local NHS Consultant Urologist.
3. One fresh cycle of IVF will be funded for patients in whom it is clinically indicated and who meet the criteria for access. Appendix 1 & 2.  
Two cycles will be funded for all new referrals as from 1<sup>st</sup> September 2008 with a review in February 2009. Cycles includes cycles that are abandoned on the basis of clinical reasons.
4. Couples have the option to choose from 1 fresh cycle of IVF/ICSI or 3 cycles of IUI.
5. The current providers for treatment are:
  - Mayday
  - Queen Mary's Hospital, Roehampton
6. The specialist fertility units will be solely responsible for initial consultation, treatment planning, counselling and advising patients, consent all drugs, egg collection, semen analysis, embryo transfer, pregnancy test, all consumables, pathology tests, scans and Human Fertilisation & Embryo Authority (HFEA) fees if required.
7. This policy should be read in conjunction with the Surrey PCT Criterion for Access to Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI) see Appendix 1. Couples **must** meet all the criteria in order to be eligible for NHS funding of treatment.
8. **Pre-implantation genetic diagnosis**  
Pre-implantation genetic diagnosis can avoid transmission of serious genetic disease. Funding of pre-implantation genetic diagnosis is separate from infertility treatment and is covered under the Surrey Low Priorities Procedures. GPs need to make referrals to Surrey PCT Exceptions Panel via the panel administrator.
9. **Sperm Donation**  
Surrey PCT does not fund sperm donation procedures.
10. **Egg Donation**  
Surrey PCT does not fund egg donation procedures.

**11. Surrogacy**

Surrey PCT does not fund any element of surrogacy procedures.

**12. IVF treatment and drugs**

These elements are included in the cost of the package managed by the lead Consultant provided by the specialist unit and will not be funded as separate elements by Primary Care clinicians (GPs and/or Nurse Prescribers).

13. Surrey PCT will fund treatment for people due to undergo cancer treatment that will affect their fertility, as long as they meet the current criteria (Appendix 1) for treatment. Patients with cancer seeking egg donation are not covered by this policy and need to refer to Surrey PCT Low Priorities Procedures.

**Working Group:**

*Niki Bartrop, Abigail Groves, Marion Heron, Anna Raleigh and Sue Waters*

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**Surrey Primary Care Trust Criteria for Access to Assisted Conception  
 Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)**

- A. Surrey PCT will fund one cycle of IVF treatment per eligible couple until 31<sup>st</sup> August 2008.
- B. All couples will be expected to have completed the primary and secondary care pathways (as defined in Appendix 2) appropriate to them before eligibility for IVF, IUI or ICSI is considered. Sub fertility will be defined as no live birth following insemination at, or just prior to, the known time of ovulation, on at least ten documented non stimulated cycles or fertility problem demonstrated at investigation.
- C. One cycle of IVF is defined as one full fresh cycle including ovulation induction, egg retrieval, fertilisation and implantation including all appropriate diagnostic tests, scans and pharmacological therapy.
- D. These criteria will be reviewed no later than February 2009.
- E. It is anticipated that, rarely, patients who are not eligible for treatment because they do not fulfil these criterion may, by virtue of their personal circumstances, be considered an exceptional case for NHS funding. If it is thought to be applicable, the patient's GP or Hospital Consultant may contact the Surrey PCT Exceptions Panel for the consideration of funding. The PCT will fund assisted conception treatment prior to cancer treatment that is likely to cause infertility if the couple meet the criterion.

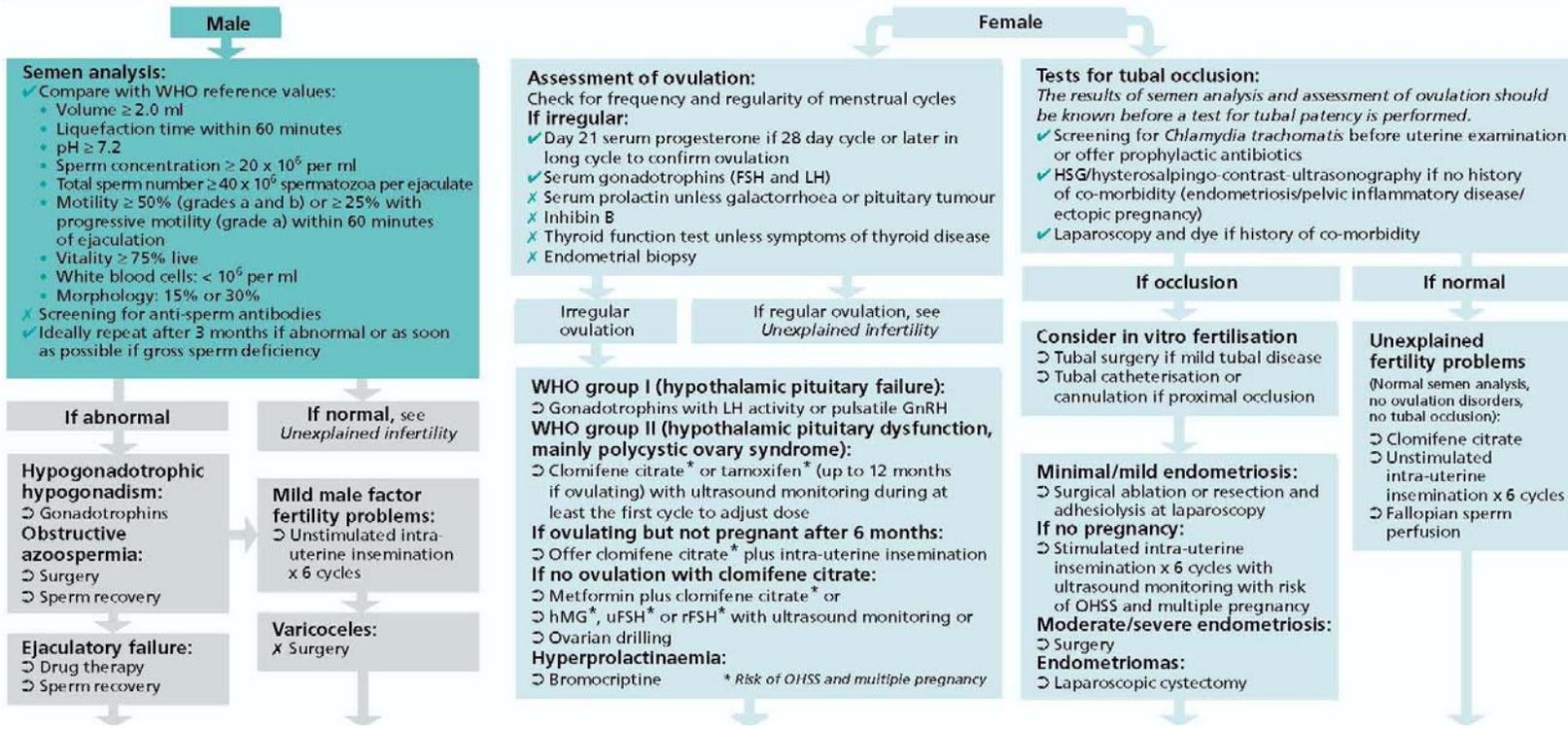
Reference	Title	Criterion
1	Age of female at time of starting cycle	The time of starting the cycle of IVF for the first time should be after the female's 23 <sup>rd</sup> birthday and before the female's 40 <sup>th</sup> birthday.
2	Age of female at time of referral to tertiary care from secondary care	The age at referral will be 23 to 39 years inclusive in order to make eligible age range for referral consistent with the eligible age range for treatment. Funding will be available for IUI/IVF or ICSI for couples in which the woman is aged 23-39 at the time of treatment <b>if the cycle will be begun</b> before the female partner has reached the age of <b>40</b> . An exception will be made for women who are aged 39 at the point of referral to an assisted conception unit who must be treated within six months of their 40 <sup>th</sup> birthday.
3	Age of male partner	No upper age limit for male partner (as per adoption laws)
4	Previous infertility treatment	Any previous NHS funded IVF/IUI/ICSI treatment will be an exclusion criterion. Previous self-funders are eligible for one NHS funded cycle of IVF/ICSI if they have not already received three cycles of IVF/ICSI in line with the evidence of effectiveness within NICE guideline. Alternatively they will be entitled to 3 cycles of IUI.
5.	Childlessness	Treatment for sub fertility will be funded if the couple does not have a living child (regardless of age) from their or any previous relationship. This includes a child adopted by the couple or adopted through a previous relationship. It is estimated that 66% of all couples attending out patient fertility clinics are both childless. One partner is childless in a further 16% of this group. Once accepted for treatment, should a child be adopted or a pregnancy leading to a live birth occur the couple will no longer be eligible for treatment.

6.	Sterilisation	Fertility treatment will not be available if the sub fertility is the result of a sterilisation procedure in either partner. In addition, the surgical reversal of either male or female sterilisation will not be funded except in exceptional circumstances. If the individual's situation is thought to warrant such consideration, the patients' GP should make an application to the Surrey PCT Exceptions Panel Administrator.
7.	Body Mass Index	Women must have a BMI of between 19.0 and 29.9 inclusive for a period of 6 months or more before receiving any assessment treatment. They must be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary and secondary care. GPs are encouraged to provide unambiguous and clear information about BMI criteria to infertile couples.
8.	Smoking/Health Lifestyles	Only non-smoking couples (both partners) will be accepted for IVF treatment inclusive for a period of 6 months or more before receiving treatment. They must be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary and secondary care. GPs are encouraged to provide unambiguous and clear information to infertile couples. It should also be recognised and emphasised the importance of an active, healthy lifestyle whilst highlighting the dangers of smoking, passive smoking, obesity, alcohol, prescription and recreational drugs and caffeinated beverages as important causes of infertility.
9.	Alcohol	Couples accepted for IVF treatment should adhere to the NICE guidelines of less or equal to 1-2 units per week for women and 3-4 units per week for men.
10.	Follicle Stimulating Hormone Levels	The level of FSH affects the success of treatment. Access to treatment will be determined by FSH of 9mmols
11	HFEA Code of Ethics	Couples not conforming to the HFEA's Code of Ethics, will be excluded from having access to NHS funded assisted fertility or other treatment. This includes consideration of the 'welfare of the child which may be born' which takes into account the importance of a stable and supportive environment for children as well as the pre existing health status of the parents.

## Assessment and treatment for people with fertility problems

<p><b>Initial advice for people concerned about delays in conception:</b></p> <ul style="list-style-type: none"> <li>• Cumulative probability of pregnancy in general population:             <ul style="list-style-type: none"> <li>– 84% in 1st year</li> <li>– 92% in 2nd year</li> </ul> </li> <li>• Fertility declines with a woman's age</li> <li>• Lifestyle advice:             <ul style="list-style-type: none"> <li>– Sexual intercourse every 2–3 days</li> <li>– ≤ 1–2 units alcohol/week for women; ≤ 3–4 units/week for men</li> <li>– Smoking cessation programme for smokers</li> <li>– Body mass index of 19–29</li> <li>– Information about prescribed, over-the-counter and recreational drugs</li> <li>– Information about occupational hazards</li> </ul> </li> <li>• Offer pre-conceptual advice:             <ul style="list-style-type: none"> <li>– Folic acid</li> <li>– Rubella susceptibility and cervical screening</li> </ul> </li> </ul>	<p><b>Infertility:</b> Failure to conceive after regular unprotected sexual intercourse for 2 years in the absence of known reproductive pathology <i>This guideline does not include the management of people who are outside this definition, such as those with sexual dysfunction, couples who are using contraception and couples outside the reproductive age range.</i></p> <p><b>Early investigation if:</b></p> <ul style="list-style-type: none"> <li>• History of predisposing factors (such as amenorrhoea, oligomenorrhoea, pelvic inflammatory disease or undescended testes); woman's age ≥ 35 yrs; people with HIV, hepatitis B and hepatitis C; prior treatment for cancer</li> </ul> <p><b>People preparing for cancer treatment:</b></p> <ul style="list-style-type: none"> <li>• Follow Royal College of Physicians and Royal College of Radiologists guidance</li> <li>• Cryostorage of gametes and/or embryos</li> </ul>	<p><b>Principles of care:</b></p> <ul style="list-style-type: none"> <li>• Couple-centred management</li> <li>• Access to evidence-based information (verbal and written)</li> <li>• Counselling from someone not directly involved in management of the couple's fertility problems</li> <li>• Contact with fertility support groups</li> <li>• Specialist teams</li> </ul>
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## Clinical investigation of fertility problems and management strategies For people who have not conceived after 1 year of regular unprotected sexual intercourse



**If no pregnancy with azoospermia, bilateral tubal occlusion or 3 years' infertility and the woman is aged 23–39 years, offer up to 3 stimulated cycles of in vitro fertilisation treatment**

**Additional principles of care for people undergoing in vitro fertilisation treatment:**

Access to evidence-based information (verbal and written) on risks/implications of assisted reproduction, including health of resulting children; genetic counselling; consideration of welfare of the child

**Factors affecting the outcome of in vitro fertilisation treatment:**

- Salpingectomy before in vitro fertilisation treatment for women with hydrosalpinges
- Optimal woman's age is 23–39 years at time of treatment
- Increased success with previous pregnancy and/or live birth
- Ideal body mass index is 19–30
- Increased success with low alcohol/caffeine intake
- Increased success in non-smokers
- Consistent for first 3 cycles of treatment, effectiveness after 3 cycles is uncertain

**Procedures for in vitro fertilisation treatment:**

**1. Offer screening:**

- ✓ HIV, hepatitis B, hepatitis C; specialist referral if positive

**3. Embryo transfer:**

- ✓ No more than 2 embryos to be transferred during any 1 cycle
- ✓ Offer cryostorage of supernumerary embryos if more than 2 embryos
- ✓ Frozen embryos to be transferred before further stimulated cycles
- ✓ Ultrasound-guided embryo transfer on day 2 or 3, or on day 5 or 6

**4. Luteal support:**

- ✓ Progesterone

**2. Ovulation induction:**

- ✗ Natural cycle
- ✓ Pituitary down-regulation with GnRH agonist long protocol
- ✓ GnRH agonist with gonadotrophins with consideration to minimising cost
- ✗ GnRH antagonists
- ✗ Growth hormone adjuvant
- ✓ Monitor follicular development with ultrasound: clinics should have protocols for management of OHSS
- ✓ Oocyte maturation with human chorionic gonadotrophins
- ✓ Oocyte retrieval: offer conscious sedation (follow Academy of Medical Royal Colleges guidance)
- ✗ Follicle flushing
- ✗ Assisted hatching

Women should be informed of the risks of OHSS and multiple pregnancy

**Management options associated with in vitro fertilisation treatment and other forms of assisted reproduction**

**Intracytoplasmic sperm injection – for couples with:**

- Severe semen quality deficits
- Azoospermia
- Poor in vitro fertilisation treatment response

**Screening:**

- Male karyotype

**Donor Insemination – for couples with:**

- Azoospermia
- Genetic/infectious disease in male partner
- Severe rhesus isoimmunisation
- Severe semen deficits

**Screening of sperm donors:**

- Follow British Andrology Society guidance
- Assessment of female partner:**
- ✓ Confirm ovulation
- ✓ HSG if no pregnancy after 3 cycles

**Donor Insemination:**

- ✓ Time insemination with either urinary luteinising hormone or basal body temperature changes
- ✓ If regular ovulation, offer 6 unstimulated cycles

**Oocyte donation – for women with:**

- Premature ovarian failure
- Gonadal dysgenesis including Turner syndrome
- Bilateral oophorectomy
- Ovarian failure following chemotherapy or radiotherapy
- Certain cases of in vitro fertilisation treatment failure
- Genetic disorder transmission to offspring

**Screening of oocyte donors:**

- Follow Human Fertilisation and Embryology Authority guidance

**Oocyte donors:**

- Risks of ovarian stimulation and oocyte collection
- Egg sharing: counselling**

This algorithm should, where necessary, be interpreted with reference to the full guideline

**Key:** FSH follicle-stimulating hormone; GnRH gonadotrophin-releasing hormone; HIV human immunodeficiency virus; hMG human menopausal gonadotrophin; HSG hysterosalpingography; LH luteinising hormone; OHSS ovarian hyperstimulation syndrome; rFSH recombinant FSH; uFSH urinary FSH; WHO World Health Organization

