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NCL Fertility Pathway

Optimising care for those worried about their fertility

OCTOBER 2022

Agenda

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1. Introductions
2. Context setting
3. Aims of this session
4. Review the primary care pathway
5. Scenario testing
6. Recap on the pathway

CONTEXT

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1. Reminder on policy update process – ACT focus (not on the medical or surgical treatment of fertility problems) and **NCL wide**
    - IVF cycles, increased provision for F:F same sex couples (up to 6 NHS funded IUI cycles), eligibility criteria for ACT
2. Commissioning changes – provider choice
    - Awareness of the fertility offer from different providers (fertility medical, surgical and ACT)
    - Fertility Services - North Central London GP Website (icb.nhs.uk)
3. Learning from stakeholder feedback and recommendations
    - Variation in primary care understanding of fertility and the pathway
    - Perceived blockers in primary care

AIMs

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- Improve understanding of the fertility journey to optimise patient experience and improve referral quality
- Improve understanding of key history, examination and tests that primary care can use
- Improve knowledge of the secondary care pathway and ACTs

Fertility is complex, we cannot cover all scenarios and will not be covering specific causes of infertility and their management.

There may be overlaps and intersections with other pathways too (general gynaecology, urology, endocrinology) and it is a tailored clinical review that determines the additional involvement and timings of the other specialities.

UPDATED FERTILITY PATHWAY

Refer to full PDF

[Download: Fertility Primary Care Clinical Pathway - North Central London GP Website (icb.nhs.uk)]

Purpose of the GP flowchart: This is intended as a guide for GPs. It provides an overview of the whole fertility pathway and recommends overarching steps and key elements within the steps. The fertility pathway is designed to enable personalised care and discussion and so you will find many recommendations opposed to must dos. There is clear eligibility criteria for assisted conception treatment though and its important to bear that in mind in your patient conversations. It is very difficult to foresee and plan all clinical scenarios and you should use clinical judgement and ask for advice if you are unclear.

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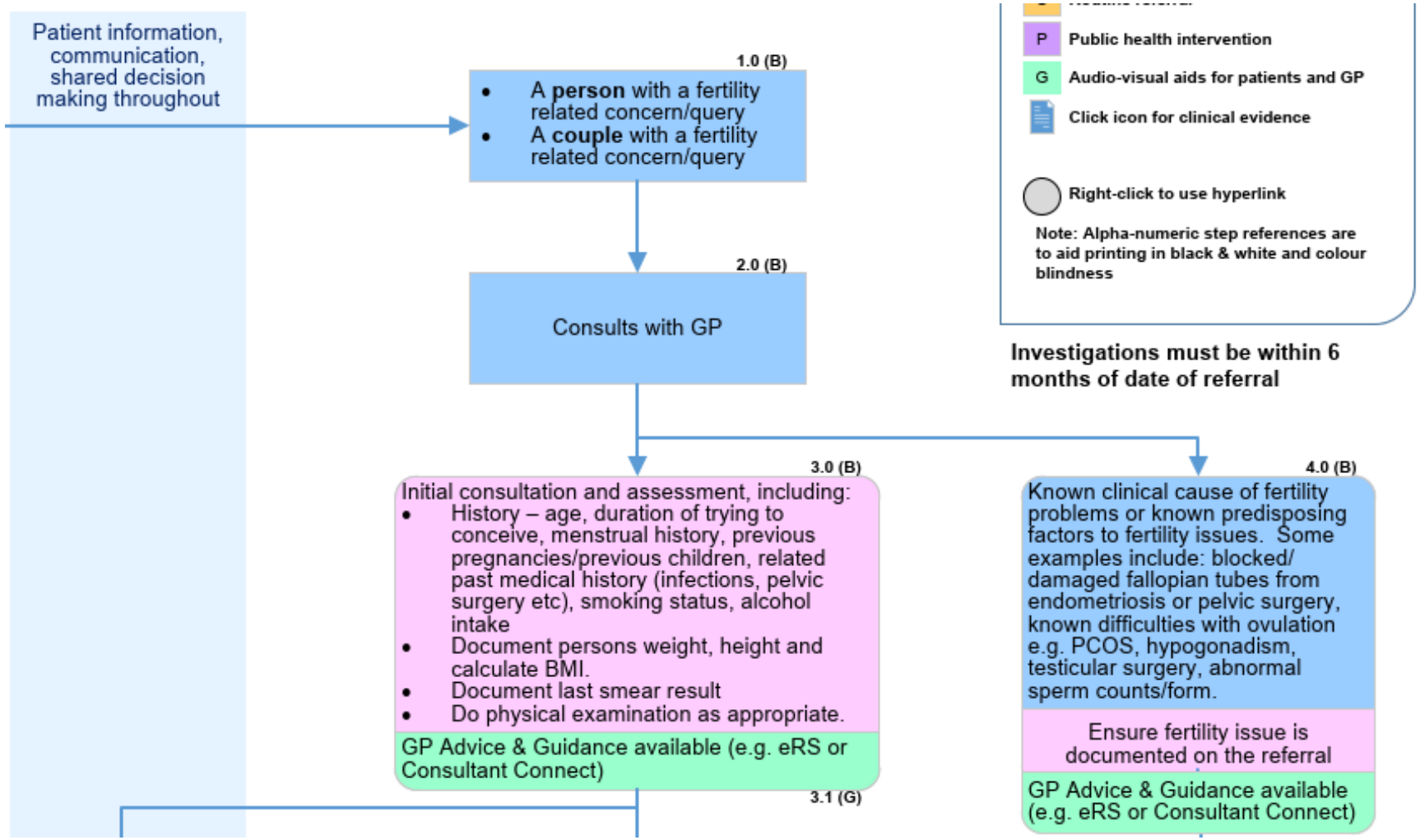

Pathway 'highlights'

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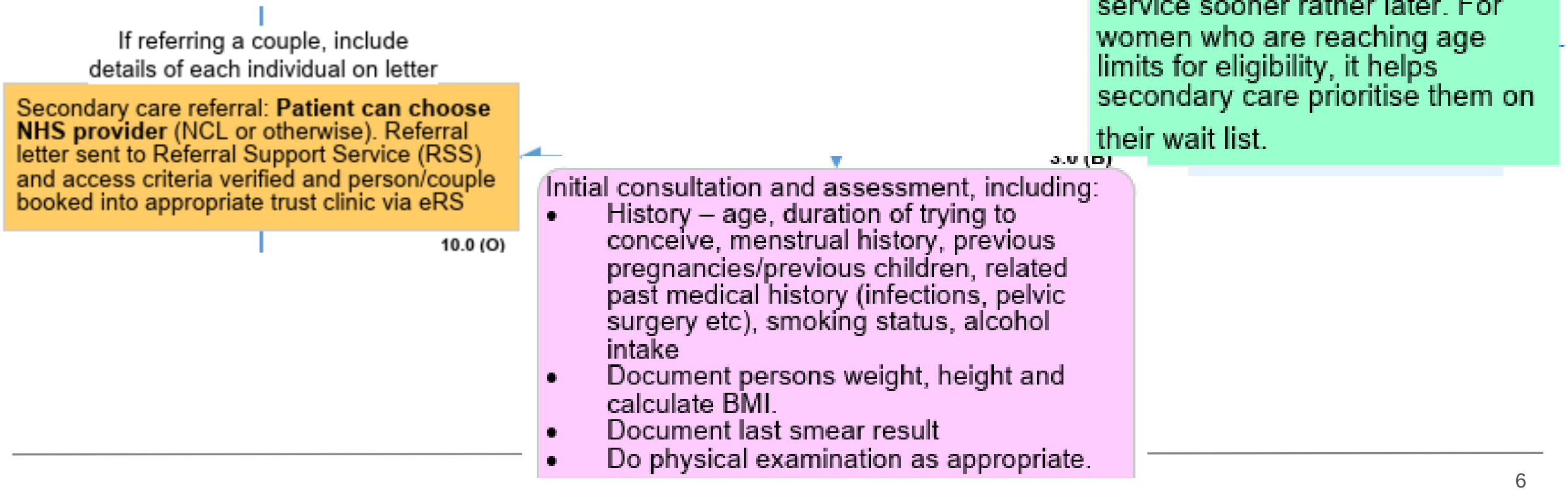
- Signpost to ask for advice/guidance at multiple points and hyperlinks for further information
- 'Must-dos' on the pathway link back to eligibility criteria ACT
- Day 21 progesterone – not helpful in reality
- Patient information (hyperlinks at end of PP)



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SCENARIOs for PRIMARY CARE

Scenario 1a & 1b

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History

- Heterosexual couple have been trying for over a year, regular SI – not pregnant.
- Man: 35 years, Female: 29 years. No significant PMH for either. No previous children.

Considerations

- What next?
- Investigations:
- If these are unremarkable in primary care – then what?

History

What if – F: 36 and M: 40, report regular SI for 6/12.
How does the female age impact on decision making and next steps?

Lessons: Primary care history and investigations, when and what next, expectant management, clinical reasoning.

Endometriosis

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History
28-year-old female, with **known** endometriosis is seeing their GP with questions about their fertility.

Considerations
- Are they sexually active and planning?
- What do we know about extent of endometriosis?
- What tests would you do in primary care?

What if: this lady **did not** have known endometriosis but on further history, she has had very painful periods, deep dyspareunia and describes cyclical urinary symptoms. She has been trying to get pregnant and has been putting up with her symptoms as thought they were 'normal'.
- What now?
- US?
- Cycles suppression not an option due to pregnancy aspirations
- Fertility or Gynae referral?

Lessons: Pregnancy not possible with expectant management, ACT provider, Endometriosis diagnosis and management!

Pathway snapshot – management- medical, surgical and finally IVF

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Management for:

- Male factor fertility problems, include gonadotrophin drugs, surgical sperm retrieval etc
- Ovulation disorders, include ovulation induction
- Tubal and uterine surgery includes tubal surgery (e.g. tubal cannulation or catheterisation)
- Endometriosis includes a wide range of medical and surgical interventions as set out in NICE.
- In unexplained infertility, women to have regular unprotected sexual intercourse for 2 years before IVF considered.

PCOS (an ovulation disorder)

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Common - heterogeneous endocrine disorder, emerges in puberty/adulthood

Clinical features may include hyperandrogenism (with the clinical manifestations of oligomenorrhoea, hirsutism, and acne), ovulation disorders, and polycystic ovarian morphology.

Context: Infertility spotlight

- PCOS is the single most common cause of infertility in young women
- It is the underlying cause in 75% of women who have infertility due to anovulation

History – extract frequency and regularity of cycles

BMI important – weight loss improves chances of pregnancy

Tests: Testosterone, SHBG, free androgen index, US ovaries

Referral – already has PCOS or investigations in primary care point to PCOS

Multiple options to optimise fertility prior to ACTs

Lessons: Pregnancy may not possible with expectant management, consider ACT providers

Male factor infertility

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- Ejaculation problems
- Hypogonadism
- Semen abnormalities

What next? Some conditions are amenable to medical and surgical management, and these would be recommended.

How do we approach this scenario from a couple perspective? How do we minimize protracted/disjointed referral routes?

Semen abnormalities - What are the factors in play for a successful pregnancy for a couple?

- age of female, use of own sperm, donated sperm with IUI or IVF.

Consider provider – who has access to what services?
Tertiary fertility care services are multidisciplinary: Fertility, Endocrinology, Urology etc

Lessons: MDT approach, Advice and guidance if unsure

Scenario 3a & 3b

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History
Same sex female couple (28 and 33 in age) seek advice on having a baby?

Considerations
- What have they done so far?
- What would they need to do prior to investigations and referral?
- What AI is accepted in NHS referrals? IUI vs IVI (at home AI).

History
Single female (aged 40) seeking advice on having a baby on her own?

Considerations
- Considerations
- Steps taken herself?

Lessons: IUI not IVI, up to 6xIUI funded on the NHS (subject to criteria), relaying correct

Scenario 4

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History
Heterosexual couple – M:45 F:41. They have had 2 rounds of IVF privately

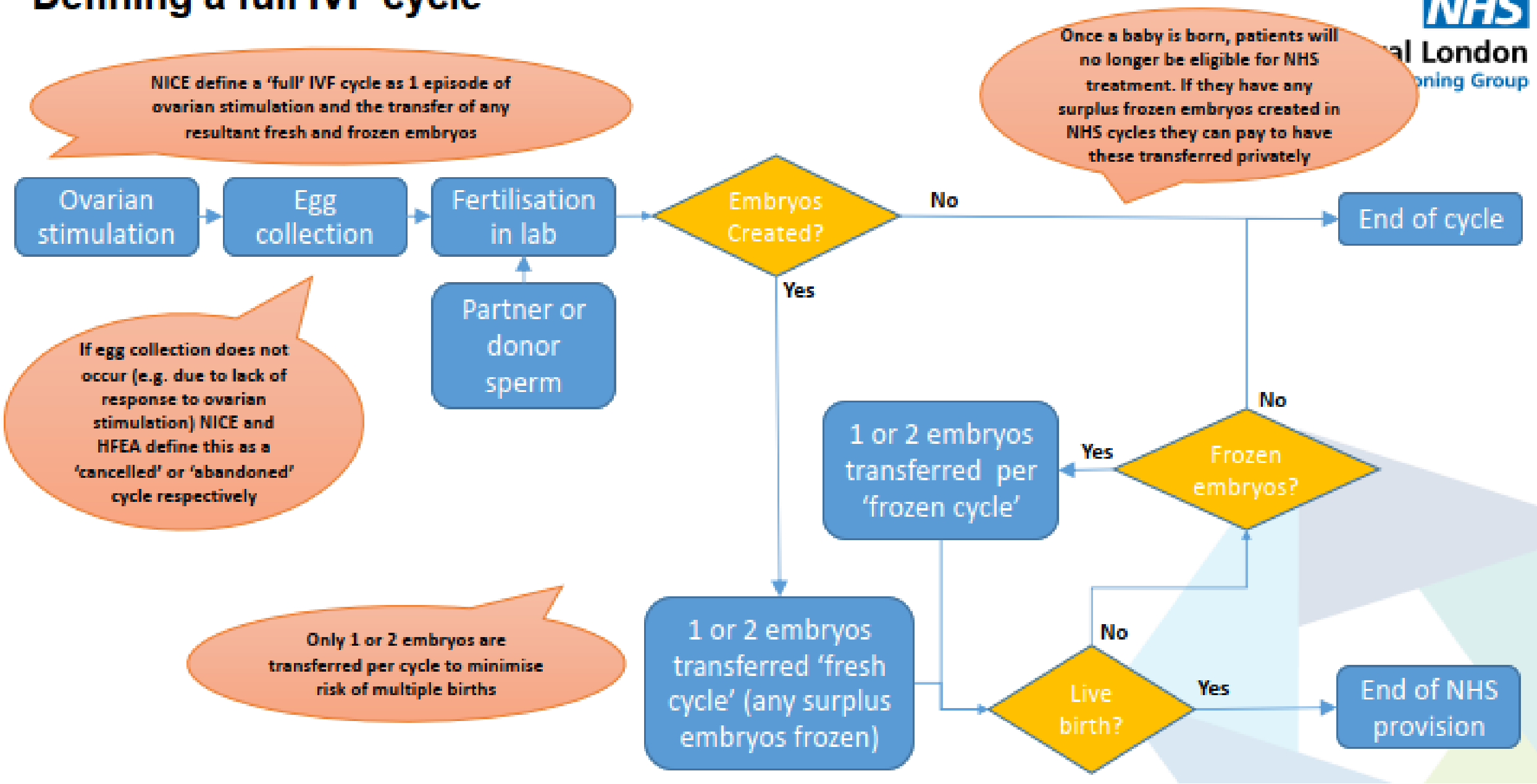
Considerations
What can they get on NHS?

History
Heterosexual couple – M:45 F:39. Have had 2 rounds of IVF privately

Considerations
What can they get on NHS?

Lessons: NCL funds up to 6 embryo transfers (shift from cycles alone) in females under 40 from a max. Of 3 fresh cycles. Females aged 40-42 up to 2 embryo transfers from 1 fresh cycle. Female age is a crucial factor.

Defining a full IVF cycle



Previous children

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History
A heterosexual couple have one child together. They have been trying for a second baby for over a year.

Considerations
- Primary care investigations
- Eligibility for IVF

History
What about a heterosexual couple where the male has one child with another person?

Considerations
- Primary care investigations
- Eligibility for IVF

Lessons: Eligibility criteria, reminder that this doesn’t stop you referring/investigating

ELIGIBILITY CRITERIA for IVF	DETAILS in Policy
Demonstrating infertility for eligibility for IVF	In order to be eligible for IVF, infertility must be demonstrated in one of the following ways: Investigations show there is no chance of pregnancy with expectant Management1 and IVF is the only effective treatment, OR Patients have not conceived after either 2 years of regular unprotected intercourse OR 12 cycles of IUI
Age of the woman or person trying to conceive	The woman or person trying to conceive who is receiving fertility treatment must be aged under 43 years. IVF medication must start with the provider before their 43rd birthday. Referrals should be made to fertility clinics allowing adequate time for work up. If the woman or person trying to conceive reaches the age of 40 during treatment, the current full cycle will be completed but no further full cycles will be available. A full cycle of IVF treatment, with or without ICSI, should comprise one episode of ovarian stimulation and the transfer of resultant fresh and frozen embryo(s), in line with Section 1 of this document.
Previous IVF cycles for the woman or person trying to conceive	Treatment will not be funded for those aged under 40 years if three previous fresh cycles of IVF have been received, irrespective of how these were funded. Treatment will not be funded for those aged 40–42 years if they have undergone any previous IVF treatment, irrespective of how this was funded.
Body mass index (BMI)	The woman or person undergoing treatment with the intention of trying to conceive must have a BMI within the range 19–30 kg/m2.
Smoking	Treatment will not be funded if the woman or person undergoing treatment with the intention of trying to conceive smokes. Treatment will not be funded if the man or partner providing sperm for treatment Smokes.
Ovarian reserve	There should not be evidence of low ovarian reserve, defined in this policy as more than one of the following: antral follicle count (AFC) of less than or equal to 4 anti-Müllerian hormone (AMH) of less than or equal to 5.4 pmol/l follicle-stimulating hormone (FSH) greater than 8.9 IU/l
Previous Children	Couples: At least one individual in a couple must not have a living child from their relationship or any previous relationship. Single persons: Individuals should not have a living child. Foster children are outside the scope of this criterion. ‘Child’ refers to a living son or daughter irrespective of their age or place of residence.
Previous sterilisation	Couples: Neither individual in a couple should have undergone sterilisation. Single persons: Individuals should not have undergone sterilisation.

Primary Care Tests

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Must do's, recommendations and personalised care delivered to the person/couple.
History, examinations, tests
Patient information, communication, shared decision making throughout,

Specifics:

- Ovarian reserve - FSH - note secondary care - AMH/AFC
- Mid luteal progesterone – taken out
- Screens – Chlamydia, HIV, Hep B and C

Resources

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1. Fertility-policy-NCL-ICB-V1.0_250722.pdf (nclhealthandcare.org.uk)
2. https://nclhealthandcare.org.uk/wp-content/uploads/2022/07/Fertility-Policy-NCL-Patient-Leaflet-2785.56-v7.pdf
3. https://nclhealthandcare.org.uk/wp-content/uploads/2022/07/Fertility-Policy-Final-FAQs-on-ICS-template.pdf
4. Download: Fertility Primary Care Clinical Pathway - North Central London GP Website (icb.nhs.uk)
5. Fertility-policy-development-Review-Recommendations-Report.pdf (nclhealthandcare.org.uk)