



An Australian Government Initiative

Supporting patients with infertility through the Public Fertility Care Service

Tuesday 28 November 2023

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network & The Royal Women's Hospital would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People. We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



Housekeeping – Zoom Webinar

All attendees are muted

Please ask questions via the Q&A box only

Q&A will be at the end of the presentation

This session is being recorded, you will receive a link to this recording and copy of slides in post session correspondence.

Questions will be asked anonymously to protect your privacy



Housekeeping – Zoom Webinar

Please ensure you have joined the session using the same name as your event registration (or phone number, if you have dialled in)

NWMPHN uses Zoom's participant list to mark attendance and certificates and CPD will not be issued if we cannot confirm your attendance.

If you are not sure if your name matches, please send a Chat message to 'NWMPHN Education' to identify yourself.

Feel free to chat, however please ask Questions in the Q&A (not chat).





Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts



- clear and
 concise,
 evidence based medical
 advice
- Reduce variation in care
- how to refer to
 the most
 appropriate
 hospital,
 community
 health service
 or allied health
 provider.
- what services are available to my patients

HealthPathways – Supporting patients with Infertility



Infertility, Fertility Care Pathways Resources and Referral pages

Obstetrics

Preconception Assessment Cervical screening Persistent Pelvic Pain Endometriosis Polycystic Ovarian Syndrome (PCOS) Early Pregnancy Bleeding Pregnancy Bleeding Recurrent Pregnancy Loss Antenatal Care Antenatal Care - First Consult Antenatal - Second and Third Trimester Care

Related and relevant LGBTIQA+ pages

GBTIQA+ Fertility, Parenting, and Children

GBTIQA+ Friendly Clinics

IQA+ Resources

nsgender Health and Gender Diversity Referral

Referrals and Resources

Fertility Specialised Referral

<u>Acute Gynaecology Referral or Admission (Same-day)</u> <u>Non-acute Gynaecology Referral (> 24 hours)</u>

Early Pregnancy Assessment Service (EPAS)

Pregnancy Booking

Radiology Services and Advice

<u>Pregnancy Genetics</u> <u>Prenatal Screening and Diagnosis of Fetal Anomalies</u> <u>Genetic Laboratory Testing</u> <u>Genetic Health Advice and Referrals</u>

Infertility, Fertility Care Pathways Resources and Referral pages

Related and relevant pages

Sexual Health Sexual Health Advice Sexual Health Check Abnormal Vaginal Discharge **Anogenital Ulcers Bacterial Vaginosis** Candidiasis (Genital) Chlamydia Epididymo-orchitis Gonorrhoea Human Immunodeficiency Virus (HIV) Genital Warts and Human Papilloma Virus (HPV) Acute Lower Abdominal Pain in Adults With a Uterus and/or Ovaries Mycoplasma Genitalium Pelvic Inflammatory Disease (PID)

<u>hilis</u>

omoniasis

rethritis (Penile)

Contraception and Sterilisation Sterilisation Combined Hormonal Contraceptives (CHCs) Contraceptive Implant Contraceptive Injection Emergency Contraception Intrauterine System or Device (IUD) Progestogen Only Pills (POPs)

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



General Inquiries 🛩





Register via QR code



info@healthpathwaysmelbourne.org.au

RWH GPLiaison Unit

A/Prof Ines Rio – The Royal Women's Hospital

- A/Prof Ines has extensive experience in many facets of health care.
- Ines is a Chairperson for the North Western Melbourne PHN, Director of Sexual Health Victoria, Head of the General Practice Liaison Unit and GP Obstetrician at The Royal Women's Hospital, General Practitioner North Richmond Community Health, member of the TGA advisory committee on vaccines, and newly appointment as Chief Medical Officer at Monash University and as member of the National Women's Health Advisory Council.
- Ines is committed to quality, effective, efficient, equitable and integrated health care services and the central importance and role of general practice and primary care in this provision.

The Royal Women's Hospital GP Liaison Unit

Head of GP Liaison unit A/Prof Ines Rio – <u>gp.liaison@thewomens.org.au</u> Primary Care Liaison officer Emily Lawson – <u>gp.liaison@thewomens.org.au</u>

Sign up for RWH GP Liaison's "GP News" https://www.thewomens.org.au/health-professionals/for-gps/gp-

Speakers

Introduction to Public Fertility & Freezing for the future: advances in medical fertility preservation Associate Professor Kate Stern, Head of Reproductive Services Unit - The Royal Women's Hospital

Kate Stern is an associate professor of obstetrics and gynaecology at the University of Melbourne, Royal Women's Hospital and is the head of reproductive services at the Royal Women's Hospital, Melbourne, and clinical director and head of clinical research at Melbourne IVF. She also co-chaired the Clinical Oncology Society of Australia's Fertility Preservation Guidance Committee. Kate is a fertility specialist, gynaecologist and reproductive endocrinologist, and her special interest is in medical fertility preservation. She was appointed an Officer of the Order of Australia for distinguished service to gynaecology, reproductive medicine and fertility research in 2022.

Causes and investigations of subfertility

Dr Wan Tinn Teh, Co-Medical Director, Public Fertility Care Services - The Royal Women's Hospital

Dr Wan Tinn Teh serves as the co-medical director of the Public Fertility Service. She is an Australian-trained fertility specialist and gynaecologist, holding a Bachelor of Medicine and Bachelor of Surgery degree from Monash University, a Master of Reproductive Medicine from the University of New South Wales, and a PhD from the University of Melbourne.

With over 15 years of clinical experience in obstetrics and gynaecology, she possesses a strong commitment to research and teaching. Her contributions include her appointment as an honorary senior clinical lecturer at the University of Melbourne. She is the recipient of multiple research grants and has over 1,000 citations.

Speakers

Assisted reproductive technology and treatments

Dr Rashi Kalra, Co-Medical Director, Public Fertility Care Services - The Royal Women's Hospital

Rashi Kalra is the co-medical director of the Public Fertility Service. She is a gynaecologist and fertility specialist at the Royal Women's Hospital and a sub-specialist in reproductive endocrinology and infertility. She is also a clinical director of Genea Melbourne City. Her areas of interest are recurrent miscarriage and preimplantation genetic testing.

Victorian public fertility care service

Katie Beveridge, Operations Manager, Reproductive Services Unit - The Royal Women's Hospital

Katie Beveridge is a highly experienced fertility nurse with a 17-year career in the private and public sectors. Her expertise includes managing a busy donor and surrogacy program, and providing exceptional leadership as the nurse unit manager of The Royal Women's Hospital reproductive service unit for 8 years. In her current role as the operations manager of the Public Fertility Service, Katie oversees the medical, nursing and scientific staff and operations and is committed to enhancing fertility services for the residents of Victoria.

Introduction:

Public Fertility Care Service

A/Prof Kate Stern MBBS FRCOG FRANCOG CREI

Director of Fertility Services Reproductive Services Unit



Causes & Investigation of Subfertility

Dr Wan Tinn TEH MBBS, MRMed, FRANZCOG, PhD

Co-medical director Public Fertility Services



Infertility – WHO global data

- 1 in 6 adults has experienced infertility
- Prevalence
 - 16.5 (low-middle income countries)
 - 17.8% (high income countries)
- Study on 8500 couples
 - 37% female factor
 - 8% male factor
 - 35% both female and male factor
 - 5% unexplained
 - 15% became pregnant during study period



Causes of female infertility

Age

Endometriosis

Ovulatory dysfunction

Hypothalamic-pituitary – functional, hypogonadotropic hypogonadism, hyperprolactinemia Thyroid dysfunction Premature ovarian failure Polycystic ovarian syndrome

Tubal factors

Previous STI/PID Endometriosis Previous salpingectomy /tubal ligation

Uterine factors

Congenital anomalies – uterine septum, agenesis Fibroids – submucosal, intramural with cavity involvement Polyps Asherman's syndrome





Causes of male infertility

Endocrine and systemic disorders

Congenital disorders – hypogonadotrophic hypogonadism Acquired diseases – tumours, head injury, hyperprolactinaemia, drugs Serious systemic illness, obesity

Dysfunctional of sperm production

Idiopathic dysspermatogenesis Genetics – Y chromosome and related defects Congenital or developmental – Klinefelter syndrome, undescended testes Acquired disorders of testes– varicocele, infection, drugs and radiation Environmental factors – toxins, smoking, hyperthermia Antisperm antibodies

Sperm transport problems

Abnormalities of the epididymis Congenital absent of vas deference (cystic fibrosis), vasectomy Retrograde ejaculation Erectile / ejaculation issues





Clinical history and examination

- Age of couple
- Time trying to conceive
- Timing and frequency of intercourse
- Genetic and family history
- General health, BMI
- Social history:
 - Smoking
 - Alcohol
 - Caffeine
 - Drugs and steroids



Clinical history and examination

<u>FEMALE</u>

- Previous pregnancy history
 - Mode of conception
 - Pregnancy complication
- Menstrual history
 - Cycle length (25-45 is ovulatory)
 - Menstrual flow
 - Dysmenorrhoea
 - Abnormal bleeding
- Pelvic infection

<u>MALE</u>

- Sexual history
- Undescended testes
- Genital infection e.g. mumps orchitis
- Surgical procedures or significant trauma involving genital area



Screening tests for women

- Blood tests
 - Serologies Rubella, Varicella, Syphilis, Hep B, Hep C, HIV, +/-CMV, toxoplasmosis
 - FBE, blood group & antibodies, ferritin
 - Endocrines
 - TSH
 - FSH, LH, estradiol, progesterone*
 - Prolactin
 - SHBG, free testosterone
 - AMH (optional)*
 - Karyotype (optional)*

- Pelvic ultrasound
- Cervical screening test
- Chlamydia and gonorrhea (if indicated)
- Genetic carrier screening (optional)*



Screening tests for men

- Blood tests
 - Hepatitis B
 - Hepatitis C
 - HIV
 - Syphilis
 - Male hormones (if appropriate)
 - Karyotype (optional)*

- Semen tests*
 - Semen analysis
 - Semen antibodies (if appropriate)
- Genetic carrier screening*





Midluteal progesterone

- Measurement of ovulation
- Variation in cycle length is due to variable follicular phase.
- Length of luteal phase
 - Average 14 days
 - 70% between 13-15 days
- Formula for midluteal Progesterone

= Average cycle length – 7 days

- Mid luteal in 28 days cycle = day 21
- Mid luteal in 35 days cycle = day 28
- NOT ALWAYS DAY 21!



Anti-Mullerian Hormone (AMH)

- AMH is secreted by granulosa cells of small pre-antral and early antral follicles
- Reflects the size of primordial follicle pool
- High variability within age groups, undetectable at menopause
- It is helpful for fertility treatment planning (IVF) and identifying patients with reduced ovarian reserve.







- High Normal for age (51st-90th percentile)
- Low Normal for age (10th-50th percentile)
- Low for age(< 10th percentile)

Method used: Roche



AMH – important points

- It measures ovarian reserves, measures egg quantity not quality
- Diagnostic accuracy for predicting live birth or future fertility is poor
- Blood test with minimal fluctuation within the menstrual cycle
- AMH level can be falsely reduced by OCP use



Karyotype

- Chromosome abnormalities 1 in 200 general population
- 2-4 times more common in infertility couples (1/50-1/100)
- Pre-implantation genetic testing (PGT), prenatal testing (CVS, amniocentesis)





Reproductive genetic carrier screening



- Provides information about the chance of having children with inherited conditions.
- 2% of couples (regardless of family history or ethnicity).
- MBS covers Cystic fibrosis, Spinal muscular atrophy and Fragile X Syndrome
- Offer reproductive choice and autonomy. Optional!



Semen analysis

- Instruction for collection
 - Abstain for 2-7 days
 - Masturbation
 - No condom
 - No lubricant
 - Specimen to lab within 1hr
 - Keep specimen at body temperature
- Repeat in 6-8 weeks if abnormal

	WHO 2010	WHO 2021
Semen volume (mL)	1.5 (1.4–1.7)	1.4 (1.3–1.5)
Total sperm number (10 ⁶ per ejaculate)	39 (33–46)	39 (35–40)
Total motility (%)	40 (38–42)	42 (40–43)
Progressive motility (%)	32 (31–34)	30 (29–31)
Non progressive motility (%)	1	1 (1–1)
Immotile sperm (%)	22	20 (19–20)
Vitality (%)	58 (55-63)	54 (50–56)
Normal forms (%)	4 (3–4)	4 (3.9–4)



Timing of Infertility evaluation

- If female age <35yrs, inability to conceive after 12 months of unprotected intercourse
- If female age >35yrs, inability to conceive after 6 months of unprotected intercourse
- Consider early evaluation +/- referral if
 - Female age >40 yrs
 - Oligomenorrhea/amenorrhea
 - Advanced stage endometriosis
 - Known or suspected uterine/tubal disease
 - Male with history of groin/testicular surgery, adult mumps, sexual dysfunction
 - History of chemotherapy, radiation therapy (female and male)
 - History of subfertility with another partner



Questions



the women's hospital

Assisted Reproductive Technology and Treatments at PFCS

Dr Rashi Kalra

Csc, MBBS (Hons), FRANZCOG, CREI

Co-Medical Director Public Fertility Care Services

Fertility Specialist, Genea Melbourne



ART Treatment options- currently offered



ART Treatment options- to be offered in 2024



Donor Egg bank

Surrogacy

PGD (Genetic testing)

Donor sperm bank

Ovulation Induction (OI)

Inducing ovulation in anovulatory women



- Intercourse (or insemination of sperm) at time of ovulation.
- Recommended for women who have difficulty ovulating due to hormonal imbalances.
- Conditions treated include
 - PCOS
 - hypothalamic amenorrhoea
 - Kallman syndrome
 - Hyperprolactinaemia
 - congenital hypopituitarism
 - irregular cycles
- But multiple pregnancy risk depending on drugs used
- Success rates in women under 35yo can be upto 20% per cycle

What treatments can be used for ovulation induction

Oral agents

- Letrozole
- Clomiphene citrate 'clomid'
- Metformin

FSH injections

Laparoscopic Ovarian drilling



Letrozole

Letrozole should be the first-line pharmacological treatment for ovulation induction

There is no evidence for increased teratogenicity compared to other ovulation induction agents.

Letrozole vs CC

Superior for ovulation rate, CPR, LBR

FSH Injections

Second line therapy for women with PCOS who are letrozole or CC resistant.

Also required in LH deficient women ie hypothalamic amenorrhoea

Intensive ultrasound monitoring is required

Increased risk of multiple births

International Evidence-based Guideline for the assessment and management of polycystic ovary syndrome 2023



asrm

European Society
Ovulation induction and Assisted Insemination (IUI)

Sperm injected into Uterus

 $\boldsymbol{>}$



Indications for Ovulation Induction and IUI

Indications:

- Fertility treatment utilising donor sperm: including same sex female couples
- Unexplained infertility
- Mild endometriosis
- Couples unable to have intercourse
- Of note, it remains unclear whether there is a role for IUI in mild male factor.

Contraindications:

- Pelvic inflammatory disease
- Bilateral tubal occlusion
- Severe sperm abnormalities



ESHRE guidelines unexplained infertility

- IUI with ovarian stimulation is recommended as a first-line treatment for couples with unexplained infertility
- To avoid multiple pregnancies and ovarian hyperstimulation syndrome (OHSS), care is needed by using gonadotrophin treatment only in a low-dose regimen with adequate monitoring.
- It is expected that the decision to use IVF is individualized by patient characteristics such as age, duration of infertility, previous treatment, and previous pregnancy.
- Number of IUI cycles are reviewed on a case by case basis before considering moving onto IVF.

IVF and ICSI

IVF

A process bringing eggs and sperm together in our lab to fertilise, and create a blastocyst (embryo) for transfer into a womans uterus.

ICSI

An IVF technique for overcoming infertility due to sperm with poor mobility, poor morphology or low sperm count. It involves a scientist injecting the egg with the sperm.

Once successfully fertilised the embryo is left to develop in our lab over the next 5 to 6 days.



The IVF Process



• • • • •



STEP 1

TED 2

gg pick up perm collectior

STEP 3 n the lab: Fertilising &

TEP 4 mbryo transf

STEP 5

_uteal phase & oregnancy test



Ovary with natural cycle or ovulation induction treatment.



Stimulated ovary with IVF.



Ovulation stimulation

STEP 2 💦 🎾

Egg pick up Sperm collection

TEP 3

n the lab: Fertilising & urturing the embryo

TEP 4

mbryo transfer

STEP 5

Luteal phase & pregnancy test



Step 2: Transvaginal Oocyte pick up



Short day surgery stay.



Transvaginal oocyte pick up is performed under sedation



Takes about 20 minutes.







In the lab

Embryo development





- Blastocyst culture allows selection of which embryos are most likely to achieve a pregnancy.
- Single embryo transfer is best practice.



STEP 1 Dvulation stimulatic

STEP 2

gg pick up perm collectioı

STEP 3 n the lab: Fertilising & nurturing the embryo

STEP 4

STEP 5

_uteal phase & pregnancy test



Transferring an embryo to your uterus is usually straightforward and painless.

A fine plastic catheter is loaded with the embryo is passed through the cervix into the uterus. This is done under ultrasound guidance.



No anesthetic is usually required and it takes about 15 minutes .



Step 5: Luteal phase & pregnancy test

STEP 1 Dvulation stimulatio

STEP 2

gg pick up perm collectior

STEP 3 n the lab: Fertili

TEP 4

STEP 5 🗦 🔊

Luteal phase & pregnancy test



After embryo transfer luteal phase support with progesterone pessaries is continued. A pregnancy test is taken 14 days after egg collection.

With a positive pregnancy test progesterone is continued till 8 weeks gestation.



Clinical pregnancy; A pregnancy is verified by ultrasound at approximately six to seven weeks into the pregnancy.

Live birth; The birth of a living baby or babies (multiple births are classed as a single live birth).

Success rates- VARTA 2022



Preimplantation Genetic Testing (PGT) PGT-SR (Structural Rearrangement)

• For balanced translocation carriers

PGT-A (Aneuploidy)

 Previously Preimplantation Genetic Screening (PGS)

PGT-M (Monogenic)

 Previously Preimplantation Genetic Diagnosis (PGD)

Removing the cells for analysis Embryo biopsy

>

>>



PGT-M - Pre-implantation Genetic Testing for monogenic/single gene disorders

Also referred to as PGD, PGT-M

Genetic testing of embryos for the variants identified through carrier screening or genetic conditions affecting the patient or their family member

Accuracy ranges from up to 90% - 99%

Familial controls required

Aneuploidy detection built into platform

Misdiagnosis can occur - Confirmation via CVS/Amnio should be discussed

In rare cases PGD is not an option, even if couple have identified gene variants

Advisable for couple to have genetic counselling before referring PGT-M – for some conditions couples may not elect PGT due to mild or variable expression e.g. hearing loss variants GJB2



Pros: avoid pregnancy and birth of a child with a serious genetic condition, avoid decision whether to stop a pregnancy

Cons: expense, medical process, no guarantee of unaffected embryos/ongoing pregnancy, need for testing other family members therefore disclosing reproductive plans

PGT: Medicare rebate

73384 Test work up73385 Embryo Biopsy 173386 Embryo Biopsy 273387 Embryo Biopsy 3

New help for Australians on the IVF journey

From 1 November 2021, people will be able to claim a Medicare rebate for five new Medicare Benefits Schedule (MBS) items for new Pre-implantation Genetic Testing (PGT) services provided within the existing IVF process.

(a) the patient or the patient's reproductive partner: has an identified gene variant which places the patient **at risk of having a pregnancy affected by** a **Mendelian or mitochondrial disorder, an autosomal dominant disorder or a chromosome disorder.** (b) **there is no curative treatment** for the disorder and there is severe limitation of quality of life despite contemporary management of the disorder. (c) the **patient has previously had a consultation**, with a specialist or consultant physician practising as a **clinical geneticist**, that included a discussion about the disorder. Genetic tests must be requested by a specialist or consultant physician.

PGT available for Multiple disorders



Summary

- PFCS offers comprehensive ART services from ovulation induction to IVF/ ICSI.
- We hope to expand to donor services, PGT-M/SR and surrogacy in 2024.
- Success rates are audited quarterly to ensure we are in line with state and national standards.
- We are well positioned to treat complex patients that require tertiary obstetric referral and multidisciplinary team management.
- We are the state and national referral centre for fertility preservation, particularly ovarian tissue freezing/grafting.



Questions



the women's hospital

Freezing for the Future: Advances in medical fertility preservation at The Women's

A/Prof Kate Stern MBBS FRCOG FRANCOG CREI

Director of Fertility Services Reproductive Services Unit



RWH FPS since 1994 (Australia's first dedicated service)

- * freezing ovarian tissue since 1994 (Deb Gook and John McBain)
 * freezing eggs since 1990
 * freezing sperm since 1976
- * freezing embryos since 1984
- * ovarian tissue research and grafting
 * research into slow freezing and vitrification methodology
 * ongoing extensive research
- *world's first birth from ovarian tissue grafted into distant site



Why (and for whom) is fertility preservation important?



Biggest risks to fertility addressed at The Women's



80-90 % recovery under 35 yrs



Fertility preservation referrals (females)



Presenting diagnoses – oncology (female only) (n = 2780)





- (Avg age = 32 yo) (Avg age = 34 yo) (Avg age = 33 yo) (Avg age = 23 yo) (Avg age = 25 yo) (Avg age = 29 yo) (Avg age = 24 yo) (Avg age = 24 yo) (Avg age = 19 yo)
- (Avg age = 24 yo)

Presenting diagnoses – medical, non-oncology (female only) (n = 724)



AutoImmune	(Avg age = 26 yo)		
Turner's Syndrome	(Avg age = 24 yo)		
Endometriosis	(Avg age = 33 yo)		
Genetic	(Avg age = 30 yo)		
POI	(Avg age = 34 yo)		
TransGender	(Avg age = 27 yo)		
Other	(Avg age = 32 yo)		

Presenting diagnoses – oncology (male only) (n = 185)



Bowel	(Avg age = 33 yo)		
Brain	(Avg age = 9 yo)		
■ HL	(Avg age = 14 yo)		
■ NHL	(Avg age = 14 yo)		
Leuk	(Avg age = 9 yo)		
Other Haematological	(Avg age = 11 yo)		
Bone	(Avg age = 9 yo)		
Other	(Avg age = 8 yo)		

Presenting diagnoses – medical, non-oncology (male only) (n = 116)





What can we do

FPS consultation and services



semen cryo

testicular biopsy

prepubertal testicular biopsy



Mature egg freezing

Clinical pregnancy rates from vitrified vs fresh oocytes



Live birth rate for different indications of oocyte vitrification



	Cancer diagnosis	Other Medical	Non Medical	P value
Live birth rate per thaw cycle	0.30 (14/47)	0.35 (102/291)	0.38 (93/244)	0.5
Live birth rate per fresh ET	0.32 (12/37)	0.29 (61/208)	0.36 (69/194)	0.4

Ovarian tissue cryopreservation and grafting

Ovarian tissue cryopreservation and grafting (OTC and OTG)

- Innovative
- Avoids delay
- Only option for prepubertal girls
- Multiple opportunities for conception
- Large supply of oocytes
- Allows spontaneous conception

- Surgery required x 2
- Requires specialised lab expertise
- Difficulties with graft fn and tissue ischaemia
- Finite duration of function
- Risks of tumour cell transmission




Grafting sites

anterior abdo wall

Ovarian tissue grafting



Clinical pregnancy rate per ET 22% (15/67)

Live birth rate per ET 21% (14/67)



What about kids?



FP referrals by age : oncology/serious medical

	pre-pubertal < 16 yo	AYA ≥ 16 to < 25 yo	adults <u>></u> 25 yo	TOTAL
female	244	692	2487	3423
male*	249	13	1	263

(*testicular tissue only)

what about access





- Phone/fax/email/pager
- Dedicated FPS nurse coordinator
- See patients within 24-48 hrs
- Multidisciplinary : nurses/scientists/counsellor/fellows/consultants/researchers/administrators

National model for equity of access: NOTTCS



What about research?

eggs sperm tissue transport





Fertility preservation at the The Women's

Rapid response FP consultation services

Affordable options with public fertility care (no cost)

Better education of HCP

Improved access to specialized services

Realistic expectation of future fertility

Exciting options to make it better/safer

Questions



the women's hospital

Katie Beveridge

Operations Manager Public Fertility Care Service











- LGBTQI+ people,
- people with intersex variations,
- sole parents by choice,
- culturally and linguistically diverse people,
- Aboriginal and/or Torres Strait Islander people,
- people with disabilities,
- and low-income earners.

Public Fertility Care Service Catchments



Public Fertility Locations Across Victoria



The first public IVF lab in Australia

- State of the art equipment
- Provides 2 x stimulation cycles per person at <u>no cost</u>
- Includes use of any frozen embryos created
- Minimal cost for medication and screening tests

Fertility Care Services Eligibility Criteria

- Maximum egg age is 42 years at time of treatment
- Victorian Resident
- Medicare Card



Oct 2022, Government Announcement



Services include

- Fertility assessment and management
- IVF/ICSI
- |U|
- Ovulation Induction
- Frozen embryo transfers
- Donor sperm & egg programs
- Medical fertility preservation

https://www.thewomens.org.au/egg-spermdonors





To be introduced in 2024

- Altruistic surrogacy program
- Genetic testing of embryos for Monogenic and Structural Rearrangement conditions (PGT-M & SR)
- Donor embryo program

Services not offered

- Elective egg freezing
- PGT-Aneuploidy for advanced maternal age, recurrent miscarriage etc
- Reversal of sterilisation procedures



Referral Process

- Centralised referral system through RWH
- Pre-screening to be attached with referral
- Refer to RWH website for details

The Royal Women's Hospital (thewomens.org.au)



Key Points To Remember

- Victorian Resident
- Medicare Card
- Egg age ≤42
- 2 cycles per patient
- No cycle fees
- Short wait times
- All referrals via RWH with attached screening tests



www.thewomens.org.au

Questions



the women's hospital

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code



You will receive a post session email within a week which will include slides and resources discussed during this session. Attendance certificate will be received within 4-6 weeks. RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit, https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week. https://nwmphn.org.au/resources-events/resources/





melbourne.healthpathways.org.au