



## IVF – Frequently Asked Questions

### WHEN IS IVF NEEDED?

IVF was originally developed for women with blocked tubes or missing fallopian tubes and it is still the procedure of choice for these situations. It is also used when other conditions are present, including endometriosis, male factor infertility and unexplained infertility in which no medical cause for infertility can be found. Our physicians will review your history and help to guide you to the treatment and diagnostic procedures that are most appropriate for you.

### WILL MY BABY SUFFER BIRTH DEFECTS?

It is important to recognise that the rate of birth defects in humans in the general population is about 3% of all births for major malformations and 6% if minor defects are included. Fortunately, 20-plus years following Louise Brown's birth (the first IVF baby), we now have ample data that children conceived through IVF have no increase in these rates of birth defects. Further follow-up on older children indicates that IVF children have done as well or better than their peers in academic achievement (probably a social bias) and have no higher rates of behavioural or psychological difficulties.

### WILL THE HORMONES CAUSE LONG-TERM HEALTH RISKS?

An ongoing National Institutes of Health funded study is specifically designed to address the question of whether fertility medications themselves may play a causal role in ovarian, breast or uterine cancer. While the study is still under way and needs another 5-10 years of follow-up to be conclusive, preliminary results suggest no association between fertility medications and risks for invasive cancers. At this time, we can say that there is no direct evidence that fertility drugs play a causal role in increasing a woman's risk of invasive ovarian, breast or uterine cancer.

### ARE THE INJECTIONS PAINFUL?

With the advent of newer fertility medications (Puregon and Gonal F), many injections that were given intramuscularly can now be replaced by medications given as a little injection under the skin (subcutaneous). This method is similar to insulin injections to diabetic patients. Additionally one medication, which has been given as a subcutaneous injection (Lucrin), can be replaced by a medication administered as a nasal spray (Synarel). Both medications are equally effective.

Once the egg retrieval is performed, progesterone supplementation is used to prepare the lining of the uterus for the transfer of embryos. For most of our treatment cycles, we recommend using progesterone gel (Crinone) or progesterone pessaries. Sometimes your Doctor may recommend low dose hCG injections subcutaneously, during the second half of your IVF cycle.

Women on average, may have to inject only 10-12 days of Puregon or Gonal F and one subcutaneous injection of hCG before the eggs are ready to retrieve.

### ARE THE PROCEDURES PAINFUL?

The only procedure that could be considered minor surgery in the IVF process is the retrieval of the eggs from the ovary. During this procedure a needle attached to a vaginal ultrasound probe is passed through the wall of the vagina and into each ovary.

A light anaesthetic is administered intravenously prior to retrieving your eggs, which wears off quickly after the procedure. Without anaesthetic for this procedure, it could be quite painful. The procedure is relatively quick (approx 20-30 minutes). After the procedure the patient may feel some minor cramping in the ovaries that can also be treated with very safe medications.

Each patient at every egg retrieval procedure is closely monitored by a fully board certified anaesthesiologist. This allows us to safely provide as much anaesthetic as may be necessary to provide complete pain relief for the procedure.

In pain or discomfort terms, an embryo transfer is often compared to a PAP smear. It is a rapid procedure (5 min)

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that is performed with no sedation unless medically required or requested. Partners are welcome to be present during the transfer procedure (provided sedation is not used)

## IF I LIVE OUT OF TOWN, HOW LONG DO I HAVE TO STAY AT THE CLINIC?

We care for many patients who come for treatment from other parts of Australia, and throughout the world. All initial consultations can be done by telephone (medical, nurse coordinator, financial), and communication with our staff throughout your treatment can be via telephone). Many of the required screening blood tests and procedures can be coordinated with your local gynaecologist or reproductive endocrinologist. If there is a local fertility centre in your area, we may be able to have you start your stimulation treatment locally, and then come to our clinic about 5-7 days later. On the average, most patients need to be near our clinic for 3-5 days.

Our staff can provide recommendations for local accommodations, restaurants, and sights to visit!

## SHOULD I TRAVEL?

Many of our patients have to travel various distances to return home after treatment.

Air travel in commercial aircraft is fine (pressurised aircraft). Drink lots of fluids while flying, since the circulated air can be quite dry, and dehydration should be avoided.

Car travel is also fine. Sitting for an extended period of time will not affect chances of pregnancy.

If you live out of town, most patients return home the day after the transfer if there is no medical reason to stay any longer.

## AM I USING UP ALL MY EGGS IF I DO IVF?

In a natural ovulation cycle, the ovary selects one egg from a pool of approximately 20-30 eggs. Those eggs which are not selected for that month undergo a natural cell death process called atresia. Fertility medications override the

body's selection process, and cause many of these "rescued" eggs to grow (hopefully between 6-12 eggs). These eggs would otherwise undergo atresia. Therefore, you are not "using up eggs faster" by undergoing ovulation induction, but are "rescuing" eggs to use in that cycle, which otherwise would have expired.

## WHAT ARE MY CHANCES OF PREGNANCY WITH FROZEN EMBRYOS?

In general, the success of frozen-thawed embryo transfer procedures depends on 3 things: the quality and survival of the frozen-thawed embryos, the age of the patient who produced the eggs, and the uterus of the woman receiving the embryos. For patients <37 years, the chances of pregnancy with frozen-thawed embryos is similar to fresh embryos. For patients >37 years, the pregnancy chances with frozen-thawed embryos decline.

## CAN I DO A NATURAL CYCLE FROZEN EMBRYO TRANSFER (FET)?

For most patients, frozen-thawed embryos can be transferred in either a Hormone Replacement Therapy (HRT) cycle to prepare the uterus for implantation (for women who are anovulatory or who do not have functioning ovaries) or, a natural cycle (for women with normal functioning ovaries and regular menstrual cycles). We have extensive experience coordinating these types of cycles, and have a very successful FET program. Natural FET cycles save patients money (less medications and monitoring needed), time, and still provide a good pregnancy rate.

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