PROGRAMME

Alison Richardson & Stephen Davies
Welcome from the module leads

Allan Pacey
GP assessment of Male Fertility

Kevin McEleny
Urology and Fertility

Susie Jacob
Ovulatory dysfunction/PCOS

Matt Prior
OI, IUI, IVF and ICSI

Alison Richardson
Ovarian reserve/POI
Fertility and Infertility

Oliver O’Donovan
Tubal disorders including endometriosis

Mostafa Metwally
Fibroids and Fertility

Stephen Davies
GP management of infertility

Raj Mathur
Regulation and Funding of Fertility Treatment

Ed Coats
Risks and complications of ART

Angela Pericleous Smith
What happens when IVF fails?

Maya Chetty
Fertility preservation

Ellissa Baskind
Pre-implantation Genetic Testing
Allan Pacey

Professor of Andrology
Department of Oncology and Metabolism
University of Sheffield

Allan is Professor of Andrology in the Department of Oncology and Metabolism at the University of Sheffield. His research interests include aspects of male fertility and has published over 200 research papers, book chapters and review articles on the topic. He is a former Secretary (2005-2010) and Chairman (2012-2015) of the British Fertility Society as well as the current Editor in Chief of the BFS journal Human Fertility.

In addition, Allan is an accomplished science communicator and broadcaster. Recent television programmes include Me, My Brother and our Balls (2020), Alex Jones – Fertility and Me (2016), Britain’s Secret Code Breaker (2011), Donor Unknown (2011), The Great Sperm Race (2009), The Truth About Food (2007), Make me a Baby (2007) and Lab Rats (2004). In 2016 he was awarded an MBE by the Queen for services to Reproductive Medicine.

You can follow his general musings about science, fertility and the life of an academic on Twitter and Instagram @allanpacey. His University web page is at http://www.sheffield.ac.uk/oncology-metabolism/staff/pacey.

Kevin McEleny

Consultant Urologist and Associate Clinical Lecturer
Newcastle Fertility Centre

Kevin McEleny is Consultant Urologist and Associate Clinical Lecturer. After training in the North East Region he set up a Supra-regional Male Service at Newcastle Fertility Centre. He set up the http://All-About-Fertility.com site and is Secretary of the BFS Executive committee.

He has published on a range of male fertility topics and his current interests include male fertility genomics and psychosocial aspects of the male fertility experience.

Talk Title: GP assessment of Male Fertility

The GP plays a critical role in the initial assessment of male fertility and is an important source of information and reassurance. If pregnancy has not been achieved within 12 months, or there are concerns from current or past medical history, a semen analysis should be arranged. Semen analysis assesses sperm concentration (how many per unit volume), sperm motility (how well sperm swim) and sperm morphology (their size and shape). These can be compared to data for recent fathers published by the World Health Organisation.

Risk factors for poor semen quality include: (i) smoking; (ii) excessive alcohol consumption; (iii) high BMI; (iv) tight underwear or working in excessively hot environments; (v) poor diet; (vi) previous cancer treatment. There are few proven treatments to improve sperm production, but men should be encouraged to be as healthy as possible, eat fresh fruit and vegetables and reduce known risk factors (if possible). GPs should be aware of the risk of testicular failure in men who take anabolic steroids at the gym and counsel them appropriately. Any repeat test should be done at least 3 months after the first to allow for another full cycle of spermatogenesis to be completed.

Key learning points

- To understand the process of spermatogenesis and how semen quality is linked to fertility
- To be aware of the known risk factors for poor semen quality and what advice to give to men
- To interpret a semen analysis and understand its limitations

Talk Title: Urology and Fertility

In recent years there has rightly been much focus on male fertility matters and a rising awareness of their importance. Couples nowadays expect that those affected by male fertility issues will have a fuller assessment and an attempt to identify the reason for a sperm quality issue. Due to the links between male fertility and general health, the general practitioner is ideally placed to use fertility assessment as an opportunity to discuss health, including in the context of lifestyle issues.

Key learning point

- Following this presentation you should have an understanding of how to clinically assess and investigate male’s with fertility issues
Susie Jacob

**Consultant Gynaecologist & Subspecialist in Reproductive Medicine & Surgery**

**Yorkshire Fertility, Calderdale & Huddersfield Foundation Trust**

Dr Susie Jacob is a consultant gynaecologist and subspecialist in reproductive medicine and surgery. She is clinical lead for Yorkshire Fertility and has many years of experience in the field of reproductive medicine. Her specialist interests include ovulatory dysfunction, male factor infertility and paediatric and adolescent gynaecology. She has completed research in risk reduction strategies for those with PCOS undergoing assisted conception.

---

Matt Prior

**Consultant and Subspecialist in Reproductive Medicine**

**Newcastle Fertility Centre**

Dr Matt Prior is a Consultant at Newcastle Fertility Centre and is passionate about working together with patients to provide individualised care. During his training, he was Chair of the Royal College of Obstetricians and Gynaecologists Trainees’ Committee and sat on the prestigious RCOG Council. Matt has been invited all over the world to speak on topics including mitochondrial donation, three-dimensional ultrasound, recurrent pregnancy loss and reproductive surgery. He coordinated the Miscarriage Priority Setting Partnership, which for the first time, brought women who have experienced miscarriage, others affected by miscarriage and clinicians together to develop priorities for future research. He was awarded a PhD for research into miscarriage and fertility problems. In his role as a Save the Children Health Ambassador, he has visited Liberia and participated in campaigns doing media work and lobbying politicians at Westminster.

---

**Talk Title: Ovulatory dysfunction/PCOS**

Ovulation requires a smooth coordination of hormones, environmental factors and good health. Understanding the contributions of different hormones to this process, helps to guide investigation and management when things go wrong. Polycystic Ovary Syndrome is the most common endocrine disorder of women in their reproductive years. Most cases of ovulatory dysfunction in a fertility clinic will be due to PCOS. Apart from fertility, PCOS can have significant long-term health implications. Lifestyle and diet are a mainstay of treatment, before considering other pharmacological therapies. Clear and consistent diagnostic criteria help to limit overdiagnosis whilst ensuring women with the condition are managed effectively with clear education and support.

**Key learning points**

- Understand ovulation
- Diagnosis of PCOS
- Management of PCOS

---

**Talk Title: OI, IUI, IVF and ICSI**

This talk will take you from what may seem like a garbled jumble of letters to an understanding of the range of fertility treatments available for patients. The talk outlines what ovulation induction (OI), intrauterine insemination (IUI), in-vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are, and how they work. You will understand the indication for each treatment and what the chances are of success for patients using these treatments.

**Key learning points**

- Understand the range of fertility treatments available
- To be aware of the indication for different fertility treatments
- To be able to counsel patients on the chance of successful treatment and options if it fails
Alison Richardson  

**Consultant Gynaecologist and Subspecialist in Reproductive Medicine and Surgery**  
Leicester

Alison is a Consultant Gynaecologist and Subspecialist in Reproductive Medicine and Surgery in Leicester. She has a particular interest in ovarian reserve, premature ovarian insufficiency and fertility preservation. Alison was the Junior Clinician Representative on the BFS Executive Committee between 2017 and 2020 and has recently been invited back to join the Training Sub-Committee as Module Lead for this GP study day. She is also on the DRCOG sub-committee at the RCOG. Alison is keen to nurture the relationship between primary and secondary/tertiary care by helping to equip GPs with the necessary knowledge and skills to provide high-quality, evidence-based care to couples trying to conceive.

---

**Talk Title: Fertility and Infertility**

The majority of couples will conceive spontaneously within 12 months of trying if they are having regular unprotected sexual intercourse but one in six couples will struggle to do so. Achieving a pregnancy relies on having a plentiful supply of eggs, regular ovulation, patent fallopian tubes, a good supply of healthy sperm and a receptive endometrium. Problems in any one of these areas could lead to difficulty conceiving. This can have a profound impact on couples’ biological, psychological and social well-being.

Half of these couples will often achieve a pregnancy with relatively simple advice that can be provided very easily by their GP. The remainder will require referral to secondary or tertiary care for more complex treatment which may involve ovulation induction, insemination treatment, IVF or ICSI. These are specific treatments for specific indications and do not contribute to a step-wise progression of intervention.

**Key learning points**

- To understand the epidemiology of infertility and some of the common causes of it
- To appreciate which investigations and what management can be initiated in primary care and when it is appropriate to do so
- To know when referral to secondary/tertiary care is more suitable and what treatments might be initiated there

---

**Talk Title: Ovarian reserve/POI**

Most clinicians appreciate that a woman's fertility decreases with increasing age but what is less well known is why this is the case and to what extent does it matter. Ovarian reserve is defined as the number of eggs or oocytes remaining in the ovary at a given point in time. It decreases as women get older but there is considerable variation in the rate at which this occurs.

Measures of ovarian reserve exist but there is often a misconception about the information that they provide and many believe that the negative effect of female ageing can be overcome with IVF treatment. Additionally, a small proportion of women will go through the menopause prematurely (before the age of 40). Management of this condition, although relatively simple, is often suboptimal, contributing to a reduction in both the quantity and quality of life for these women.

**Key learning points**

- To better appreciate the relationship between age and fertility
- To understand the different ovarian reserve tests and what they do and don't tell us
- To be able to effectively manage women with premature ovarian insufficiency
Oliver O’Donovan
Gynaecology Consultant
University Hospitals Bristol & Weston

Mr O’Donovan is a gynaecology consultant at University Hospitals Bristol and Weston, where he leads the St Michael’s Endometriosis Centre. He is also a consultant fertility specialist at The Bristol Centre for Reproductive Medicine. His private practice is conducted at The Spire Hospital in Bristol.

He completed fellowships in subfertility and advanced laparoscopic surgery (endometriosis) at University College London Hospital and has particular expertise in the diagnosis (including ultrasound) and management of endometriosis and subfertility. He has published and presented (nationally and internationally) on many topics related to fertility, endometriosis and minimal access surgery, and is regularly invited to teach on courses.

Mostafa Metwally
Consultant in Reproductive Medicine and Surgery
Sheffield Teaching Hospitals

Mostafa Metwally is a Consultant in Reproductive Medicine and Surgery at Sheffield Teaching Hospitals.

He is the Chair of the BFS Training Committee and the RCOG Reproductive Medicine Research Group. He is also the former Vice Chair of the RCOG Scientific Advisory Committee.
Stephen Davies

**GP Clinical Assistant**

**Jessop Fertility**

Having qualified in 1987, he joined the RAF, completing GP training in 1992. He joined the Jessop hospital training scheme for Obstetrics & Gynaecology in 1994 where he worked for 2 years.

Following this he moved into a full-time infertility post under Professor Cooke at the Sheffield Fertility Centre in 1996. Later in 1996 he moved back into Primary Care and he continued working part time as a Clinical Assistant until 2000.

In 2002 he was appointed Clinical Assistant at Jessop Fertility in Sheffield. He continues in that role alongside being a GP partner in Retford. The practice offers baseline ultrasound for gynaecological problems and early pregnancy assessment.

He feels particularly satisfied to have followed many patients through their entire infertility journey whatever the outcome.

**Talk Title: GP management of infertility**

Infertility is one of many areas of medicine that will never be seen a priority area within General Practice. New presentations maybe relatively infrequent and may naturally gravitate to particular doctors in any given practice. As a result, the role of the GP in the initial assessment is often poorly understood in terms of which tests to do; in which order, and then the onward referral pathways.

The provision of secondary and tertiary referral centres can vary widely depending on the location of the surgery. The criteria that apply to funding varies countrywide and this causes further confusion.

However, the key gatekeeper role of primary care is indeed perfectly placed to ensure that the right patients are referred sooner where indicated, and I see the GP having a significant role in this area. The increased prevalence of obesity in our population also has many ramifications in the treatment of infertility. This is best tackled at the outset by primary care physicians.

I hope this presentation will provide clarity to interested primary care physicians.

**Key learning points**

- Understanding the key features of assessment in primary care
- How to prioritise who needs urgent onward referral and where too?
- The crucial role of obesity

---

Raj Mathur

**Consultant Gynaecologist**

**Manchester Foundation Trust**

Raj Mathur is a subspecialist in Reproductive Medicine and Surgery and the clinical lead for a large NHS assisted conception unit. He has experience of leading HFEA-accredited units in the NHS and private sector. He is an Advisor to the Scientific and Clinical Advances Advisory Committee of the HFEA and Chair of the British Fertility Society.

**Talk Title: Regulation and Funding of Fertility Treatment**

**Key learning points**

- Assisted conception is unique in medicine for having its own act of parliament and regulator, the HFEA which enforces a Code of Practice
- Treatment can only be provided in premises licensed for this purpose by the HFEA and led by a Person 3 Responsible legally responsible for ensuring that the Clinic works according to the Code
- Before providing treatment, clinics have a legal duty to consider the welfare of a child that may be born from treatment, and the welfare of existing children
- Funding for IVF in the UK is post-code dependent, except in Scotland, and the majority of CCGs do not fund the full NICE-recommended number of cycles
- The majority of treatment cycles are funded privately, and this can place patients in a position of financial and clinical vulnerability
Ed Coats

**Consultant Gynaecologist & Fertility Specialist**

*Oxford Fertility - The Fertility Partnership*

Mr Coats is a Consultant Gynaecologist and Specialist in Reproductive Medicine and Surgery. He is a member of the British Fertility Society, and The Royal College of Obstetricians and Gynaecologists. Mr Coats worked initially as an Consultant at The Royal United Hospital in Bath before moving to work with The Fertility Partnership in Oxford and London. He holds Diplomas in Sexual and Reproductive Health and has completed a Masters in Medical Law. His special interests include reproductive endocrinology, the menopause and turners syndrome.

**Talk Title: Risks and complications of ART**

Fertility treatment is usually undertaken in Secondary and Tertiary Care but the patients will often require advice and support from Primary Care during treatment. The risks of fertility treatments are not always well understood and managing patients can be a challenge. This talk aims to identify the key risks associated with Assisted Reproduction Treatments and how to identify and manage the common complications you might face in Primary Care.

**Key learning points**

- Understand the risk of fertility treatments
- Understand the complications of fertility treatments
- Safely manage ART complications in primary care

Angela Pericleous Smith

**Fertility Counsellor, Chair of BICA**

Angela is Chair of the British Infertility Counselling Association (BICA), a member of the British Association of Counsellors and Psychotherapists (BACP) and counsellor representative for British Fertility Society (BFS).

Angela has specialised in fertility counselling within the NHS and private practice since 2004, offering counselling to those experiencing infertility, secondary infertility and those who are involuntarily childless.

**Talk Title: What happens when IVF fails?**

IVF is only successful around a third of the time. What options are available for those patients unable to conceive through IVF? Patients are faced with grief and loss; the loss of their fertility, the loss of the family they’ve already imagined.

What alternative options may be available to achieve their dreams of parenthood? Egg donation, sperm donation, surrogacy, adoption? How do patients begin processing their emotions and treatment choices whilst considering the impact on them as an individual, couple, their wider network and importantly their “unborn child”. What support is available for patients faced with these decisions.

**Key learning points**

- How do patients manage their grief and loss when IVF fails?
- What choices do they have next?
- What support can you give your patients?

Angela has written and spoken about the emotional impact of infertility and has co-authored BICA Guidelines for Good Practice in Fertility Counselling 4th Ed. 2019. Her recent research and writing have focused on Covid-19’s impact on UK counselling provision and patients’ experiences.

Angela is passionate about supporting patients to make choices which feel right for them as they navigate the challenges faced by fertility.
Maya Chetty
Consultant Gynaecologist and Subspecialist in Reproductive Medicine
Royal Infirmary of Edinburgh
Dr Maya Chetty is a consultant gynaecologist and subspecialist in reproductive medicine at the Royal Infirmary of Edinburgh. She has particular interests in assisted reproduction and fertility preservation and is the clinical lead for fertility preservation at Edinburgh Fertility Centre.

Talk Title: Fertility preservation
Fertility preservation involves freezing and storing reproductive material or embryos for use in a person’s future fertility treatment. Indications for fertility preservation include both benign and malignant conditions where the condition itself or the treatment of the condition is damaging to fertility. The techniques for storing gametes and embryos are now well established and progress has been made with the preservation of ovarian and testicular tissue. Ovarian tissue cryopreservation for pre-pubertal girls and testicular tissue cryopreservation both remain experimental and not part of routine clinical practice.

The process of egg freezing can usually be completed in around 14 days, while sperm and tissue freezing can be done almost immediately. Egg and sperm freezing can be done in a standard IVF clinic setting. Both ovarian and testicular tissue cryopreservation require scientific expertise which is only available in a few centres in the UK.

Key learning points
- All children and adults who require treatment that could compromise future fertility should be informed of this risk and the options available to preserve fertility discussed with them
- Established fertility-preservation options for females include egg freezing, embryo freezing and ovarian-tissue cryopreservation. Semen storage is the established fertility preservation option for males
- There are strict laws on how long eggs, sperm or embryos can be stored determined by the indication for storage

Ellissa Baskind
Consultant Gynaecologist & Subspecialist in Reproductive Medicine and Surgery
Leeds Fertility, Leeds Teaching Hospital
Ellissa joined the specialist reproductive medicine team at Leeds Fertility in May 2017. She is a graduate of the University of Birmingham (Bachelor of Medicine and Surgery 2001), and achieved a Doctorate of Medicine in Reproductive Medicine (commendation) by the University of Leeds for her work on folliculogenesis in the pathogenesis of infertility (2013).

She successfully completed RCOG-accredited subspecialty training in reproductive medicine and surgery in Leeds (2017). She has a number of publications in peer review journals as well as book chapters. Her interests include all aspects of Assisted Conception, Pre-implantation Genetic Diagnosis and gamete donation.

Talk Title: Pre-implantation Genetic Testing
Pre-implantation genetic testing (PGT) involves the selection and transfer of healthy embryos created in an IVF cycle in couples where there is a risk of transmission of an inherited disorder (PGT-M: single gene disorder e.g. cystic fibrosis or BRCA gene; or PGT-SR: structural chromosomal disorder e.g. Robertsonian translocation). In the U.K., genetic conditions must be licensed by the HFEA to undergo PGT-SR/M.

Aneuploidy testing (PGT-A) uses the same technology, namely taking a biopsy of a day 5 embryo (blastocyst) but rather than testing for a specific inherited disorder, the embryos are screened for aneuploidies. Whilst PGT-SR/M is well established in the U.K., there is more controversy surrounding PGT-A, but there is emerging evidence for its benefit in older women and possibly in women with recurrent implantation failure or miscarriages. Couples must be counselled carefully about the risks and evidence for these techniques, and the alternatives available e.g. pre-natal testing (CVS or amniocentesis), gamete donation, elective childlessness or adoption.

Key learning points
- Definitions of pre-implantation genetic testing for monogenic disorders (PGT-M), structural disorders (PGT-SR) and aneuploidy screening (PGT-A)
- The patient journey of the PGT cycle
- Risks and controversies in PGT-M/SR and PGT-A
The British Fertility Society would like to thank our 2021/2022 Corporate Partners

Thank you for participating in Virtual Study Week 2021.
Should you have any questions please contact bfs@profileproductions.co.uk