

Welcome to St Mary's Hospital

Welcome to the Department of Reproductive Medicine at St Mary's Hospital, Manchester.

This booklet explains the treatments we provide and, we hope, will answer many of your questions – but please feel free to ask staff anything that you are concerned about.

We understand the anxieties surrounding infertility and its treatment – we will do our best to support you and keep you informed about the progress of your treatment.

Your first treatment steps

Attending our Waiting List Meeting marks your first step as a new patient in our unit. Please **read this booklet and our *Treatment Results* booklet carefully** before your first consultation, as IVF and associated treatments are complex, and the more you understand before treatment starts, the better.

Do all you can to help your treatment succeed.

- **Watch your weight** - the chance of becoming pregnant is increased when women are the right weight for their height. We only treat women close to their ideal body weights
- **Stop smoking** – smoking can damage eggs and sperm. We can only treat you if are both non-smokers.
- **Eat and drink healthily** – eat a well-balanced diet, and start taking 400µg folic acid daily. Women should drink less than 10 units of alcohol and men less than 21 units per week. (One unit equals half a pint of beer or small glass of wine)
- **Sexual intercourse** – you may have intercourse during treatment, but you should use a condom. During treatment male partners should ejaculate every 3-4 days – abstain from ejaculation for only 3-4 days before egg recovery

In Vitro Fertilisation – IVF

Before we look at IVF and associated treatments, it is helpful to understand the basics of human fertility.

Ovulation, fertilisation and implantation

With natural conception, a single egg develops in one of the ovaries each month. It grows in a fluid-filled cyst (*follicle*) for about two weeks before it is released – the process known as ovulation.

The egg enters the fallopian tube and meets the sperm. Fertilisation creates a fertilised egg or *embryo*. As the embryo passes down the tube to the womb (*uterus*) its cells divide and grow. If the embryo implants into the lining of the uterus (the *endometrium*), a pregnancy is established approximately one week after ovulation.

The developing follicle produces a hormone (*oestrogen*). Oestrogen levels can be measured in blood and follicles can be seen using ultrasound scanning. After ovulation, the follicle is transformed into a structure known as a *corpus luteum* which produces the hormone progesterone as well as oestrogen. These hormones help to support the lining of the womb and any developing pregnancy.

IVF

The IVF breakthrough in the late 1970s was the most important advance made in treating infertility. In Vitro Fertilisation – the so-called “test tube baby” technique – literally means *fertilisation in glass* (*vitro*). These days plastics are used rather than glass, and *in vitro* now refers to any procedure taking place outside the body.

In IVF treatment, eggs are removed from the ovary just before ovulation. Eggs and sperm are put together in a dish. If fertilisation occurs, the embryo is cultured in an incubator and placed in the womb two or three days later. If a pregnancy is achieved, the pregnancy continues naturally. IVF and its developments are widely used to treat male and female disorders.

IVF is divided into four main stages:

- Egg production
- Egg recovery
- Insemination
- Embryo transfer

Egg Production

The chance of pregnancy is increased if more than one egg is recovered.

Initially the function of the ovary is suppressed using a drug called *buserelin*. The ovary is then stimulated with another drug called *gonadotrophins*. The drugs are given by injection just under the skin and rarely cause soreness. Most women give themselves the injections after training from our nurses.

Buserelin injections begin approximately one week before the start of a period. When that period starts you will start the gonadotrophin injections. The buserelin and gonadotrophin injections together continue for another 10-12 days until you are ready for egg collection.

We routinely use this **long treatment protocol**. We may reduce the dose of drugs as you undergo treatment, depending on the results of your blood tests and scans.

We also use a short treatment protocol known as Co-Flare. This protocol is used in specific cases where we have concern about how well the ovaries will respond to gonadotrophins.

We carry out daily blood tests during the period of stimulation to measure the level of oestrogen in the blood to see how the ovaries are responding and check for excessive response. We perform ultrasound scans to measure the size of the developing follicles. The scans are carried out using a vaginal ultrasound probe. Vaginal scans do not hurt and do not require you to have a full bladder.

Egg recovery

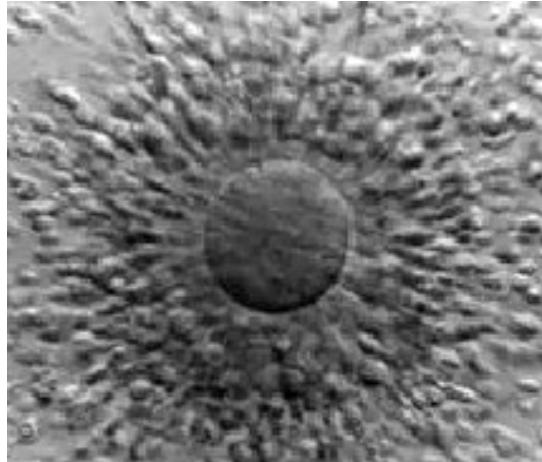
Egg recovery is carried out under sedation. Sedation involves an injection into a vein in your arm and reduces awareness but you do not lose consciousness. Sedation may not provide complete pain relief. Most women do not recollect the egg recovery operation because of the drugs used.

Eggs are recovered by needle aspiration under vaginal ultrasound guidance. Laparoscopic egg recoveries are only necessary in exceptional circumstances when it not possible to use the vaginal route.

You will be admitted to the hospital ward at 8 a.m. **Do not eat food of any kind or chew gum after the previous midnight. Limit fluid intake to one glass of water before 7**

a.m. After egg recovery, one of the nursing staff will tell you how many eggs have been retrieved.

A single human egg surrounded by cumulus cells



Insemination and fertilisation

The male partner provides a sperm sample on the day of egg recovery (unless you are using frozen sperm). After egg recovery, the most active and normal sperm are added to the eggs. The eggs and sperm are incubated overnight and checked the next morning for signs of fertilisation. You will be asked to telephone the nurses the day after egg recovery to find out how many eggs have fertilised (just over half on average).

After the fertilisation check, the embryos are left in the incubator to develop

Two or three days after egg recovery, the best one or two embryos are replaced in the womb. These embryos are called *early cleavage* (EC) embryos. Any remaining EC embryos of good quality may also be frozen.



Day 2 – Two 4 cell embryos – above

Day 3 – 8 cell embryo - right



Embryo transfer

This process is similar to having a smear test taken and usually takes 10-15 minutes. You should wear a loose fitting skirt or dressing gown. Partners, a friend or relative are welcome to attend.

Before you go home, you will receive a date to contact the Unit. You should not take part in any strenuous activity or have unprotected intercourse until the outcome of treatment is known. After embryo replacement you will be given another injection or hormone pessaries to support the lining of the womb.

The number of embryos to be replaced

We replace a maximum of two embryos in any one cycle (see *Treatment Results* booklet). Some patients are advised to have one embryo replaced in each cycle, if it is thought that the risk resulting from a multiple pregnancy would be too great. Many patients elect to have one embryo replaced to reduce the risk of multiple pregnancy– this is your choice. Please consider this before your consultation.

Frozen embryo replacement cycles

If you create extra good quality embryos, these can be frozen for use in the future. We replace one or two frozen/thawed embryos in each cycle and this will be discussed with you. The embryos are thawed the day before replacement. If the embryos do not survive, further embryos are thawed if possible. The embryos are kept in the incubator overnight and the best one or two embryos are selected for replacement.

Frozen/thawed embryos are replaced in a cycle controlled by drugs. This involves buserelin injections, followed by oestrogen tablets and progesterone vaginal pessaries.

Outcome of IVF treatment

Sadly IVF and associated treatments still fail more often than they succeed. Approximately a fifth of IVF pregnancies may miscarry after a positive pregnancy test, a similar proportion as following natural conception. We do not want to be pessimistic, but it is unfair to give you an unrealistic expectation of success. You can find treatment results at St Mary's in our *Treatment Results* booklet and results for the UK can be obtained from the HFEA (see later).

Over one million babies have been born from IVF worldwide with no indication of major health problems. There is no evidence that babies born after frozen embryo replacement have an increased rate of abnormality. Some studies have suggested that birth weight is

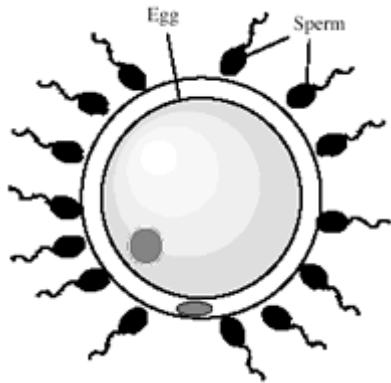
lower for IVF babies which could have implications for health in later life. There are some very rare genetic conditions which also appear to be increased after IVF, although so far only a handful of these have been reported. However IVF is an experimental treatment and we cannot know the full implications until the current generation of IVF children have had children themselves and reached old age.

ICSI

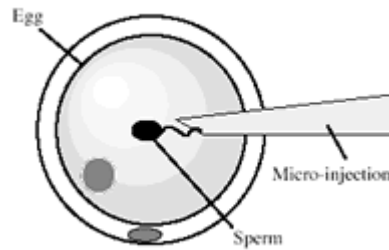
ICSI is a refinement of the IVF technique and offers hope to men with sperm problems. However ICSI is a relatively new technique and it will be many years before we can be sure of all the risks and implications of treatment

If sperm fails to fertilise the egg naturally or during IVF, this is usually because the sperm fails to penetrate the egg's outer and inner membrane.

Conventional IVF



Intracytoplasmic sperm injection - ICSI



With ICSI, eggs are collected from the woman and sperm from the man in exactly the same way as in IVF. After egg recovery a single sperm is injected with a tiny needle directly into the egg. Approximately one in five eggs are not mature and cannot be injected. Approximately one in ten eggs which are injected will not survive. If fertilisation occurs, the embryos are replaced as in standard IVF.

A mature egg being injected with a single sperm

We offer ICSI to couples who have an increased risk of fertilisation failure due to low sperm counts



or sperm disorders. If it is felt that ICSI is the treatment of choice for you, we will discuss it with you in detail and you will be asked to sign a separate consent form. However we cannot ensure that normal fertilisation will follow ICSI or that it will result in the birth of a normal child.

There is growing evidence that disturbances in sperm production are associated with a range of genetic abnormalities. A simple blood test will show whether the correct number of chromosomes are present and arranged correctly, but it will not show if small fragments of chromosomes or individual genes are missing.

Humans have 23 pairs of chromosomes which carry the genes responsible for their make up. One pair of these, the “sex chromosomes” is responsible for the differences between the sexes. In the general population, 0.4% of people will display a chromosome abnormality, a third of which involve the sex chromosomes. Among men with no sperm or low sperm counts, the incidence is almost 6% of which three-quarters are associated with sex chromosomes. Disorders of the sex chromosomes occur in about 1 in 700 births, with ICSI this increases to 1 in 100. We offer chromosome testing to all men who have a very low sperm count and this will be discussed with you at your consultation.

If an abnormality in your chromosomes is found, the chance of pregnancy is reduced and it may increase your chance of a miscarriage. However a child may be born who inherits an abnormality which affects it more than the father. One of our genetics counsellors will discuss the matter with you in more detail if an abnormality is found in your chromosomes.

Men with reduced sperm counts are also more likely to have small fragments of one of their sex chromosomes missing, but this cannot be detected by this routine test. This abnormality can be passed on to sons, causing them to have reduced sperm counts.

We do not refuse treatment based on the results of screening chromosome tests or if a couple decline to undergo tests.

Many follow up studies are ongoing looking at children conceived using the ICSI technique. The results from these studies vary, but it is felt that ICSI doubles the chance of a child being born with an abnormality compared to a child conceived spontaneously. Some follow-up research on a small number of children born through ICSI outside the UK suggests possible developmental delay with some of these children. This is not supported by ongoing follow-up studies in the UK.

Percutaneous epididymal sperm aspiration (PESA) and Testicular sperm extraction (TESE)

PESA and TESE techniques are used when sperm is produced in the testes but the sperm cells cannot enter the seminal fluid.

With TESE, the sperm is extracted directly from the testis and with PESA it is aspirated from a tube lying next to the testis. The decision to use TESE or PESA will depend on the diagnosis. In both techniques, the sperm is obtained before the IVF cycle and frozen. The sperm is then injected into the egg using ICSI.

We are only rarely able to offer a PESA and TESE service, as most Health Authorities do not fund these treatments.

How many treatment cycles are offered?

Our aim is to provide effective treatment to as many infertile couples as possible. The number of IVF treatment cycles that we can offer depends upon the Purchasing Authority. Any previous treatment cycles are taken into account and the number adjusted accordingly.

Screening

All couples accepted for treatment are tested for syphilis, hepatitis B and C and HIV. To minimise the risk of embryos contaminating other embryos in the containers, we are only able to offer treatment to couples where both partners are negative to viral screening. If you are found to carry one of these viruses, we will discuss the possibility of treatment at another unit.

Female patients are screened for Chlamydia. This must be treated before your IVF treatment if it is found.

Patients receiving donated eggs or sperm are also tested for cytomegalovirus (CMV).

Some couples will have a known higher risk for a genetic condition. If this is the case this will be discussed with you at your consultation and testing offered, if appropriate.

Your Treatment cycle

Your treatment cycle starts when you begin injections of gonadotrophins.

Your treatment cycle is only complete after all embryos created during an egg recovery cycle have been replaced. One cycle may therefore involve several embryo replacements.

How do we make sure eggs sperm and embryos are not confused in the laboratory?

All samples are labelled with your name, date of birth and hospital number. These details are always checked against your hospital notes. In the laboratory all containers have your name and details written indelibly or etched on them. All procedures e.g. preparation of sperm are carried out for only one couple at a time and are witnessed by two embryologists. All frozen embryos are stored individually and labelled permanently with your full details. We are confident that these procedures, which are regulated by the HFEA, reduce the risk of confusing sperm eggs or embryos to the minimum.

Sperm and embryos from many patients are stored in large liquid nitrogen containers. Although we only treat patients who negative to viral screening, there remains a theoretical possibility that an undetected virus from one couple's embryos could contaminate others in the container.

Consent to storage and use of gametes

Anyone who consents to the storage and/or use of their gametes (eggs and sperm) or embryos can vary or withdraw their consent at any time until the tissue has been introduced into the patient in one of the following ways:

- Semen has been used for insemination
- Donor eggs have created embryos which have been replaced in the recipient
- Embryos have been replaced

Possible complications

IVF and its associated treatment can involve certain complications. There are two main risks - multiple pregnancy and ovarian hyperstimulation syndrome (OHSS).

Multiple Pregnancy

We transfer a maximum of two embryos. This policy virtually eliminates triplet pregnancies but twins are common – approximately 20- 30% of all pregnancies.

Multiple pregnancies have many more complications than a singleton pregnancy. Premature birth is the most significant, since babies born too soon may not survive or have serious life-long disabilities. A multiple pregnancy also carries greater risk for the mother. Twins can also place great emotional and physical strain on couples after birth. Please consider whether you would like to elect to have embryos replaced singly.

Ovarian Hyperstimulation Syndrome (OHSS)

In about 7% of cases, ovarian hyperstimulation can occur after the ovaries have been stimulated for IVF. The severe form may have life threatening implications.

The ovaries swell and become painful and the high oestrogen levels cause nausea and vomiting. Fluid accumulates in the abdomen and sometimes around the lungs. A small number of women – less than 1% - will have severe symptoms and require hospital admission.

We monitor for OHSS throughout treatment and if your ovaries show excessive response, we may cancel the cycle. Sometimes it is possible to recover and inseminate your eggs and freeze the resulting embryos. The embryos can be replaced two to three months later when symptoms have settled.

Let us know if you have abdominal pain or swelling, feel sick or start vomiting during stimulation, after egg recovery or embryo replacement. Contact the nurses on 0161 276 6209. Out of working hours, telephone 0161 276 6006 or 0161 276 6105 where the nursing staff will advise you.

Ovarian cancer

There have been reports that repeated ovarian stimulation increases the risk of ovarian cancer, although no link has been proven. IVF treatment is relatively new and therefore it will be many years before all the data are available. Women who never conceive have a higher risk of ovarian cancer. Women who conceive after ovarian stimulation appear to carry the same risk of ovarian cancer as those who conceive naturally.

Other treatments

Induction of ovulation

In this treatment, gonadotrophins stimulate the ovaries to produce between one and three eggs. This treatment is used for women who fail to produce eggs but who have normal tubes and whose partner's semen is normal.

The injections usually continue for two weeks. The ovarian response is monitored by ultrasound scans and blood tests. Once the scan and blood tests suggest a mature follicle(s) you will be advised to have intercourse. If too many follicles grow, treatment is stopped and it is essential that you avoid sexual intercourse or use condoms.

Intrauterine insemination (IUI) using donor or partner's semen.

With IUI, specially prepared samples of semen are inseminated into the womb using a fine tube passed through the cervix. This is not painful and is carried out by one of our nurses or doctors.

We carry out ovarian stimulation in addition to IUI for many couples with unexplained infertility. We offer IUI alone for couples with coital or ejaculatory disorders. We also use IUI for couples requiring donor sperm insemination.

In some cases, IVF has to be stopped and may be converted to treatment using IUI.

Egg, Sperm and Embryo donation

Some couples may need to consider the use of donated eggs, sperm or embryos.

Deciding to undergo treatment using donated eggs, sperm or embryos will raise personal issues and requires careful consideration. Therefore patients undergoing these treatments are seen by one of our counsellors to carefully consider all the implications involved for yourselves and any child conceived. **Since the recent change in the law, we provide treatment only with donors who are willing to become known to any offspring born from treatment when they reach the age of 18.**

Sperm Donation

Sperm donation may be offered to couples with a sperm disorder or those with a high risk of passing on a serious genetic disorder.

Our sperm donors are carefully chosen, healthy men aged from 18 to 40, all of whom are screened for Syphilis, Chlamydia, Gonorrhoea, Cytomegalovirus, Hepatitis B and C, HIV and cystic fibrosis. We try to match the donor with the male partner as closely as

possible, with similar skin complexion, race, height, hair and eye colour. Donor insemination can either be used alone or in conjunction with other procedures like IVF.

Couples referred for donor insemination will have a consultation and assessment before treatment. If suitable, they are given a course of five inseminations. The insemination is timed by daily blood tests from day 8 of the cycle.

Egg Donation

Egg donation is an option if the woman is a known carrier of a serious genetic disorder or when her ovaries are absent, have ceased to function or are unlikely to respond to induced ovulation.

Couples referred for egg donation will have a consultation and assessment before treatment. The donor and her partner are also counselled. The donor undergoes a cycle of ovarian stimulation as described above.

Our main problem is lack of donors. Egg donation is an act of outstanding altruism - the process involves great commitment from the donor. Therefore couples undergoing treatment using donated eggs need to find someone who would be willing to act as an egg donor for them.

Embryo donation

Some couples who have undergone treatment at St Mary's donate their frozen embryos after their family is complete. Donated embryos can be offered to couples who have neither eggs nor sperm or if the couple require treatment with donated eggs but are unable to find a donor.

There are increased risks of disorders in pregnancy associated with the use of donated eggs or embryos. These will be discussed with you in detail if you are undergoing this type of treatment. Before this treatment proceeds couples who donate and receive embryos will be seen by one of the counsellors.

Research programmes in the unit

There are many ongoing research projects within the department and you will be asked at your consultation whether you are willing to participate in these. You may be asked to allow us to alter your treatment as part of a clinical trial, or to study sperm, eggs and embryos not required for your treatment. This research is important to help us improve our understanding of the causes of infertility and possible treatment methods. We may also ask you whether you would be prepared to donate eggs and embryos to embryonic stem cell research, aimed at curing a wide range of diseases. Each project has its own

information sheet and consent form. **Only material which cannot be used for your treatment is used for research.**

We routinely collect data on treatments carried out in the Department, as required by the HFEA and to audit the success of our treatments. We may also on occasion use these data for research purposes, however your names are removed so that these records are anonymous.

All research projects are approved by the local ethics committee and by the HFEA where required. **Your treatment will not be affected if you do not wish to participate in the research studies.**

Before your first consultation

Female

We need to carry out a blood test on the second day of your menstrual cycle. Call our nurses on 0161 276 6209 the day your next period begins to arrange your test. At this visit we will also send a sample of urine to exclude Chlamydia infection. If Chlamydia infection is detected we will arrange treatment for this before your IVF treatment.

We will measure your height and weight during this visit to ensure that they are within the normal range. If not, we can offer advice and support on how to reach your target **but will not proceed with treatment until this is achieved.**

Male

We will send you an appointment for a semen test at St Mary's. You should abstain from ejaculating for 3 to 4 days before your test. When you attend for your semen test, you will be given an appointment for your first medical consultation.

If a semen test is not required we will send you a clinic appointment by post within two weeks of the Waiting List Meeting. If you have not heard from us by then, call us on 0161 276 6494.

Your first consultation

Your first consultation will last for about 60 minutes. We will explain your treatment and complete all the consent forms.

After this consultation – and once all your test results are known – you are ready to start treatment.

Starting an IVF treatment cycle

Call us on 0161 276 6340 on the first day of your period (the day you wake up bleeding) when you wish to start treatment. We need to know your name, date of birth and the dates of your last three periods. **Call between 9 a.m. and 11 a.m. – our answering machine will be on if you call before 9 a.m.** If you do not have periods, you will be told when to ring at your first consultation.

You will be asked to call the nurses again between 2p.m. to 3p.m. to find out if we can accept you for treatment that month.

We cannot guarantee treatment in any one month, but if we are unable to accept you in a particular month we will try to provide treatment as soon as possible. Acceptance for treatment is dependent on funding from your Primary Care Trust.

Our treatment protocols

Once accepted for treatment, you will be asked to attend approximately three weeks later to start your injections. Buserelin injections may cause hot flushes, vaginal dryness and headaches – this is not unusual and the drug has no long-term side effects. **You must use barrier methods of contraception once accepted for treatment.**

Call the nurses when your **next** period starts. You will be asked to attend for a blood test and scan after which the nurse will advise you when to start the gonadotrophin injections. You usually continue with both injections for 9-13 days. The nurses can teach you or your partner to give the injections.

You should be prepared to attend the unit every morning after starting both injections for blood tests. You will usually have two or three scans during this time. Depending on your results, the dose of drugs may be altered.

When the follicles look mature on the scan you will need an injection of another hormone called hCG, usually given late at night. **The timing of this injection is crucial** and you will be told the exact time at which you must receive the injection.

Prescription charges

Patients must pay the standard NHS prescription charge for drugs used during treatment. The amount depends on the current rate of prescription charges. If you are exempt from prescription charges or have a pre-payment certificate, please bring proof of this when you come to St Mary's for treatment.

Our Counselling services

Our counselling service plays an important part in offering patients the greatest possible care and support throughout their treatment. Our counsellors are here to support, guide and reassure couples or individuals before, during and after treatment.

Counselling may help you find new ways to cope and help you reach decisions when you are considering the alternatives open to you. They are also able to give advice about adoption or fostering.

Because egg, sperm and embryo donation raise such important emotional issues, we require all couples undergoing such treatment to meet one of our counsellors to discuss the implications before treatment begins.

If you feel you need help you may refer yourself to the counselling service.

Support groups

Our support groups meet regularly. You are welcome to attend before, during or after treatment. A counsellor or nurse attends each meeting. Information about dates of the meetings can be found in the waiting room or in Reproductive News.

Parental responsibility

Parental responsibility is defined by the Children Act 1989 in England and Wales. It involves “all the rights, duties, powers, responsibilities and authority which by law a parent of the child has in relation to the child and his property”.

Where a child’s father and mother were married to each other at the time of his birth, they each have parental responsibility for the child.

Since December 2003 a father who is not married to the mother at the time of birth may obtain parental responsibility if both parents register the birth together.

Human Fertilisation and Embryo Authority (HFEA)

The HFEA licenses the services we provide at the Department of Reproductive Medicine at St Mary’s.

The Human Fertilisation and Embryology Act defines the information we can give your medical attendant – your GP or consultant. Our policy has always been to keep your GP informed about your progress during treatment. You need to consider this before your first consultation – you will be asked to sign consent forms on information disclosure.

At your consultation you will be asked to sign consent forms to use eggs, sperm and embryos. You will find these in the information pack. Please read the forms, **but do not complete until your first consultation.**

The HFEA publishes an Annual Report which includes details of treatment by IVF and donor insemination (DI) throughout the UK and Patients' Guides to IVF and DI clinics. These are available from the Authority free of charge. Tel: 0207 291 8200 or via their website www.hfea.gov.uk

The HFEA keeps a confidential register of information on donors, patients and treatments. This was set up on August 1 1991 and has detailed of children conceived from licensed treatments from that date.

From 2007, people aged 16+ (if considering marriage) or 18 (in 2009) will have the right to ask the HFEA and be told if they were born as a result of licensed assisted conception. If they were conceived using donated eggs, sperm or embryos, they can also be told if they are related to the person they want to marry.

It is a criminal offence for HFEA employees or others whose job involves handling information on the Register to release the information to anyone not entitled to it.

Lifting anonymity for sperm, egg and embryo donors

Until 1 April 2005, people donating sperm, eggs or embryos could remain anonymous. They were asked to provide some non-identifying information which could be given to people choosing a donor for treatment, and to any person conceived using their donation (when they reach the age of 18).

With a growing awareness of how important it would be for some donor-conceived people to find out more about their genetic origins, the Government lifted anonymity for donors in April 2005. This means that anyone born using donated sperm, eggs or embryos is allowed to ask the HFEA for identifying information when they reach the age of 18.

A donor-conceived person can ask for the following identifying information, as well as the non-identifying information:

- The donor's name (and their name at birth, if different)
- Date and place of donor's birth
- Last known address (or their address recorded at the time of registration)

For further information please refer to the HFEA website www.hfea.gov.uk

Suggestions and complaints

At St Mary's, we are determined to provide the best possible service to patients and visitors. Do let us know if you are unhappy with any aspect of this service or have any suggestions. We constantly strive for improvements by listening to your views and acting on them.

The leaflet *Help Us To Help You* explains how to make comments or complains. Ask a member of the staff for a copy.

Emergency phone numbers

In the event of an emergency, call us during normal working hours 8.30 a.m. to 4 p.m. on:

0161 276 6462/6209.

After 4 p.m. and before 8.30 a.m., call wards SM9 or SM10 on 0161 276 6105 or 0161 276 6006.

Useful Books on Fertility Issues

“Fertility Problems: A Simple Guide”

by Ruth Chambers
(Radcliffe Medical Press ISBN 1-85775302X)

“What Every Woman Needs to Know: Facts and Fears about Pregnancy, Child-birth and Womanhood”

Edited by Penny Junor
(Century Paperback)

‘Why Us’

by Dr Andrew Stanway

‘Making Sense of Adoption’

by Lois Melina

‘Infertility & IVF – Facts and Feelings from patients perspectives’

by Jo Benson and Dawn Robinson-Walsh

‘The Infertility Companion’

by Anna Furse

‘The Subfertility Handbook’

by Virginia Ironside and Sarah Biggs

‘Male Infertility – Men talking’

by Marie-Claire Mason

‘The Long Awaited Stork’

by Ellen Sarason-Glazer

‘In Pursuit of Parenthood, Real Life Experiences of IVF’

by Kate Brian

‘Miscarriage – What Every Woman needs to know’

by Professor Lesley Regan

‘The Gift of a Child’

by Robert and Elizabeth Snowden

‘ Experiences of Donor Conception: Parents, offspring and donors through the years’

by Caroline Lorbach

‘Planning a Family using

(letters from Donor Conception network, for mothers, fathers, using DI, Egg Donation & how to tell children)

D.C. Network – www.dcnetwork.org

Tel: 0208 245 4369

Useful Organisations

Ace Babes -

Tel: 01332 832558

www.cebabes.co.uk

(for support following successful conception through fertility treatment)

BICA

Tel: 01744750660

www.bica.net

(provides a means for people to access infertility counselling and information)

Infertility Network Tel: 08701 188088

www.InfertilityNetworkUK.com

(National Support Network)

Daisy Network

www.daisynetwork.org

(National Support Group for those who have suffered early menopause)

D.C. Network

Tel: 0208 245 4369

www.dcnetwork.org

(Network to help parents who have conceived using donor sperm, eggs or embryos and those contemplating treatment)

The Fertility Network

www.ivf.net

(Professional and patient network)

More to Life

www.moretolife.co.uk

(For people who remain involuntarily childless)

NGDT

www.ngdt.org.uk

(Charity to raise awareness of the need for sperm & egg donors)

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