

Shared Motherhood
Intra-partner egg donation /
reciprocal IVF



What is this leaflet about and who is it for?

The information provided in this leaflet is aimed at same-sex couples who are considering shared motherhood as a fertility option. Shared motherhood or reciprocal IVF allows both partners to be involved in the treatment process and to have either a biological or gestational parental relationship to the child or children.

So how does it work?

By using the process of IVF, one partner will be the egg provider (biological mother) and undergo a stimulation cycle to produce multiple eggs. These eggs will then be fertilised using donor sperm to create embryos which will be implanted into the womb of the other female partner (gestational mother). This enables motherhood to be a shared experience for both partners from the time of conception. You will be registered as partners and will complete a consent form to specify how your eggs/embryos can be used in a shared motherhood arrangement. The egg provider will need to be screened as a donor as per the Human Fertilisation and Embryology Act. Details regarding the screening process can be found in the egg donor booklet.

How is the sperm donor chosen?

A sperm donor is:

- Aged between 18-45
- Fit and healthy individual
- Have no personal or family history of inheritable disease

Donors are screened for infectious diseases and chromosome abnormalities, together with a full family medical history to reduce the risks of inheritable conditions.

How are sperm donors matched?

The donor will be matched with your physical appearance and any medical requirements for cytomegalovirus status.

What can I know about the sperm donor?

You can have a description of the physical appearance of the donor, height, hair and eye colour, weight, skin tone, and cytomegalovirus status.

Further non-identifying information such as likes and dislikes, hobbies, occupation are available if you decide you would like this. The donors are asked to write a pen-portrait and goodwill message for future offspring and these can also be seen, but no photo or identifying information about the donor.

This information can be given to the children and at age 18 they can be given identifying details about the donor through the HFEA (this will be discussed in detail at counselling appointments). The donor has no legal or financial obligations to children born as a result of treatment; these are the responsibilities of the legal parents.

Important Considerations

The increasing popularity of direct-to-consumer DNA testing and matching services has made it possible for donors and donor-conceived people to become identifiable to each other outside of the current, managed system of information provision. This can happen if they, or a close family relative, sign up to such a service that allows for genetic matching. Neither the donor nor the donor-conceived person themselves necessarily need to be signed up to such a service for a genetic link, and possibly even their identity, to be inferred. Many people undergo these DNA tests to learn more about their family heritage, however it has introduced the possibility of a donor or donor-conceived person (or a close relative) of being matched with one another. If a donor has joined a DNA testing service themselves and opted into matching, this will increase the likelihood of them being directly identifiable to genetic relatives that they are matched with. This has implications for the families of donors if they have previously been unaware that donation has occurred. Moreover, it can result in a donor-

conceived person who has previously been unaware of their origins discovering this for the first time.

The egg provider

You must be:

- Between 18 and 35 (N.B. egg providers aged 36 and over can be considered on a case-by-case basis)
- Fit and healthy with BMI between 19 – 30
- Have normal ovarian reserve (AMH level ≥ 9 pmol/l, FSH < 8 and Antral Follicle Count ≥ 12). However, this can be considered on a case-by-case basis.
- No previous history of severe endometriosis or of having had one ovary removed. However, this can be considered on a case-by-case basis.
- No history of transmissible disease including significant polycystic ovary syndrome (PCOS). However, this can be considered on a case-by-case basis.
- No personal or family history of inheritable disorders
- No higher risk of transferring a prion-related disease

What preparation is needed to select donor sperm?

You will have two implication counselling appointments with the centre's counsellor, to discuss the social aspects and implications of receiving donated sperm, and to provide you with additional information and support. Topics such as whether and when to tell a child of its origins, and information available about the donor are routinely covered. Information about legal parenthood will be provided so that you each agree and consent to your partner becoming the legal parent of any child born as a result of treatment.

What preparation is needed to donate my eggs to my partner?

You will need to have an antral follicle count scan on day 2-6 of your cycle and a blood test to check your ovarian reserve to see if you are suitable to donate your eggs to your partner.

If your investigations show that you are suitable to be the egg provider then we will arrange further blood tests to screen for infections such as hepatitis B & C, HIV, HTLV, syphilis, and cytomegalovirus.

You may need to have a blood test to screen for other conditions such as thalassaemia, sickle cell or Tay-Sachs. Your karyotype (genetic make-up) and cystic fibrosis carrier status will need to be checked via a blood test. Screening may not 100% effective and you must tell us in future if you become aware of heritable illness. You will also need to have tests to check for sexually transmitted diseases.

You and your partner will also discuss the implications of intra-partner egg donation with our centre's counsellor.

What preparation is needed to receive my partner's eggs?

To ensure the best response to treatment and for your safety your BMI (body mass index) must be ideally between 19 and 30 with an upper limit of 32 for self-funded treatment. Your BMI is calculated by your body weight in kilograms divided by your height in metres squared. If your BMI is above 30 or below 19 you will be offered help and advice to reach the required weight before starting treatment.

You will need to have some blood tests taken to ensure that you are healthy. These will include tests to screen for infections such as hepatitis B & C, HIV, HTLV, syphilis, and cytomegalovirus. You may need to have a blood test to screen for other conditions such as thalassaemia or sickle cell.

You will also need screening to ensure you have been vaccinated against German measles (Rubella).

What treatment will the egg provider undergo?

Your ovaries will be stimulated to produce more eggs than they would normally do in one month. The process of egg harvesting is a 2-month process. Once ready to start treatment, you ring on the first day of the period to book for antral follicle count scan (AFC scan), which is an internal ultrasound scan done between day 2-6 of the cycle. You are then advised about either the long or short protocol based on your age, AMH and AFC. For a standard long drug protocol, this involves a daily injection of Buserelin (Suprecur) (starting a week before your period is due) to switch off the pituitary gland which controls your ovaries. You will then have a period and contact the nurses to arrange a baseline scan and blood test. This is to check that you have responded to the injections. You then commence a second injection of gonadotrophins in the evening to stimulate the ovaries. You will be issued with a written plan detailing when your blood test and scans take place over a two-week period to check that your ovaries are responding. The dose of your drugs will be altered dependent on your response.

How are the eggs collected?

Once the ultrasound scan shows that there are a sufficient number of mature follicles, you will be instructed to give a hormone injection of hCG (Ovitrelle) which matures the eggs before they are collected.

35 – 37 hours after the hCG injection, the eggs will be removed from the ovaries. The eggs are collected by means of a fine needle being passed through the vaginal wall into the ovaries under ultrasound guidance. You will be given sedation anaesthesia and not feel or remember the procedure. The medications that we use for your sedation anaesthesia include: Propofol, Alfentanil, Midazolam; these medications make you drowsy and provide pain relief. Diclofenac

suppository can also be given rectally to provide pain relief for up to 18 hours after your egg collection.

What risks are involved?

The egg collection involves sedation anaesthesia and therefore it is important that you tell us about any other medical conditions that you have or medication that you may be taking.

Anaesthetic side effects include postoperative nausea and vomiting (usually last for 1-2 hours and can be controlled with medications), postoperative shivering, chest infection (very rare with sedation anaesthesia), awareness (becoming conscious during some part of operation; the majority of patients who are aware do not feel any pain, but may have memories of events in the operating theatre), allergic reaction to anaesthetic, very rarely anaphylaxis (risk is 1 in 10,000), risk of death or brain damage during anaesthesia (in general, the risk is 1 in 100,000 but should be even rarer in sedation for minor procedures such as egg collection).

There is a very small risk of pelvic infection after the egg collection. Symptoms include fever, moderate to severe lower abdominal pain or a malodorous vaginal discharge. Severe pelvic infection may lead to infertility and/or chronic pelvic pain.

Injury to bowel, bladder, pelvic blood vessels or nerve injury (rare).

You may experience some vaginal bleeding or laceration which may require stitching (rare).

Ovarian hyperstimulation (OHSS) occurs when there are too many follicles produced in the ovary. In severe cases, which are fortunately rare, fluid can collect in the abdomen and chest causing discomfort and difficulty in breathing. This may lead to a greater tendency for the blood

to clot causing thrombosis. For more information about OHSS please read our Patient Information Leaflet on OHSS.

What treatment will the egg recipient undergo?

Your pituitary gland will be first "down-regulated" using daily injections. You will then get a period and need to attend for an ultrasound scan.

The scan checks that your endometrium (lining of the womb) is very thin, and you then commence oestrogen hormone tablets as well as continuing to self-administer the daily down-regulation injections if you require them.

Once your partner is ready to go to theatre to have their eggs retrieved, the injections will be stopped, and you will commence progesterone vaginal pessaries.

What happens after the egg collection?

The eggs will be inseminated with the sperm of your chosen donor. The following day you will be contacted by the laboratory staff to let you know if and how many eggs have fertilised.

Embryo development will occur over the next 3 to 5 days before the egg-recipient partner has the embryo transfer.

How is my embryo put back?

Two, three or five days after the egg collection you will have one or two of the best embryos transferred into the uterus through the cervix. This is a painless procedure and does not usually require any anaesthetic. Very occasionally, local anaesthetic is applied to the cervix.

A speculum will be inserted, just like a smear test. The consultant will then clean around the cervix before the embryo(s) are loaded into a catheter (fine tube). This is then passed though the cervix into the womb. At this point a nurse will start to scan your abdomen to visualise

the tip of the catheter. The embryo(s) are replaced with a small amount of media, which can often be seen as a “white flare” on the screen. The catheter is then removed and checked by the embryologist to ensure the embryo(s) have been replaced.

You may go to the toilet after the procedure and the embryo(s) will remain in place.

Leicester Fertility Centre is unable to guarantee that your treatment will be carried out by a specific doctor. Please let us know if you would not like to proceed with treatment unless a specific doctor is available.

What happens with the other embryos?

We have the facility for embryo freezing and this will be offered to you to store suitable 'spare' good quality embryos for your own possible future use to grow your family.

What happens after the embryo(s) is implanted?

The partner who has had the embryo(s) transferred will continue with the oestrogen tablets and the progesterone pessaries.

Following the embryo transfer, you will take a pregnancy test (you will be told when to do this) and call the unit with the result. An appointment for a blood pregnancy test will then be booked for you. It is important to attend for the blood test even if you have started a period, so we can exclude the possibility of ectopic pregnancy.

What are the risks involved?

The egg collection involves sedation anaesthesia and therefore it is important that you tell us about any other medical conditions that you have or medication that you may be taking.

Anaesthetic side effects include postoperative nausea and vomiting (usually last for 1-2 hours and can be controlled with medications), postoperative shivering, chest infection (very rare with sedation anaesthesia), awareness (becoming conscious during some part of operation; the majority of patients who are aware do not feel any pain, but may have memories of events in the operating theatre), allergic reaction to anaesthetic, very rarely anaphylaxis (risk is 1 in 10,000), risk of death or brain damage during anaesthesia (in general the risk is 1 in 100,000 but should be even rarer in sedation for minor procedures).

There is a very small risk of pelvic infection after the egg collection. Symptoms include fever, moderate to severe lower abdominal pain or malodorous vaginal discharge (rare).

Vaginal bleeding/Vaginal laceration requiring stitches (very rare).

Injury to bowel, bladder, pelvic blood vessel or nerve (very rare).

When ICSI is carried out there is a risk of damage to the eggs (approximately 5-10%) due to the injection procedure. Damaged eggs cannot be used for treatment. Very rarely, some eggs or embryos could be lost by accident due to human error.

Cancelled cycles due to poor or excessive response to the drugs.

Failure of eggs to fertilise (IVF or ICSI) which would result in the cancellation of your cycle.

Failure of embryos to cleave (divide) which would result in the cancellation of your cycle.

Failure to transfer embryo via the cervical route.

Ectopic Pregnancy.

Multiple pregnancy - the risk of multiple pregnancy (mainly twins) after transferring two embryos is 20-30%. The risk of monozygotic (identical) twins after IVF is 1.5%. Monozygotic twins occur even after transfer of a single embryo. Multiple pregnancies carry more risks to the mother and baby. See leaflet about multiple pregnancy for more information.

Although donors are screened for infectious and heritable diseases, there is always a small risk as some conditions cannot be tested for currently or may become apparent in the donor at some time in the future.

Legal Parenthood

You will both be the legal parents of your child or children when going through shared motherhood. If you are not married or civil partnered, then there will be consent forms that the clinic will provide you with to read, give you opportunity to ask questions and you will complete them. This is important for when you are to register the birth of your child or children.

For a same-sex couple who are not in a civil partnership, both partners will need to consent to the woman who will not give birth being the child's second parent, in order for her to be legally recognised as such.

What follow up care is available?

We would normally offer you and your partner a follow-up clinic appointment with the consultant if your treatment has not been successful. We understand that this is a very difficult time for you both emotionally. Should you wish to access any supportive counselling during your fertility treatment you may contact the Leicester Fertility Centre to arrange an appointment with the unit's counsellor.

Embryos already stored

If the embryos have already been stored before the decision was made for shared motherhood, the embryos will need to remain in storage for 3 months from the date they were frozen prior to use to allow for the necessary quarantine period. Following this time, additional screening and consent forms will be required from the egg provider and the embryo recipient before the use of the embryos in treatment. Please see our leaflet on 'Frozen Embryo Transfers' for further information on these next steps.

Please note if you subsequently separate or divorce, any embryos in storage may only be stored and used in accordance with the consent of the egg and sperm providers whose gametes were used to create the embryos. This is the case regardless of who the eggs were intended for, and if the egg provider initially wished for her former partner to carry the pregnancy.

Our commitment to patients

We are constantly striving to improve our services to patients, and we will welcome your comments or suggestions for improvement.

Leicester Fertility Centre Contact Details

Tel: 0116 2585922

E-mail: Uhl-tr.LeicesterFertilityCentre@nhs.net

Website: www.leicesterfertilitycentre.org.uk

Useful addresses:

Human Fertilisation and Embryology Authority www.hfea.gov.uk

NICE guidelines: www.nice.org.uk

NHS - Response line: [111.nhs.uk](tel:111) / 111

NHS - Smoking Helpline: 0300 123 1044

Fertility Network UK www.fertilitynetworkuk.org / 0121 323 5025

Do you feel that you are at risk of verbal or physical abuse? If so, you may find the following numbers useful:

Domestic Violence Helpline:

United against violence & abuse (UAVA)

Helpline: 0808 802 0028

Email: info@uava.org.uk

Text support: 07715 994 962



This information was correct at the time of printing. While the Trust makes every reasonable effort to keep its information leaflets up to date, very recent changes may not be reflected in the guidance and you should discuss this with the clinical staff at the time of your appointment.

Questions

If you have any questions write them down here to remind you what to ask when you speak to your consultant.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



Today's research is tomorrow's care

We all benefit from research. Leicester's Hospitals is a research active Trust so you may find that research is happening when you visit the hospital or your clinic.

If you are interested in finding out how you can become involved in a clinical trial or to find out more about taking part in research, please speak to your clinician or GP.

If you need information in a different language or format, please call the number(s) below or email equality@uhl-tr.nhs.uk

اگر آپ کو یہ معلومات کسی اور زبان میں درکار ہیں، تو براہ کرم مندرجہ ذیل نمبر پر ٹیلی فون کریں۔

على هذه المعلومات بلغة أخرى، الرجاء الاتصال على رقم الهاتف الذي يظهر في الأسفل
જો તમને અન્ય ભાષામાં આ માહિતી જોઈતી હોય, તો નીચે આપેલ નંબર પર કૃપા કરી ટેલિફોન કરો

ਜੇ ਤੁਸੀਂ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਗਏ ਨੰਬਰ 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

Aby uzyskać informacje w innym języku, proszę zadzwonić pod podany niżej numer telefonu

0116 258 4382 or 0116 250 2959