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From: [redacted]
Sent: Sunday, 6 March 2016 23:41
To: Health:Policy & Legislation
Subject: A.R.T. Act Review - YourSAy

Dear Professor Allan,

Thank you for the opportunity to comment.
I have worked as an Obstetrician for 36 years, much of this work has involved high risk obstetric patients.
I have also worked as an infertility consultant involved with IVF for 15 years and in 1979 spent one year as a neonatal registrar (mainly neonatal ICU).
The obstetric and neonatal exposure has given an extensive experience firsthand of the risks of pregnancy both to the mother and her child.
My concerns relate to:

- The risks to mother and baby/ies from multiple embryo transfer.
- ART in the obese patient.
- overseas units who conduct IVF , transferring multiple embryos ,which may be derived from donor oocytes from young donors, into advanced age mothers , who may not be well screened for coexisting medical morbidity and not well counselled regarding the risks of multiple pregnancy. There has been one maternal death in SA in such circumstance a couple of years ago.

The first two issues may be within your realm to influence, I accept the 3rd is difficult to address, except for educating the public and any doctors who may refer patients to overseas clinics. The press probably being the most effective vehicle.

Most appropriately the underlying principle guiding ART decision making is 'what is in the best interests of the children born from ART'.
And there is no doubt that in the main this is served by SET (Single Embryo Transfer).
If an infertile couple are asked ,"Do you wish to give yourselves the best chance of a healthy child?", of course unanimously they will say 'yes'.
As success rates for IVF increase, in particular with improved success rates for frozen embryo transfer and more recently aneuploidy screening of embryos,
then numerically the cumulative success rate of SET is superior to DET (Dual embryo transfer) for most patients. Further the risks related to DET are significant. They include the unknown effect of death of one embryo within the uterus very early in the pregnancy as a second embryo continues, risk of miscarriage later in the pregnancy of a healthy embryo increased by a failure of the second fetus , the dilemma of what to do if one fetus has a significant abnormality diagnosed at say 19 weeks gestation and the other fetus appears to be normal, or even the risk of a higher order pregnancy, triplets or quads if one or both the embryos split.
The risk of a twin pregnancy to the babies is significant, particularly that of preterm birth which is increased six fold compared to a singleton pregnancy, there is also an increased risk of Intrauterine Growth Restriction with twins. As a result of these facts we see twins when compared to singletons having increased risk of Cerebral Palsy (x4 fold), stillbirth (x3), neonatal death (x5) . The risk of delivery before 28 weeks gestation is increased 6 fold and with that risk comes the increased risk of neurodevelopment problems, severe and moderate disability occurring in 19%. Twenty nine percent of children born at 24-27 weeks gestation have special education needs compared to 4% of those born at term.
This is not to mention the increased risks for the mother including hyper emesis, obstetric haemorrhage, preeclampsia, caesarean section (73% in SA 2008-2009) and postnatal depression and fatigue.
Currently the only argument for multiple ET is the cost saving of an FET cycle and perhaps it may be justified in patients where pregnancy rates are very likely to be low.
I would like to see stronger guidelines for clinicians with respect to multiple embryo transfers, not just what is an "acceptable' twinning rate at a unit.
I would like to see a requirement that the implications of multiple ET are fully discussed with a patient so that they make a properly informed consent.

To this end I would recommend a requirement that patients receive and read an information sheet about the risks of a multiple pregnancy, particularly from the babies' perspective ,if they are wishing multiple embryo transfer or have that recommended . Further I recommend they need to sign a consent for multiple ET which states they have read and understood the information sheet, that it has been discussed with them and they have had sufficient opportunity to ask questions.

Obesity, unfortunately it is a growing problem in our society and is quite frequently an issue at infertility clinics.
We have evidence of obesity affecting the quality of oocytes, the quality of embryos (especially animal studies), adversely effecting the success of embryo transfer and leading on to higher miscarriage rates, fetal abnormality rates, stillbirth and neonatal death rates.
This is not to mention the maternal risks which are increased particularly anaesthetic and airway issues, obstetric haemorrhage, pre eclampsia, gestational diabetes and Caesarean section (52% for BMI>40, Australian publication).
RANZCOG in their guidelines recommend ART should not be carried out in women with a BMI>35.
In New Zealand I believe IVF is not available if BMI is >32.
I acknowledge this is a very difficult area. Patients are often desperate to get pregnant, their age may be against them, their weight is a sensitive issue and weight loss may be very difficult. Further there is the question of discriminating against a patient if treatment is denied on the basis of obesity; although it does have sound medical reasoning.
I would like to see direction given to fertility units regarding the importance of weight reduction before IVF with attention drawn to RANZCOG guidelines.
It would be good if units had a structure in place to direct obese women and their partners ,if the partners are also obese, to weight reduction strategies -dietician, exercise plan +/- consideration of bariatric surgery where appropriate.
The reasons for these steps need to be explained, with some real sensitivity to the patients. Again an information sheet for patients including all steps to be taken to optimise pregnancy outcome could help.
If all fertility clinics could be uniform it would help stopping patients shopping around to get the unit which will give them the treatment they want immediately.

I accept the above suggestions may not be well received by some of my infertility colleges, but I expect would be strongly supported by my obstetric colleges.
It is the obstetricians who may be on the sharp end of performing an emergency Caesarean section at 3 am for a twin IVF pregnancy on a women with a BMI of 45, an epidural which is not working adequately and the patient with an airway problem which increases the risk of general anaesthetic , and are left wondering why was this allowed to happen?

Our overriding concern remains what is in the best interests of the unborn child which can clearly be affected by multiple embryo transfer and maternal and paternal obesity.

Sincerely,
James Harvey
MBBS, MRCOG,RANZCOG

PS. If you wished referenced detail regarding twins or obesity relating to the above I could provide but should get the permission of the IVF unit at which I work to release these documents which I wrote .