British Fertility Society

response to the

Human Fertilisation and Embryology Authority

public consultation on

Multiple Births after IVF in the United Kingdom

July 2007

This document represents the British Fertility Society (BFS) response to the Human Fertilisation and Embryology Authority Public Consultation “Multiple births after IVF in the United Kingdom”.

The British Fertility Society is a multi-disciplinary organization representing professionals with an interest in reproductive medicine. The objectives of the society are:

- To promote high quality practice in the provision of fertility treatment.
- To provide a common forum for members of various disciplines having an interest in the science and treatment of infertility.
- To promote high quality scientific and clinical research in the causes and treatment of infertility.
- To provide professional leadership in the provision and regulation of infertility services.
- To promote the increase of NHS funding for and equity of access to fertility treatments.

Therefore the problem of multiple births is an important issue for BFS members.

To respond to this consultation, BFS membership were circulated by email and asked to send in their replies using the standard proforma. This response represents the majority view of those who replied and was compiled by Dr Luciano Nardo (Manchester) on behalf of the Executive Committee.

It is submitted by the Honorary Secretary whose contact details are:

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The society **agrees** to the making its responses publicly available by the HFEA in accordance with the Cabinet Office Code of Practice on Written Consultation. In addition the society will be making this response available on its website (http://www.fertility.org.uk).

General views on Multiple Births after IVF

1) Is a multiple pregnancy a favourable outcome of IVF treatment?

Not always. Approximately 25% of IVF pregnancies in the UK result in a twin pregnancy. Multiple pregnancies can carry high obstetric and neonatal risks, which presents significant organizational and financial problems for the state funded healthcare service. Multiple births can result in mortality and morbidity of IVF conceived children and can compromise the future health of the mother. High rates of multiple pregnancies after IVF are no longer acceptable and should these be regularly recorded in a particular licensed clinic, then providers of IVF care should be asked to justify and review their practice. There is no doubt that the best outcome of any fertility treatment, including IVF, is the achievement of a singleton pregnancy that reaches full term and ends in the birth of a healthy child.

2) Is there a specific person or professional body responsible for educating the patients and the public?

No. Any healthcare provider, from general practitioners to IVF clinic staff, should appraise patients about potential adverse outcomes of multiple pregnancies and should emphasise the importance of the health of children born after IVF. The regulator, patients' organizations, support groups and the media should increase awareness of the risks of multiple pregnancies and should ensure that reporting of issues surrounding multiple pregnancies is well informed, clear and supported by robust evidence.

3) Is there a strategy to reduce the risk of multiple births in women undergoing IVF?

Yes. IVF professionals providing fertility care should endeavour to identify prior to IVF treatment those women who are most at risk of having multiple pregnancies. Patients with a good prognosis (mainly of young age and who have achieved a pregnancy in the past) should be made aware that the transfer of only one embryo at a time and the cryopreservation of any additional good quality embryos will nearly abolish the risk of multiple pregnancies while maintaining a satisfactory live birth rate. The cumulative pregnancy rates remain the same for single and two embryo transfer IVF cycles. The BFS supports the use of elective single embryo transfer in good prognosis women. IVF units should refer to good clinical practice guidelines and should take into account the most important prognostic markers – female age and embryo quality. The results of TowardSET Project set up in Manchester, funded by the Department of Health, are expected to provide a major contribution in this field in the forthcoming years. The regulator could facilitate changes in clinical practice according to patients' prognosis, based on age, embryo quality and perhaps previous reproductive history, without the necessity for embarking on long bureaucratic processes.

4) Should patients be treated differently in the NHS and in the independent sector?

No. Three quarters of IVF cycles are performed in the private sector in the UK, with patients seeking a positive outcome in one fresh cycle. For some couples it might be difficult to accept single embryo transfer, especially if funding of IVF services is an issue. Fertility professionals should be bound by the same proscription on embryo transfer policies, as the health risks for twins remain the same regardless of where the IVF cycle is performed. Potential advantages and disadvantages apply to every IVF patient. The burden of multiple pregnancies create an unacceptably high level of demand on maternity, neonatal and child healthcare services across the country, therefore it is important to recommend single embryo transfer to all suitable IVF candidates. The idea of developing a Code of Practice Guidance that defines in which cases only one embryo should be transferred is attractive.

5) Should there be a blanket ban on two embryo transfer?

No. Two embryo transfers can be offered to those patients who have lower chances of success. In IVF it is important to balance the wish to reduce the risk of multiple pregnancies with the desire to maintain current pregnancy rates. Whilst a flexible approach might not lead to a consistent and effective reduction of the multiple pregnancy rate after IVF, a more restrictive approach might make it more difficult for clinicians to do what they consider best for each of their patients. We should use the available body of evidence and the experience of other countries to best inform our patients so that their children can have a better start to life.

6) Are there obstacles to implementing elective SET?

Yes. Although research shows that parents of twins find it very demanding and stressful, patients' perception of twins is often more positive. The limited access to NHS funded IVF treatment cycles is indeed another obstacle to eSET. European countries that have already made successfully the transition towards single embryo transfers appears to have a system that is in many ways different from that in the United Kingdom. A more generous state provision of IVF services might contribute to the introduction of eSET for the sub-groups of patients with the highest risk of multiple pregnancies.

Commissioning of IVF services

1) Should healthcare commissioners pay attention to multiple pregnancy rates?

Yes. Primary care trusts (PCTs) should carefully watch and monitor the rate of multiple pregnancies in the assisted conception units with whom they contract the provision of IVF services. Commissioners might wish to take account of multiple pregnancy rates when purchasing IVF treatments and they should have a maximum twin rate which each

centre should not be allowed to exceed. Guidance on commissioning should be uniform across the country. Variation in provision and practice will inevitably continue until equitable access to publicly funded IVF becomes freely available for all patients in the UK.

Conclusions

The evidence base linking the practice of multiple embryo transfer and the consequent achievement of pregnancies at significantly greater risk of serious neonatal and maternal complications is well known. All the major risks of morbidity and mortality are significantly increased for twins compared with singletons. The BFS strongly believes that the health benefits to children, the reduction in distress for families and the enormous cost savings for society, through reduction in the need for immediate and long-term health care for affected children, make an overwhelming case for change in this area of clinical practice. This view was shared in a recently published *Consensus Statement* (Hum Fertil 2007, 10:71-74). Modification of embryo transfer policy through careful patient and embryo quality selection can significantly reduce the risk of twins after IVF. A balanced approach will allow clinicians to take into account the individual circumstances of any given patient without compromising the chances of conception.