Fertility Clinic

Gynaecology
Women and Children's Services

Key fertility information from National Institute for Health and Care Excellence (NICE).

Initial Advice to People Concerned About Delays in Conception

1. Chance of Conception

Over 80% of couples in the general population will conceive within 1 year if:

- The woman is aged under 40 years

  and

- They do not use contraception and have regular sexual intercourse

Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate over 90%).

If you are using artificial insemination to conceive and are concerned about your fertility you should know that:

- Over 50% of women aged under 40 years will conceive within 6 cycles of intrauterine insemination (IUI)
- Of those who do not conceive within 6 cycles of intrauterine insemination, about half will do so with a further 6 cycles (cumulative pregnancy rate over 75%)

Female fertility and (to a lesser extent) male fertility decline with age.

2. Frequency and Timing of Sexual Intercourse or Artificial Insemination

Vaginal sexual intercourse every 2 to 3 days optimises the chance of pregnancy.

If you are using artificial insemination to conceive, you should have your insemination timed around ovulation.

3. Psychological Effects of Fertility Problems

Did you know that stress in the male and / or female partner can affect the couple's relationship and is likely to reduce libido and frequency of intercourse which can contribute to the fertility problems.

You may find it helpful to contact a fertility support group.

Counselling is available because fertility problems, and the investigation and treatment of fertility problems, can cause psychological stress. You may raise the issue with your GP in the first instance.

4. Alcohol

If you are a woman who is trying to become pregnant, did you know that drinking no more than 1 or 2 units of alcohol, once or twice per week, and avoiding episodes of intoxication reduces the risk of harming a developing foetus?

Men who keep their alcohol consumption within the Department of Health's recommendations of 3 to 4 units per day for men are unlikely to affect their semen quality, but excessive alcohol intake is detrimental to semen quality.

5. Smoking

Did you know that women who smoke are likely to reduce their fertility, but can be referred to a smoking cessation programme to support their efforts in stopping smoking? You should also be aware that passive smoking is likely to affect the chance of conceiving.

Men who smoke should be aware that there is an association between smoking and reduced semen quality (although the impact of this on male fertility is uncertain), and that stopping smoking will improve their general health.

6. Caffeinated Beverages

Did you know that there is no consistent evidence of an association between consumption of caffeinated beverages (tea, coffee and colas) and fertility problems?

7. Obesity

Women who have a body mass index (BMI) of more than 30 are likely to take longer to conceive. If women who have a BMI of 30 or over are not ovulating (producing eggs), losing weight is likely to increase their chances of conception. Participating in a group programme involving exercise and dietary advice leads to more pregnancies than weight loss advice alone.

Men who have a BMI of 30 or over are likely to have reduced fertility.

8. Low Body Weight

If you are a woman with a BMI of less than 19 and have irregular menstruation or are not menstruating, increasing your body weight is likely to improve your chance of conception.

9. Tight Underwear

There is an association between elevated scrotal temperature and reduced semen quality, but it is uncertain whether wearing loose-fitting underwear improves fertility.

10. Occupation

Some occupations involve exposure to hazards that can reduce male or female fertility and therefore enquiries about occupation are made to people who are concerned about their fertility and appropriate advice offered when needed.

11. Prescribed, Over-the-Counter and Recreational Drug Use

Did you know that over-the-counter and recreational drugs interfere with male and female fertility? Enquiries about these are made in clinic to people who are concerned about their fertility and appropriate advice offered.

12. Complementary Therapy

Did you know that the effectiveness of complementary therapies for fertility problems has not been properly evaluated and further research is needed before such interventions can be recommended?

13. Folic Acid Supplementation

Did you know that supplementation with folic acid before conception and up to 12 weeks' gestation reduces the risk of having a baby with neural tube defects (spina bifida)? The recommended dose is 0.4 mg per day. For women who have previously had an infant with a neural tube defect (or who are receiving anti-epileptic medication or who have diabetes (see Diabetes in pregnancy, NICE clinical guideline 63), a higher dose of 5 mg per day is recommended.

14. Regularity of Menstrual Cycles

Women who are undergoing investigations for infertility will be offered a blood test to measure serum progesterone in the mid-luteal phase of their cycle (day 21 of a 28-day cycle) to confirm ovulation even if they have regular menstrual cycles.

Women with prolonged irregular menstrual cycles should be offered a blood test to measure serum progesterone (egg production). Depending upon the timing of menstrual periods, this test may need to be conducted later in the cycle (for example day 28 of a 35-day cycle) and repeated weekly thereafter until the next menstrual cycle starts.

The use of basal body temperature charts (a natural method of ovulation detection) to confirm ovulation does not reliably predict ovulation and is not recommended.

15. Investigation of Suspected Fallopian Tubal and Uterine Abnormalities

Women who are not known to have comorbidities (such as pelvic inflammatory disease, Chlamydia, previous ectopic pregnancy or endometriosis) would be offered Hysterosalpingography (HSG) to screen for tubal occlusion (blockage of the fallopian tubes) because this is a reliable test for ruling out tubal occlusion, and it is less invasive and makes more efficient use of resources than laparoscopy.

Where appropriate expertise is available, screening for tubal occlusion using hysterosalpingo-contrast-ultrasonography (HYCOSY) should be considered because it is an effective alternative to hysterosalpingography for women who are not known to have comorbidities.

Women who are thought to have comorbidities would be offered laparoscopy and dye so that tubal and other pelvic pathology can be assessed at the same time.

16. Susceptibility to Rubella (otherwise known as German measles)

Women who are concerned about their fertility would be offered testing for their rubella status so that those who are susceptible to rubella can be offered vaccination. Women who are susceptible to rubella would be offered vaccination and advised not to become pregnant for at least 1 month following vaccination.

17. Cervical Cancer Screening

To avoid delay in fertility treatment a specific enquiry about the timing and result of the most recent cervical smear test would be made to women who are concerned about their fertility. Cervical screening should be offered in accordance with the national cervical screening programme guidance.

18. Screening for Chlamydia Trachomatis

Prophylactic (preventive) antibiotics would be considered before uterine instrumentation if screening has not been carried out e.g. at Hysterosalpingogram (HSG).

19. Ovulation Disorders

A. World Health Organisation (WHO) Group I Ovulation Disorders (Not Producing Eggs)

Women with WHO Group I anovulatory infertility (failure to produce eggs) can improve their chance of regular ovulation, conception and an uncomplicated pregnancy by:

- Increasing their body weight if they have a BMI of less than 19

  and / or

- Moderating their exercise levels if they undertake high levels of exercise

B. WHO Group II Ovulation Disorders (Receiving First Line Treatment of Ovulation Induction)

In women with WHO Group II ovulation disorders receiving first-line treatment for ovarian stimulation, please be advised that:

Women with WHO Group II anovulatory infertility who have a BMI of 30 or over will be advised **to lose weight**. Please know that this alone may restore ovulation, improve their response to ovulation induction agents, and have a positive impact on pregnancy outcomes.

In women with WHO Group II anovulatory infertility, one of the following treatments, taking into account potential adverse effects, ease and mode of use, the woman's BMI, and monitoring needed will be offered:

- Clomiphene Citrate

  or

- Metformin

  or

- A combination of the above

For women who are taking Clomiphene Citrate, ultrasound monitoring may be offered during at least the first cycle of treatment to ensure that they are taking a dose that minimises the risk of multiple pregnancy or offered selectively in those with symptoms of hyperstimulation.

For women who are taking Clomiphene Citrate, you will not continue treatment for longer than 6 months.

Women prescribed Metformin should be aware of the side effects associated with its use (such as nausea, vomiting and other gastrointestinal disturbances).

For women with WHO Group II ovulation disorders who are known to be resistant to Clomiphene Citrate, NICE suggests that one considers one of the following second-line treatments (depending on clinical circumstances and the woman's preference):

- laparoscopic ovarian drilling

  or

- combined treatment with Clomiphene Citrate and Metformin if not already offered as first-line treatment

  or

- Gonadotropins (These are injectable hormones , also called LH and FSH, which stimulate the ovaries and used for treating fertility problems)

Surgical Treatment for Hydrosalpinges (Blockage of Fallopian Tube) Before in Vitro Fertilisation Treatment (IVF)

Women with hydrosalpinges would be offered salpingectomy (removal of fallopian tubes), preferably by laparoscopy (keyhole), before IVF treatment because this improves the chance of a live birth.

Medical Management (Ovarian Suppression) of Endometriosis

Medical treatment of minimal and mild endometriosis diagnosed as the cause of infertility in women does not enhance fertility and should not be offered.

Surgical Ablation

Women with minimal or mild endometriosis who undergo laparoscopy would be offered surgical ablation or resection of endometriosis (surgical removal of endometriosis) plus laparoscopic adhesiolysis (separation of scar tissue by key hole method) because this improves the chance of pregnancy.

Women with ovarian endometriomas would be offered laparoscopic cystectomy because this improves the chance of pregnancy.

Women with moderate or severe endometriosis would be offered surgical treatment because it improves the chance of pregnancy.

Unexplained Infertility (Infertility Where All the Common Investigations Are of Normal Result)

Ovarian Stimulation for Unexplained Infertility

Oral ovarian stimulation agents (such as clomiphene citrate, anastrozole or letrozole) are not offered to women with unexplained infertility.

Inform women with unexplained infertility that clomiphene citrate as a stand-alone treatment does not increase the chances of a pregnancy or a live birth.

Advise women with unexplained infertility who are having regular unprotected sexual intercourse to try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered.

Offer IVF treatment to women with unexplained infertility who have not conceived after 2 years (this can include up to 1 year before their fertility investigations) of regular unprotected sexual intercourse.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service offers confidential advice, support and information on any health related matters.

If you have a comment, concern, complaint or compliment about the care or service you have received from the Trust you can contact the PALS team as follows:

Telephone: 03033 306518

Email: nlg-tr.PALS@nhs.net

There are also offices at both the Diana Princess of Wales Hospital (near the main entrance) and Scunthorpe General Hospital (on the C Floor, near the outpatient department), should you wish to visit.

Please note: PALS should not be contacted for clinical advice relating to the content of this leaflet. The service should be contacted directly in the first instance.

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