

Summary: Year 1 evaluation of HFEA multiple births policy

The following information and data has been summarised from a full evaluation of the first year of the multiple births policy available on the HFEA website¹, to aid centres as they audit and revise their multiple births minimisation strategies.

National data analysis

The overall multiple birth rate for 2009 is predicted to remain around 24% of all live births across all patients. However there has been a shift in clinical practice, with centres carrying out more elective single embryo transfers (eSET) in 2009 compared to 2008. There also appears to be a difference between patients aged under 35 and patients aged 35 and over (Figures 1 – 5²).

Patients aged under 35

- The greatest increase in eSET in 2009 has been in women aged under 35
- The proportion of blastocyst eSET appears to have increased in women aged under 35 in 2009, though centres are still carrying out more double blastocyst transfers than single blastocyst transfers
- The multiple pregnancy rate in women aged under 35 appears to have decreased in 2009 compared to 2008

Patients aged over 35

- There appears to be a slight increase in eSET in women aged 35 – 37 in 2009
- There does not appear to be an increase in the proportion of blastocyst eSET in women aged 35 – 39. However there has been an increase in the proportion of double blastocyst transfers in these women
- The multiple pregnancy rate in women aged 35 – 39 appears to have increased in 2009. This has negated the decrease in multiple pregnancy rate in women aged under 35 and may be linked to the increase in double blastocyst transfers in slightly older women.

It is not yet possible to say what effect there has been on the overall clinical pregnancy rates for 2009³.

The HFEA will make more in depth national data analysis available to centres as we carry it out.

¹ http://www.hfea.gov.uk/docs/2009-12-09_Authority_papers_-_527_Multiple_Births.pdf

² Figures 1 – 5 presents the 2008 and available 2009 elective single embryo transfer data, blastocyst transfer data and clinical pregnancy data from fresh IVF and ICSI cycles using the patient's own eggs. Data is UNVERIFIED and retrieved from the HFEA register in November 2009. For more information on how the data analysis was carried out, please see the full evaluation on the HFEA website (link above)

³ At the time of evaluation, centres had not submitted a quarter of their early outcome forms and therefore clinical pregnancy data is incomplete

Centres' experience of implementing their strategies

The first year of the policy has been a steep learning curve and centres have focused on developing their strategies and setting up processes to implement them. However many clinicians acknowledge that they are now in a position to analyse the data they have accumulated over the past year, revise their strategies and present a stronger, more convincing message to patients.

Criteria for selecting patients for eSET

- Centres were initially cautious when implementing their multiple births minimisation strategies. Clinics commonly set more restrictive criteria for identifying patients suitable for eSET than the BFS/ACE professional body guidelines⁴ recommended, for example selecting women aged under 35 for eSET instead of the guidelines' recommendation of women aged 37 and under.
- Some centres have been getting very high pregnancy rates from patients with two or more good quality blastocysts available who have eSET. However patients who decide to not follow a centre's recommendation for eSET and have two blastocysts transferred, have very high multiple pregnancy rates. There has been some concern from clinicians that blastocyst transfers may have a higher monozygotic twinning rate. Other centres are getting good results from cleavage stage embryos.
- Embryo quality appears to be more important than patient criteria such as age when predicting which patients are likely to become pregnant or have a multiple pregnancy. Effective and consistent embryo grading is clearly vital in maximising pregnancies from eSET and some centres have found staff training in embryo grading has dramatically increased their pregnancy rates.
- Effective freezing policies are very important in maximising a woman's overall chance of having a live birth. Some centres have changed their freezing protocols in 2009, for example introducing vitrification and freezing single embryos. However feedback suggests that centres would like more professional body guidance around effective freezing policies.

The HFEA will be running a series of four regional workshops for clinics in March and May 2010 focusing on effective embryo grading and freezing policies.

Patient uptake of eSET⁵

- Some centres have been struggling with patient uptake of eSET. This was strongly influenced by how patients' treatment cycles are funded, whether NHS funding arrangements are supportive and how clinics inform patients about the risks of multiple births and eSET.
- Patients were more willing to have eSET if staff gave information to patients about multiple births and eSET from the very beginning of their treatment pathway. Staff

⁴ <http://www.informaworld.com/smpp/content~content=a902139975~db=all~order=pubdate>

⁵ Patient data from online HFEA patient questionnaire with 66 respondents

members across the centre need to support the policy and give consistent information to patients.

- The most common way of giving information to patients was through face-to-face discussions. Patients found this method the most helpful, though phone conversations, presentations (eg, at patient information evenings) and leaflets were also useful. Patients found information they were directed to on websites less helpful.
- Centres gave information to patients at all stages of treatment, most commonly at the initial consultation and on the day of embryo transfer. Patients who were only given information on the day of embryo transfer, or were given information on the day of embryo transfer that differed from previous information, found this confusing.
- Two thirds of patients looked for more information on eSET outside of the information that their centre gave them, mostly just before or during their treatment. Patients found talking to other patients, discussion forums and support groups the most helpful.
- A small proportion of patients said their centre did not discuss the risk of multiple births or that information was inconsistent between different staff members within a clinic.
- The vast majority (92%) of patients who did not have SET thought that they could increase their chances of getting pregnant by not choosing SET; 41% thought that the risks of multiple pregnancy were acceptable; 21% were influenced by the cost of treatment; 26% because the emotional burden of treatment was so high; and 15% wanted twins. When asked what may have changed their minds, 73% said better success rates from SET; 55% said more cycles provided on the NHS (with 15% wanting frozen cycles included); and 30% said less expensive treatment (with 18% wanting frozen cycles included or reduced in price).

Infertility Network UK, in conjunction with the Department of Health, HFEA and Multiple Births Foundation, is producing a patient information leaflet on multiple births and single embryo transfer. This will address some of the common queries and misconceptions that patients have around single embryo transfer. The leaflet will be made available to all centres in the next few months along with information and advice to centre staff about the best way to inform patients.

For more information please contact Helen Richens, Policy Manager
helen.richens@hfea.gov.uk

Figure 1. Women under 35, 35-37, 38-39: elective single embryo transfers

Proportion of fresh, stimulated, own egg IVF & ICSI embryo transfers by patient age that are elective single embryo transfers (eSET) **UNVERIFIED DATA**

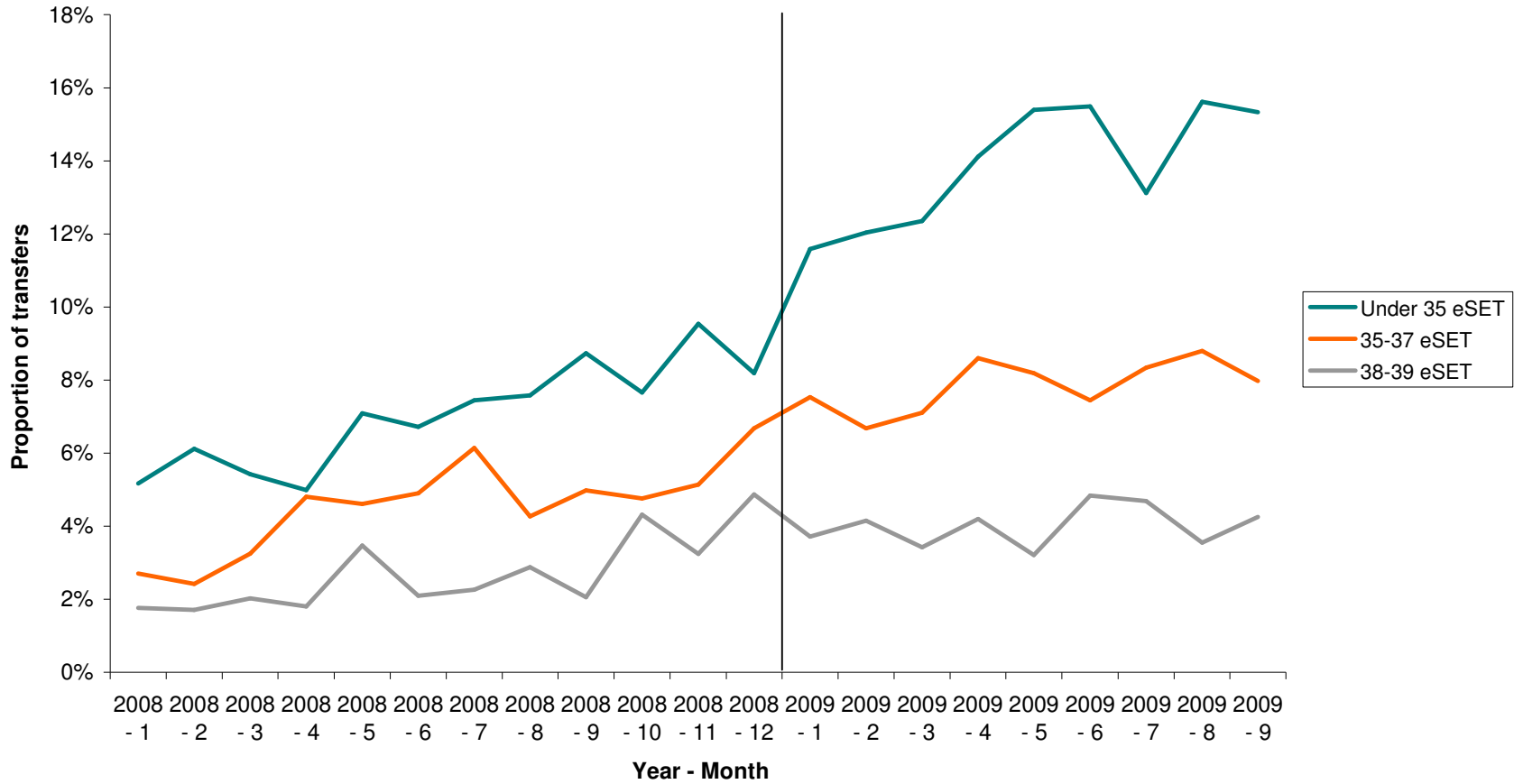


Figure 2. Women aged under 35: blastocyst transfers

Proportion of fresh, stimulated, own egg IVF & ICSI blastocyst transfers for patients under 35 (proportion of all transfers) **UNVERIFIED DATA**



Figure 3. Women aged 35 - 37: blastocyst transfers

Proportion of fresh, stimulated, own egg IVF & ICSI blastocyst transfers for patients aged 35-37 (proportion of all transfers) **UNVERIFIED DATA**

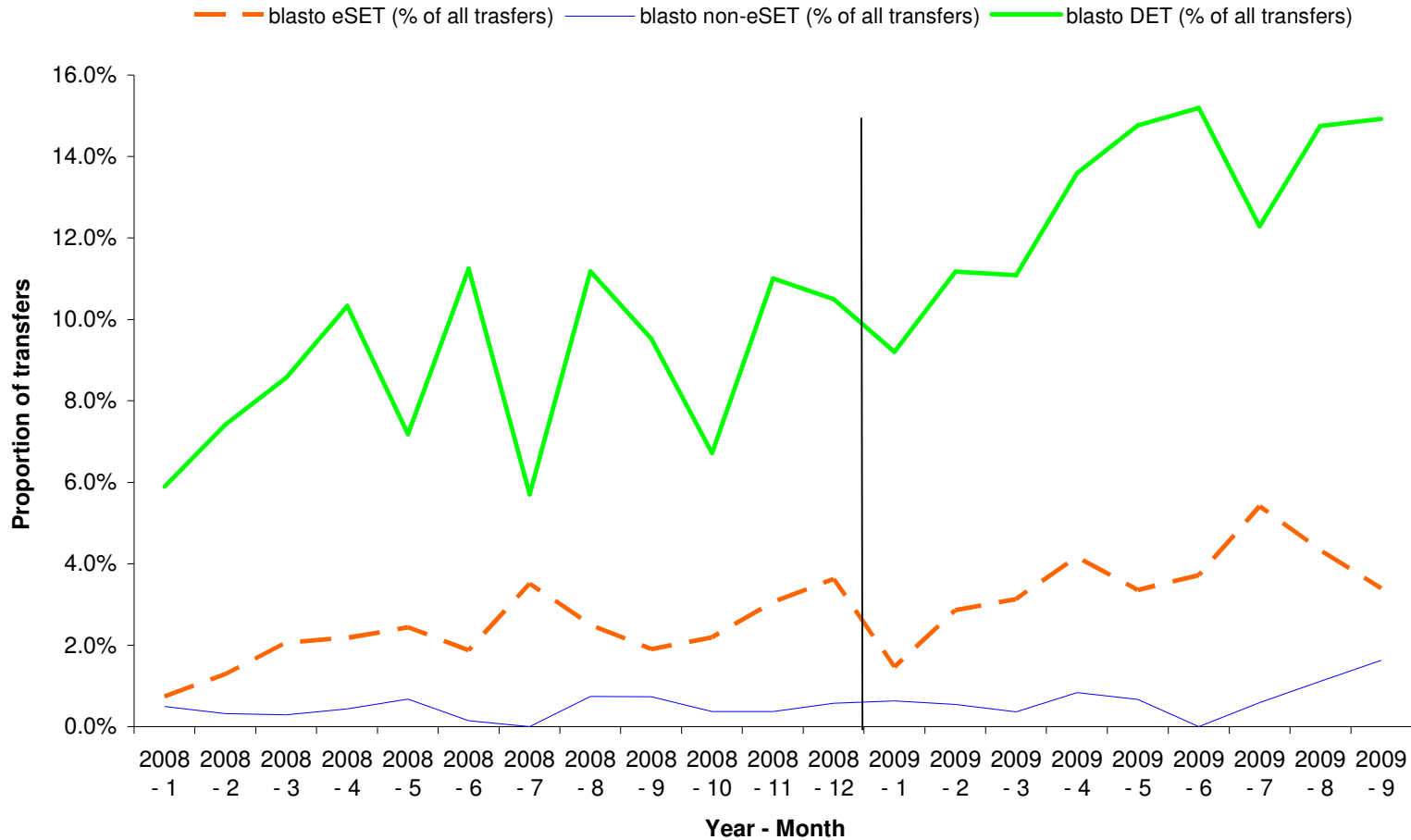


Figure 4. Women aged 38-39: blastocyst transfers

Proportion of fresh, stimulated, own egg IVF & ICSI blastocyst transfers for patients aged 38 - 39 (proportion of all transfers) **UNVERIFIED DATA**



Figure 5. Women under 35, 35-37, 38-39: multiple pregnancy rate
 Multiple pregnancy rate per pregnancy for fresh, stimulated, own egg IVF & ICSI embryo transfers by patient age **UNVERIFIED DATA**

