REPROMED
REPRODUCTIVE UPDATE

Fertility in focus

SPRING
2023

Welcome

Welcome to our newsletter, 'Fertility in focus' specifically designed to keep you up to date with the latest science, technology and specialised services on offer at Repromed as well as provide you with quality information on fertility treatment within Australia.

I know you will find this issue informative as it contains what we believe to be the best medical advice at this time in relation to fertility treatment in Australia that will have a direct and positive impact for many of your patients.

Repromed consistently achieves high success rates year on year by having world leading Fertility Specialists and Scientists and implementing the very latest technologies and advancements into our clinical program. We ensure that our patient experience and model of care are cutting edge and our patients experience the best outcomes.

Repromed has made significant investments in state-of-the-art laboratory equipment and laboratory systems across our clinics. This investment reflects our continued focus on quality control and quality assurances. We continue to invest in world-class equipment as part of our commitment to improving success rates and outcomes for patients.

We also regularly conduct comprehensive, end-to-end laboratory reviews which allow us to assess how our laboratories are running, and make improvements as required. As part of our laboratory reviews, we complete education and knowledge assessments for our entire scientific workforce.

So when considering a fertility clinic for your patient/s I encourage you to consider Repromed if you do not already do so. We are one of this country's leading fertility clinics, we have leading industry voices, leading technologies and leading success rates.

Professor Kelton Tremellen
MB BS(Hons) PhD FRANZCOG CREI

SA Medical Director – Repromed

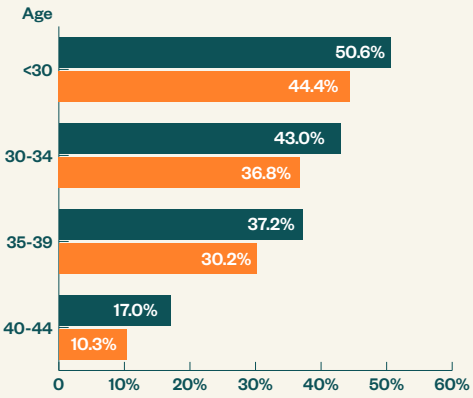
Repromed clinical pregnancy and live birth success rates 2020

Fresh embryo transfer success rates

These success rates include data for all Repromed clinics.

The graph shows IVF and ICSI treatments that took place between 1 January and 31 December 2020.

This data excludes cycles completed by patients using donated embryos and donated eggs.

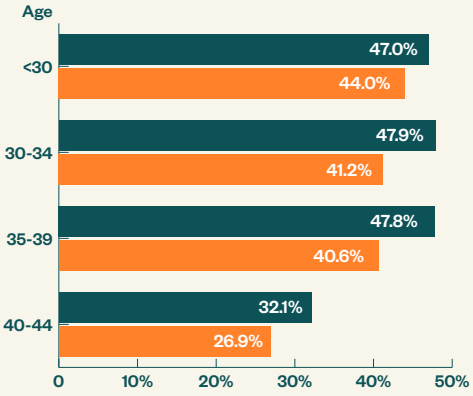


Frozen embryo transfer success rates

These success rates include data for all Repromed clinics.

The graph shows treatments using all frozen embryos created via IVF or ICSI. These cycles took place between 1 January and 31 December 2020.

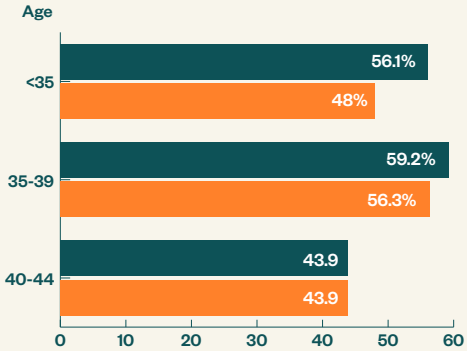
This data includes treatment cycles that incorporated Pre-Implantation Genetic Testing (PGT). However, it excludes cycles completed by patients using donated embryos and donated eggs.



Pre-implantation genetic testing embryo transfer success rates

These success rates include data for all Repromed clinics.

The graph shows treatments with blastocyst-stage embryos that have undergone Pre-Implantation Genetic Testing (PGT) using trophectoderm biopsy. The <30 and 30-34 age groups have been combined due to the low utilisation of PGT in the <30 age group. These cycles took place between 1 January and 31 December 2020.



Clinical Pregnancy/ Embryo Transfer

Live Birth/ Embryo Transfer

Repromed have formed a partnership with the Australian Athletes' Alliance (AAA), a professional body representing player and athlete associations including in AFL, cricket, football, basketball, netball, rugby league and hockey.

This partnership aims to educate and empower sports stars to help them take early steps to optimise their reproductive health and give them the best chance of starting families when they are ready to.

Want to refer a highly active person who may be experiencing menstrual health or fertility issues?

E. enquiries@repromed.com.au
T. 08 8333 8111

AUSTRALIAN ATHLETES' ALLIANCE

Fertility Wellness Partner

Monash IVF Group

By Professor Kelton Tremellen
MB BS(Hons) PhD FRANZCOG CREI

SA Medical Director – Repromed

Managing recurrent pregnancy loss

Couples who experience consecutive miscarriage require empathy during this distressing time. Frustration is also often prominent as in at least 50% of cases there is no clear underlying pathology.

Desperation can lead to investigations and interventions that have no proven benefit and there are few evidence-based treatment strategies. Couples main concern is finding a cause and their risk of recurrence.

This article concentrates on the proven investigations and management.

Investigations can be commenced prior to referral to a specialist unit or fertility specialist/gynaecologist.

The definition varies between 2 or 3 losses and whether the pregnancy was biochemical or clinical. Many couples will be keen for investigations after a second miscarriage as the prospect of facing a potential subsequent miscarriage is daunting.

For any couple that become pregnant again TLC (tender loving care) and monitoring of viability with weekly ultrasound is equally important.

"Many couples will be keen for investigations after a second miscarriage as the prospect of facing a potential subsequent miscarriage is daunting."

Causes and potential treatment

Chromosomal

Maternal age
The risk of miscarriage is strongly influenced by female age due to increasing aneuploidy rate and consequently the chance of recurrent miscarriage is also increased. The background rate of 3 miscarriages < 25 yrs is 0.13% but rises to 13% for those > 40 yrs.

Parental structural chromosome abnormalities
These can account for 3-5% of cases and are mainly due to balanced translocations.

Genetic counselling may be required and discussion around the option of IVF with PGT for aneuploidy or translocations. For aneuploidy the outcomes are similar to expectant management but the number of miscarriages prior to a successful birth can be reduced.

Antiphospholipid Syndrome
This accounts for 5%-20% of recurrent miscarriage and is a treatable cause. Positive Lupus Anticoagulant and Anticardiolipin antibodies 6 weeks apart are required for diagnosis. Haemtologist review is recommended. Treatment involves low dose aspirin prepregnancy and LMWH once pregnancy occurs.

Endometrial
Infection of the endometrium (chronic endometrioses) is a cause of recurrent pregnancy loss.

Uterine structural abnormalities
The frequency of structural uterine abnormalities is increased in recurrent miscarriage and warrants investigation but their role in causation can be unclear. Uterine septum is the most common congenital abnormality (others include bicornuate, unicornuate and didelphys) and acquired pathology including fibroids and polyps. Pelvic Ultrasound in expert hands is needed for investigation. Uterine polyps should be removed and surgical

management of uterine septum or submucous fibroids can be considered.

Adenomyosis (uterine endometriosis) is also recognised as a cause of euploid (genetically normal) miscarriage.

Obesity
Increasing BMI can increase miscarriage risk by 50%.

Sperm DNA damage
Sperm DNA damage can increase the risk of miscarriage. This can be tested for with a Halo Sperm Test through Repromed.

Endocrine

Hypothyroidism
Overt hypothyroidism is a known cause but subclinical disease is less clear. Treating TSH levels over 4 mIU/L with thyroxine, especially when associated thyroid antibodies can improve outcomes.

PCOS
The miscarriage risk in PCOS is higher although the mechanism is unknown and a meta-analysis found that metformin did not reduce the miscarriage risk in PCOS.

Unexplained

For half of couples investigated no cause is found which can be both reassuring and frustrating. They can be reassured that the chance of live birth is still good. Lifestyle modifications should be encouraged especially to reduce smoking and BMI for obese women.

Supplemental vaginal progesterone in the luteal phase has not been shown to improve the live birth rate but can be considered especially if there is bleeding in early pregnancy.

"Many couples will be keen for investigations after a second miscarriage. For any couple that become pregnant again, TLC and monitoring of viability with weekly ultrasounds is equally important."

Sperm DNA fragmentation test

At Repromed, our goal is to do whatever we can to help our patients realise their dream of having a baby.

Part of this is determining what may be contributing to their fertility struggles. When generally speaking about infertility, the focus is often on female factors, however the reality is after a female's age, male factor infertility is the second most common reason a couple may have difficulty conceiving.

A semen analysis is the single most important piece of information needed to assess male fertility, and therefore it is crucial to obtain an accurate analysis.

We perform our analysis according to the World Health Organisation's latest criteria which is considered the gold standard in performing a semen analysis. On top of a semen analysis Repromed is proud to now be able to offer a test called Halosperm, which determines the health of the DNA in sperm.

Smoking, alcohol, heat, some chemicals and other factors can damage the DNA in cells, including sperm cells. Halosperm allows us to assess any DNA damage in sperm. The test can be performed in conjunction with a routine semen analysis and provides additional information as to the quality of the sperm.

The test is recommended for couples who have repeated IVF failure, poor blastocyst development, recurrent miscarriage or for patients who are heavy smokers. Patients can be referred onto Repromed by calling **08 8333 8111** or emailing **enquiries@repromed.com.au**

40% of infertility is due to male factors alone.

Repromed's Andrology Laboratories are some of the only facilities within South Australia and the Northern Territory with an automated Semen Analysis machine ensuring consistent, accurate and rapid turnaround of results. Repromed's fully NATA (National Association of Testing Authorities, Australia) accredited Andrology Laboratories are one of the main providers of semen testing for fertility assessment, post vasectomy checks, sperm DNA damage tests and cryopreservation of sperm (eg. prior to cancer treatment) across South Australia and the Northern Territory.

Children conceived using assisted reproduction methods – a study into their psychological health

Since the advent of third- party reproduction, there have been concerns about how children conceived by these techniques would feel about their conception. For individuals conceived via anonymous egg and sperm donation, concerns have included how they would react to lacking a genetic connection with one of their parents and not knowing the identity of their donor [(1)]. As for individuals born following surrogacy, questions remain about whether they feel distressed in adulthood by the knowledge that their surrogate gave them away to their intended parents.

Studying the perspectives of individuals born following donor conception and surrogacy has been inherently difficult. This is due to the high rates of non-disclosure of the child's origin in families headed by heterosexual couples [(2)]. Thus, overall studies of this topic are limited. Non-disclosure runs the risk of the child finding out accidently or at a later age, which has been associated with more negative feelings about donor conception, including feelings of anger, shock, and confusion [(3)].

A UK Longitudinal Study of Assisted Reproduction Families has followed children born through egg donation, sperm donation and surrogacy from infancy to adulthood[1]. The families were seen at seven time points; when the children were aged 1, 2, 3, 7, 10, 14, and 20 years. This seven-phase study recruited 50 sperm donation families, 51 egg donation families, 42 surrogacy families, and 80 natural conception families.

The study concluded that most of the young adults followed felt unconcerned about being conceived through gamete donation or surrogacy. Although their method of conception was not often raised, when it was, these conversations were conducted with ease and were rarely difficult or awkward. These positive findings may be attributed to the young age at which these young adults had been told about their conception. In this sample group, the majority have been told about their conception before the age of 4 years.

The study also showed that individuals born through surrogacy are mostly unconcerned about the method of their conception. For the surrogacy-born young adults who were in contact with their surrogate, the amount of contact varied, as did the closeness of the relationship. Regardless of the extent of contact, all the young adults felt positive about their birth through surrogacy, and those who wanted to contact their surrogate wished to do so because they were curious, or wished to thank them, and not because they felt a need to form a relationship with them.

Overall, the study found that those children born by third-party assisted reproduction are just as psychologically healthy and have family relationships of the same quality as those conceived naturally. There were minimal differences in the family dynamics formed after egg donation, sperm donation, surrogacy, or unassisted conception.

References:

1) 'I know it's not normal but it's normal to me, and that's all that matters': experiences of young adults conceived through egg donation, sperm donation, and surrogacy . V. Jadva , C. Jones, P. Hall , S. Imrie , and S. Golombok
2) Lassalzede T, Paci M, Rouzier J, Carez S, Gnisci A, Saias-Magnan J, Deveze C, Perrin J, Metzler-Guillemain C. Sperm donor conception and disclosure to children: a 10-year retrospective follow-up study of parental attitudes in one French center for the study and preservation of eggs and sperm (CECOS). Fertil Steril 2017;108: 247–253. MacCallum F, Lycett.
3) Turner AJ, Coyle A. What does it mean to be a donor offspring? The identity experiences of adults conceived by donor insemination and the implications for counselling and therapy. Hum Reprod 2000;15:2041–2051

Dr Tristan Hardy
MBBS (Hons) MRMed PhD
FRANZCOG FRCPA

Medical Director Genetics,
Monash IVF Group.

Top 10 reasons to consider genetic carrier screening

1. Genetic conditions affect one in 400 babies.

One in 400 babies that are born are affected by a genetic condition. Some genetic conditions are manageable, but others can have more serious outcomes. Patients who are able to identify potential genetic risks can work through their options by knowing their carrier status before conceiving.

2. Genetic carrier screening allows patients to understand their options earlier.

Undergoing genetic carrier screening before pregnancy gives patients time to understand their reproductive options without a time restriction. If patients find out that they have an increased risk of having a child with a single gene condition, having time to talk to a fertility clinician or genetic counsellor is incredibly valuable.

3. One in 20 reproductive couples will find out they have a high chance of having a child with a single gene condition.

Of the reproductive couples that undergo genetic carrier screening, one in 20 will discover they have a high chance of having a child with a single gene condition. In this situation, for every pregnancy there is a one in four chance of having a child with the condition they have screened positive for.

4. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends genetic carrier screening.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is the leading body for Obstetricians and Gynaecologists in Australia and New Zealand. They recommend that anyone considering pregnancy should be offered genetic carrier screening.

5. The majority of children born with a single gene condition have no other affected family members.

Patients may not know whether someone in their family has a single gene condition – but that doesn't mean that their children won't inherit a single gene condition from them. Genetic carrier screening will give vital information to patients to enable them make informed decisions about their reproductive options.

6. Patients can now complete genetic carrier screening at home.

Repromed now offers At-Home Genetic Carrier Screening Tests. Tests can be ordered online and are shipped directly to your patient's home. Patients don't need to come into a clinic for any procedures or tests – the test is completed in the comfort of their own home using a saliva swab.

7. Genetic carrier screening is easy and non-invasive.

Repromed's At-Home Genetic Carrier Screening Test just requires a saliva sample using the swab included in the kit and retern via post. There are no needles or invasive procedures involved.

8. We're all carriers of around three to five genetic conditions.

On average, we're all carriers of around three to five genetic conditions. Most patients aren't aware of this, and most of the time being a carrier doesn't necessarily impact their health. About seven out of ten people having genetic carrier screening with us will find out they're a carrier of a single gene condition. Genetic carrier screening allows patients to understand the single gene conditions they carry and may pass on to any future children.

9. Genetic carrier screening can be done at any time.

Even if your patient is already pregnant, they can still undergo genetic carrier screening.

It is important to understand that it is different from non-invasive prenatal testing (NIPT), which assesses the chance of having a chromosome condition during each pregnancy. If your patient is not yet pregnant and find out they're a carrier of a single gene condition after completing genetic carrier screening, IVF and genetic testing of embryos may be one of the options offered to them.

10. Repromed's genetics team and clinical team are here to support your patients.

We understand that genetic carrier screening can raise a lot of questions and concerns. It's important to us that you're supported each step of the way.

That's why Repromed's At-Home Genetic Carrier Screening Test, comes with the support of our genetics team, including genetic pathologists and genetic counsellors. They can answer questions and help to understand what test results mean, and what a patients's reproductive options are. We also have a team of fertility clinicians who can help patients conceive if they find out they're a carrier of a single gene condition. Our genetics team is lead by our Medical Director of Genetics, Dr Tristan Hardy, who is Australia's only Fertility Specialist, Gynaecologist and Obstetrician who is dually trained as a Genetic Pathologist.

Your patients are not alone, we're here to help them every step on the way.

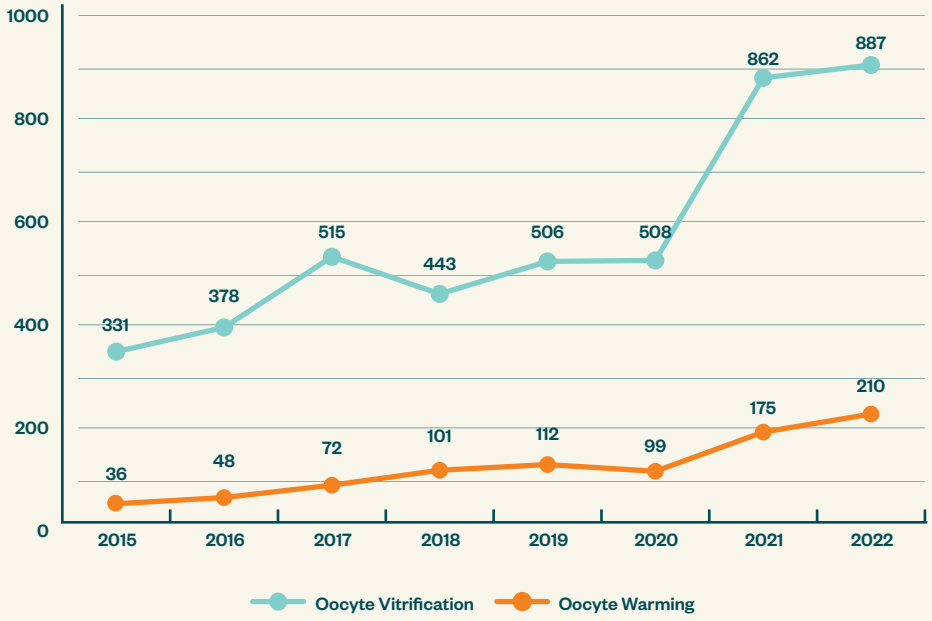
To order a kit scan this QR code or visit monashivf.com/genetic-testing

E geneticsadmin@monashivf.com
T 1800 684 198 (freecall)
monashivf.com
Repromed is a proud member of the Monash IVF Group.

"Egg freezing allows women to move forward knowing they have done everything possible to keep their reproductive options open."

Dr Juliette Koch
MBBS, FRANZCOG, CREI, MRepM

Senior Fertility Specialist & Gynaecologist



Elective egg freezing - how to counsel patients?

Elective oocyte cryopreservation is perhaps the fastest growing area in reproductive medicine.

Egg freezing enhances a woman's reproductive autonomy by allowing the capacity to delay childbearing and preserve the possibility of a biological child.

Its popularity as a treatment is due to a combination of increased efficacy (with the advent of vitrification or ultra-rapid freezing) and a changing population where long-term relationships are harder to achieve, societal pressures around career, finances and travel are increasing, and childbearing is being delayed. This is all happening in a digital age where celebrities like Jennifer Anniston and (sometimes incentivised) women of influence are baring all about their reproductive struggles, and the merits of egg freezing.

Women will see a GP or primary health professional to discuss egg freezing largely because they lack a stable relationship or other life benchmarks they believe are important before having a child.

Women considering egg freezing are motivated to provide for possible futures in which they could have the choice of a child once they have reached a period of stability and certainty. Freezing is seen by patients as a way to maintain control in an uncertain situation, where the timing and exact nature of a future reproductive relationship is unclear. In simple terms, freezing eggs allows women space to make important decisions about having children in their own time.

The decision to undergo egg freezing is complex and individual patient values play a significant role.

Sometimes counselling can also play an important role in helping women clarify their goals and make important decisions about reproductive choices.

When working with women to assist in their decision-making process the costs of freezing is of course important. Success rates are difficult to explain, because human nature is to want to know how many eggs can guarantee a baby. Unfortunately, this is not realistic, as a baby can never be guaranteed. Mathematical models have been published which allow a live birth rate to be calculated based on age at freezing and number of oocytes. The live birth rate for females who freeze their eggs at <35 years of age is approximately 5% per egg frozen, meaning they will need approximately 20 eggs to obtain 1 live birth. This may require several IVF cycles to achieve.

How effective is egg freezing?

Studies showed many women who undergo egg freezing do not return for IVF utilising the frozen eggs [1], which limits available data for frozen egg utilisation outcomes.

A recent study conducted by Repromed and Monash IVF clinicians and scientists; Dalton A, Pacella-Ince L, Filby A, Tremellen K, Zander-Fox D, Rombauts L, and Koch J, with n=>300 SA, NT, VIC patients, looked at eggs frozen between 2010-2021 and thawed between 2010-2021. Results showed that of the 3304 oocytes thawed and warmed, 619 created usable embryos. Average thaw survival was 90% and 3 out of 4 women had an embryo for transfer with pregnancy rates between 25%-30%.

Whilst pregnancy rates are not quite as good as fresh eggs, the results are promising.

Other studies comparing results of IVF using warmed cryopreserved eggs and fresh eggs reported a slightly smaller number of frozen eggs suitable for insemination but comparable fertilisation rate, pregnancy rate, and live birth rate [2].

It is also important to point out the serious but very rare health risks associated with egg freezing procedures, including being admitted with ovarian hyperstimulation, bleeding, or infective complications (occurring in less than 1% of egg freezing cycles).

Women should be made aware that the rate of genetically abnormal pregnancies increases with maternal age, however frozen eggs will give rates of embryonic aneuploidy consistent with the age at which the woman froze her eggs, not the age of use. Offspring born from frozen eggs appear to be as healthy as naturally conceived children, although their long-term health outcomes are unknown.

As women age, the number and quality of eggs produced during an egg freezing cycle will decrease, reducing their chances of a live birth. When considering egg freezing, women also need to know that there are many reasons why they may not need or wish to use their stored eggs in the future. A 10–15 year follow up study reported that 38% of women who had stored their eggs returned to use them. Worldwide the average age of egg freezing is 37 years, despite data indicating improved efficacy of the egg freeze procedure when it is performed prior to 35 years of age. It is perhaps not surprising that women who were older at the time of egg freeze returned sooner to use their eggs compared to those who froze their eggs at a younger age.

Counselling women about such an important medical decision can be challenging, and of course some women will experience decision regret, regardless of whether they decide to freeze or not. Providing a realistic assessment of their current and future reproductive status, and outlining the current status of egg freezing technology allows women to be empowered to make the right decision about whether egg freezing is right for them.

References:

1) Rodriguez-Wallberg KA, Marklund A, Lundberg F, Wikander I, Milenkovic M, Anastacio A, et al. A prospective study of women and girls undergoing fertility preservation due to oncologic and non-oncologic indicavtions in Sweden– Trends in patients' choices and benefit of the chosen methods after long-term follow up. Acta Obstet Gynecol Scand. 2019;98(5):604-15.
2) Walker Z, Lanes A, Ginsburg E. Oocyte cryopreservation review: outcomes of medical oocyte cryopreservation and planned oocyte cryopreservation. Reprod Biol Endocrinol. 2022;20(1):10-.

Professor Kelton Tremellen
MB BS(Hons) PhD
FRANZCOG CREI

SA Medical Director –
Repromed

Severe Azoospermia - options for reproduction

Types of Azoospermia

Obstructive Azoospermia (OA)
Due to a blockage; can be caused by past infection, prior surgery, congenital abnormalities (such as being a carrier of the cystic fibrosis gene which causes congenital bilateral absence of the vas deferens (CBAVD)). Here the serum hormones are generally normal (LH, FSH, testosterone).

Non-obstructive Azoospermia (NOA) (eg testicular maldescent, past chemotherapy, genetic condition)
More commonly now referred to as Azoospermia due to spermatogenic defect (ASD). This is due to an issue with sperm production, can be caused various factors such as hormones, genetics, medical conditions. This is further categorised into primary causes (at the testicular level) or secondary (such as at the hypothalamicpituitary level). Generally here the sperm FSH levels are higher and possibly testosterone may be lower.

Determining a man's fertility

The most effective way to assess a man's fertility is via a semen analysis. Semen analysis is also the most common base for all other laboratory male testing and is used to assess the concentration, motility and morphology of sperm.

If a semen analysis returns with no sperm?

You may wish to refer to a Fertility Specialist, Andrologist or Urologist at this point, who specialise in male infertility.

Follow-up tests to determine cause include serum hormones (LH / FSH / testosterone), scrotal ultrasound and genetic tests (karyotype, CF gene detection).

The initial recommendation is to repeat the semen analysis. This is best done in an andrology laboratory, with an extended search protocol. Further investigations are recommended to further identify the aetiology, such as genetic testing, hormonal profile and testicular ultrasound. If we are looking for sperm for the aim of ICSI, it may be recommended to proceed to surgical sperm retrieval.

A specialised Repromed clinician can offer the following options

Testicular Sperm Aspiration (TESA)
A needle is inserted into the testicle, and suction is applied to withdraw a small sample of testicular tissue. Any sperm can be isolated under a microscope. This is more commonly performed in cases of OA.

Testicular Sperm Extraction (TESE)
A surgical procedure whereby a piece of testicular tissue is removed via the scrotum. Any sperm can be isolated under a microscope. This is not frequently performed anymore due to the improved outcomes with MicroTESE.

Microdissection Testicular Sperm
Extraction (microTESE) This is a specialised micro-surgical technique used to retrieve sperm from the testicles of men with non-obstructive azoospermia. This is the gold standard approach to retrieval of sperm in NOA.

Expected recovery from needle surgical sperm retrieval

- Mild to moderate discomfort, recommend firm supportive underwear
- Icepacks to reduce swelling
- Analgesia, as required
- Usually performed as a day surgery procedure
- Expect to return to normal activities after 2-7 days

Management of azoospermia; includes MicroTESE, which is facilitated by Repromed through specialists in Melbourne.

Patients requiring a specialised Semen Analysis can contact Repromed.

Repromed have experienced andrology scientists at our NATA accredited andrology laboratory at Dulwich.

"Research tells us that of the couples struggling to fall pregnant, approximately 30% will be due to problems with sperm function [1]"

Reference:

1) Newman J, Paul R, Chambers G. Assisted reproduction technology in Australia and New Zealand 2020. National Perinatal Epidemiology and Statistics Unit (NPESU), the University of New South Wales Sydney, 2022.

Referring to Repromed for fertility services

When to refer

- Female age is < 35 and after 12 months of regular unprotected intercourse
- Female is > 35 and after 6 months of regular unprotected intercourse
- Irregular cycles
- Recurrent miscarriage (> 2 pregnancy losses)
- Genetic conditions
- Premature menopause
- History of PID, Endometriosis, STIs
- Fertiliity preservation
- Donor Program

How to refer

You can refer to a particular Repromed doctor or you can address the referral to 'Dear Doctor' and our New Patient Coordinators will allocate a doctor depending on your patient's clinical requirement, location of work or home. If you are referring a couple, please include both patients' names on the referral letter for Medicare rebates

We are proud to offer a complete range of in-house fertility services

Fertility health checks

- AMH (Anti-Mullerian Hormone) Test
- Semen Analysis
- Sperm DNA Damage Test
- Ultrasound
- Preconception Genetic Screening

Preliminary treatments

- Intercourse Timing
- Ovulation Induction
- IUI (Assisted Insemination)

IVF

- IVF (In Vitro Fertilisation)
- Embryo Freezing
- Sperm Retrieval

Preimplantation Genetic Testing

- PGT-A (for aneuploid embryos)
- PGT-M (for single gene disorders)
- PGT-SR (for structural chromosome reaarangements)

Fertility preservation

- Oncology Related Treatment
- Egg Freezing
- Sperm Freezing
- Embryo Freezing

Third party reproduction

- Donor Program - eggs / sperm / embryo
- Surrogacy

Book your place at our 2023 Reproductive Health Summit, Adelaide.

Hosted by Professor Kelton Tremellen, Medical Director – Repromed SA.

We're excited to be hosting our 2023 Reproductive Health Summit at SAHMRI - South Australian Health and Medical Research Institute this year.

Please join us for what will be an informative yet relaxed session where we will cover the gamut of fertility investigations and causes of sub-fertility impacting today's patients as well as how genetic testing can help improve the chances of conception.

The session will also include an open Q&A session with Professor Tremellen.

Where and when

Saturday 28 October 2023

8am for 8.30am start – 2.30pm

SAHMRI, North Terrace, Adelaide SA 5000

RSVP

As places are limited, please register by 23 October 2023 by scanning this QR code or visiting repromed.com.au/gp-seminars

Speaker panel

Professor Kelton Tremellen
Reproductive Endocrinology And Infertility Subspecialist

MB BS(Hons) PhD FRANZCOG CREI
SA Medical Director – Repromed

Professor Kelton Tremellen is a specialist Gynaecologist who also holds a sub-specialty qualification in Reproductive Endocrinology and Infertility as well as a PhD in Reproductive Immunology at the University of Adelaide.

Professor Tremellen has an active research interest in the fields of oxidative stress as a cause of male infertility, immune mediated implantation failure, ovarian reserve and the effect of nutritional supplements on fertility.

Well accomplished in the field of fertility management, he has also authored over 160 articles on the topics of reproduction, reproductive endocrinology and andrology.

Dr Juliette Koch
MBBS, FRANZCOG, CREI, MRepM
Senior Fertility Specialist & Gynaecologist
Repromed - SA

Dr Ray Yoong
MBChB, FRANZCOG, MRepM
Senior Fertility Specialist & Gynaecologist
Repromed - SA

Dr Tristan Hardy
MBBS (Hons), MRMed, PhD, FRANZCOG, FRCPA
Medical Director Genetics,
Monash IVF Group

Dr Leanne Pacella-Ince
BHSc (Hons), PhD
Scientific Director, Repromed

Agenda

8.00am	**Registration** Welcome coffee & pastries
8.30 am	Summit Begins
8.45am – 9.15am	Fertility work-ups prior to referring to a Fertility Specialist & non IVF treatment options - Professor Kelton Tremellen
9.15am – 10.00am	Navigating fertility preservation – patient pathways - Dr Juliette Koch
10.00am – 10.15am	**Break for refreshments**
10.15am – 11.00am	Genetic Carrier Screening – what is it & why is it important in family planning - Dr Tristan Hardy
11.00am – 11.45am	Endometriosis - a common fertility hurdle - Dr Ray Yoong
11.45am – 12.15pm	Creating families with donor eggs, sperm or embryos - Dr Leanne Pacella-Ince
12.15pm – 12.45pm	**Break for lunch**
12.45pm – 1.15pm	Investigations and management when routine IVF isn't working - Professor Kelton Tremellen
1.15pm – 2.00pm	Through the lab - the journey of gametes to embryos - Dr Leanne Pacella-Ince
2.00pm – 2.30pm	Q&A panel discussion with Professor Kelton Tremellen
2.30pm	Close

South Australia

enquiries@repromed.com.au

Adelaide

180 Fullarton Road
Dulwich, SA 5065
T: 08 8333 8111
F: 08 8333 8188

Mawson Lakes

8b Light Common
Mawson Lakes, SA 5095
T: 08 8333 8111
F: 08 8333 8188

Also consulting in

- Morphett Vale
- Mount Barker
- Mount Gambier
- Port Lincoln

Northern Territory

darwin@repromed.com.au

Darwin

Harry's Place
Administration Building
Willeroo Street
Tiwi, NT 0810
T: 08 8945 4211
F: 08 8945 4255

Also consulting in

- Alice Springs

repromed