AETIOLOGY AND TREATMENT OF INFERTILITY

INVESTIGATIONS

1. As per clerking sheet for female MR 053.01 and male MR 053.02.
2. A minimum male investigation is a semen analysis.
3. Hepatitis B, hepatitis C and HIV from both partners.
4. The minimum female investigations are:
   - baseline early follicular phase pelvic ultrasound examination
   - hormonal profile – luteinising hormone, follicle-stimulating hormone, progesterone, prolactin, thyroid function test
   - rubella status
   - to determine ovulatory status serum hormonal tracking, plus or minus mid-cycle follicle ultrasound scan

HYSTEROSALPINGOGRAM (HSG)
Anovulatory women with no history suggestive of pelvic pathology require a hysterosalpingogram.

- HSG is performed in the follicular phase and couples are informed to avoid the chance of conception in this cycle.
- On the day of the procedure commence antibiotic prophylaxis:
  - metronidazole 500mg three times a day
  - doxycycline 100mg twice daily
- Give analgesia pre-procedure - Voltaren 75mg if no allergy to NSAIDs.

CONFIRMATION OF POLYCYSTIC OVARIAN SYNDROME (PCOS)
PCOS is confirmed by the presence of two or more of the following:
1. Clinical or biochemical hyperandrogenaemia.
2. Oligo/anovulation
3. Ultrasound appearance of polycystic ovaries
All women with PCOS should have fasting insulin, lipids and androgens performed.
Women with or suspected of having PCOS should have a formal glucose tolerance test, lipids and triglycerides measured if their body mass index (BMI) is over 28.

LAPAROSCOPY AND DYE HYDROTUBATION AND HYSTEROSCOPY
All other women including otherwise unexplained infertility will require a laparoscopy and dye hydrotubation and hysteroscopy. Consent the woman for any possible treatment to any pathology found especially as this treatment is likely to improve their fertility (e.g. adhesiolysis or treatment of mild endometriosis). This is under antibiotic prophylaxis and concurrent treatment of minimal and mild endometriosis and minor pelvic adhesions.

At laparoscopy full description of the fallopian tubes, fimbriae, adhesions and endometriosis by AFS scoring should be performed. Isolated proximal tubal obstruction may be treated by hysteroscopic tubal cannulation.
EXCLUSIONS

1. Women who may have a significant chance of severe adhesions (due to the risk of laparoscopic injury). These women should have a hysterosalpingogram.

2. Women with a BMI over 35 should not be commenced on the series of investigations but should be encouraged to lose weight and referred to the dietitian. Investigations may be introduced slowly in women showing a gradual reduction in weight.

Formal infertility treatment should not ideally be begun until the BMI is below 30. However, in consultation with the team of other consultants, women who have achieved a weight loss of more than 10% may be considered for treatment.

ADVICE

At the first visit advice will be given regarding:

- folate administration
- stopping smoking
- regular exercise - 45 minutes of exercise on alternate days
- weight loss.
- appropriate alcohol intake.

Appropriate patients may be referred to our infertility counsellor.

TREATMENT

A couple may be directly referred for IVF if:

- the woman is nulliparous and under 37 years of age and meets the criteria for referral
  or
- has been trying to conceive for more than five years
  or
- has more than one factor involved in sub-fertility directly,

  providing they fulfil IVF referral criteria (see Clinical Guideline Management and referral for Invitro Fertilisation IVF).

REFERENCES (STANDARDS)

| National Standards – 1- Care provided by the clinical workforce is guided by current best practice |
| Legislation - Nil |
| Related Policies - Nil |
| Other related documents – Nil |

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Do not keep printed versions of guidelines as currency of information cannot be guaranteed.

Access the current version from the WNHS website.