Welcome to the July 2015 Fertility Flash newsletter from Medfem Fertility Clinic.

In this issue we are putting a big focus on Ovulation and everything you should know about your fertile time of the month. We have also included in-depth information on Tubal Disease and Infertility – a very common problem for many couples.

Our very own Dr Rodrigues attended the recent ESHRE conference in Portugal and has provided insights on some of the lectures.

And lastly, a beautiful poem from Angela Miller on baby loss.

We would love to hear your feedback, as well as topics you would like to see covered in future issues. We can be emailed at communications@medfem.co.za

From all at Medfem Fertility Clinic

Inside Every Hero, There’s a Million More.

Medfem Fertility Clinic is currently recruiting sperm donors from all ethnic groups. If you are a healthy non-smoking male between the ages of 21 – 40, give us a call! (011) 463 2244
Welcome to our new team members – it is a pleasure to have you join the Medfem family

Sr. Christina Cross

Marie Brits, Lab Assistant

Sr. Eleanor Magardie
My wife, Mandy Rodrigues and I had the pleasure of attending the ESHRE congress held recently in Lisbon. ESHRE is the European Society of Human Reproduction and Embryology, and its main aim is to promote interest in, and understanding of, reproductive biology and medicine.

This is a summary of some of the papers presented at the conference to allow infertility patients insight into the latest thought processes.

It was really fantastic to see that the keynote address was related to stress as a cause of infertility. Medfem Fertility Clinic has studied stress and its role in infertility for the last 17 years. This study emphasises the need to manage stress as an added tool to improving fertility. I have included the full paper of this address.

Kindest regards

Dr. Tony Rodrigues

KEYNOTE ADDRESS:
Preconception stress increases the risk of infertility: results from a couple-based prospective cohort study, the LIFE study

Study question: Are women's stress levels prospectively associated with fecundity and infertility?

Summary answer: Higher levels of stress as measured by salivary alpha-amylase are associated with a longer time-to-pregnancy (TTP) and an increased risk of infertility.

What is known already: Data suggest that stress and reproduction are interrelated; however, the directionality of that association is unclear.

Study design, size, duration: In 2005-2009, we enrolled 501 couples preconceptionally in a prospective cohort study in Michigan and Texas, USA. Couples were followed for up to 12 months and through pregnancy if it occurred. A total of 401 (80%) couples completed the study and 373 (93%) had complete data available for this analysis.

Participants/materials, setting, methods: Enrolled women collected saliva the morning following enrolment and then the morning following their first observed study menses for the measurement of cortisol and alpha-amylase, which are biomarkers of stress. TTP was measured in cycles. Covariate data were captured on both a baseline questionnaire and daily journals.

Main results and the role of chance: Among the 401 (80%) women who completed the protocol, 347 (87%) became pregnant and 54 (13%) did not. After adjustment for female age, race, income, and use of alcohol, caffeine, and cigarettes while trying to conceive, women in the highest tertile of alpha-amylase exhibited a 29% reduction in fecundity (longer TTP) compared with women in the lowest tertile [fecundability odds ratio =0.71; 95% confidence interval (CI)=(0.51, 1.00); p<0.05]. This reduction in fecundity translated into a more than two-fold increased risk of infertility among women these women [Relative Risk=2.07; 95% CI=(1.04, 4.11)]. In contrast, we found no association between salivary cortisol and fecundability.

For more information on stress and infertility and its management go to www.tups.co

Time Urgency Perfectionism Stress
The TUPS STRESS PROGRAM has guided so many TUPS sufferers towards an amazing life long solution on how to manage and prevent the symptoms and diseases that stress causes.

Let the TUPS App guide you to the same life long happiness.
Embryo quality scoring: A correlation between trophoderm development and aneuploidy rate in developing blastocysts.
J. Blazek, M. Large, V. Pham, M. Hughes, T. Gordon. Genesis Genetics, R&D/PGS, Houston TX, U.S.A.

Study question: Blastocysts cultured for IVF are graded based on stage of hatching and organization of the inner cell mass and trophoderm. Common practice is to implant embryos based on quality score in cases where preimplantation genetic screening (PGS) is not used. Is blastocyst embryo quality score correlated with chromosomal ploidy?

Summary answer: PGS is critical to improving success rates in implantation and live birth during IVF. In cases where PGS is not used prior to implantation, embryo quality score can be used to determine the likelihood of embryo aneuploidy based on strong correlations between embryo aneuploidy and in vitro trophoderm development.

TAKE HOME MESSAGE: The outside layer of the embryo is called the trophoderm. The analysis of this layer is the best predictor of the potential normality of embryos.

Endometrial biopsy prior to assisted reproductive techniques (ART) does not improve treatment outcome in unselected patients
L. Polanski, M. Baumgarten, A. Richardson, K. Sewell, J. Brosens, S. Quenby, B. Campbell, N. Raine-Fenning. University of Nottingham, School of Medicine, Nottingham, United Kingdom.

Study question
Does a timed mid-luteal phase endometrial biopsy (EB) affect the chances of a clinical pregnancy in an unselected population of women undergoing ART in the next menstrual cycle?

Summary answer: EB performed in the mid-luteal phase of the menstrual cycle does not increase clinical pregnancy rates in an unselected group of women undergoing ART.

TAKE HOME MESSAGE: Endometrial scratching does not increase pregnancy rates if you perform it on every patient. There may be a place in women with recurrent failed IVF cycles.

Study question: Can laser-assisted hatching of the zona pellucida (ZP) positively affect pregnancy outcome of frozen-thawed cleavage stage embryos?

Summary answer: Performing assisted hatching (AH) on frozen-thawed cleavage stage embryos prior to ET in women above 35 years was shown to reduce clinical pregnancy rate, to increase chemical pregnancy and missed abortion rates. No significant effect of AH was shown regarding those parameters in women below 35 years.

TAKE HOME MESSAGE: Assisted hatching of thawed frozen embryo’s in women older than 35 had a negative effect on the overall outcome.
Perinatal outcomes following stimulated versus natural cycle IVF: analysis of 90,980 singleton live births following stimulated and unstimulated IVF

S. Sunkara, P. Seed, Y. Khalaf. Aberdeen Fertility Clinic, Aberdeen Maternity Hospital University of Aberdeen, Aberdeen, United Kingdom.

**Study question:** Does ovarian stimulation affect perinatal outcomes such as preterm birth (PTB) and low birth weight (LBW) following IVF treatment.

**Summary answer:** There was no increase in the risk of adverse perinatal outcomes of PTB, early PTB, LBW and very LBW following acceptable limits of ovarian stimulation (≤ 20 oocytes retrieved) compared to unstimulated IVF treatment.

**TAKE HOME MESSAGE:** Pregnancies resulting from assisted reproductive treatments (ART) are associated with a higher risk of pregnancy complications compared to spontaneously conceived pregnancies. This study shows that these risks are not related to the medication used. It may be that whatever causes the fertility problems, may in fact also cause pregnancy complications.

Efficacy of Dehydroepiandrosterone (DHEA) to overcome the effect of ovarian ageing (DITTO): A double blinded Randomized placebo Controlled Trial

K. Jayaprakasa1, A. Narkwichean, W. Maalouf, M. Baumgartean, L. Polanski, N. Raine-Fenning, L. Zujovic, J. Thornton, B. Campbell. NURTURE University of Nottingham & Royal Derby Hospital, Reproductive Medicine, Nottingham & Derby, United Kingdom.

**Study question:** To evaluate the effect of pre-treatment DHEA supplementation on the outcome of In-Vitro Fertilisation (IVF) treatment in women predicted to have poor Ovarian Reserve (OR).

**Summary answer:** Pre-treatment DHEA supplementation doesn't seem to improve the ovarian response as measured by the number of oocytes retrieved or clinical pregnancy rates during IVF treatment in women predicted to have poor OR.

**TAKE HOME MESSAGE:** DHEA does not increase pregnancy rates in patients who are older and who are poor responders.

Study question: Does AMH predict the chances of natural conception and time to conception in women with unknown fertility status?

**Summary answer:** AMH does not predict the chances of conception in women <40 years and the time to conception independently from the age of women. AMH predicts the chances of conception in women aged 40 years or older.

**TAKE HOME MESSAGE:** AMH levels in women <40 years does not have a predictive value to achieving a pregnancy.
**Study question:** Is the periconceptional thyroid stimulating hormone (TSH) level in women undergoing in vitro fertilization/ intracytoplasmic sperm injection (IVF/ICSI) correlated with pregnancy outcome in terms of implantation, biochemical pregnancy, clinical pregnancy, miscarriage, live birth and pregnancy complications?

**Summary answer:** In women with a normal body mass index (BMI) who underwent IVF/ICSI, a periconceptional TSH level of ≥2.5 mU/L is correlated with a 3.8-fold increase in risk of miscarriage.

**TAKE HOME MESSAGE:** It’s important to treat pre-clinical thyroid disease to optimize fertility outcome.

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**Study question:** Does obesity affects male fertility potentials?

**Summary answer:** BMI was proved, in this study, to have a significant effect on sperm concentration.

**TAKE HOME MESSAGE:** The lifestyle of men including their eating habits influence sperm concentrations and sperm quality.

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**Study question:** Is there an association between ovarian response in IVF treatment and the risk of a trisomic pregnancy resulting from that treatment?

**Summary answer:** Subfertile women with a poor response in IVF treatment are not at a higher risk of a trisomic pregnancy resulting from this IVF treatment.

**TAKE HOME MESSAGE:** Women with low AMH levels or are older and have a poor response to stimulation are not at a higher risk for having babies with abnormal chromosomes.

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**Study question:** The aim of the present study was to evaluate the effect of Myo-inositol (INOFOCUCJ) on ovarian function in poor responders patients undergoing ovulation induction for ICSI cycle.

**Summary answer:** The results suggest that myo-inositol may improve ovarian response to stimulation in poor responder patients.

**TAKE HOME MESSAGE:** Inofolic use for 3 months before IVF in poor responder patients may improve ovarian response.
Apart from being healthy, what might help you get pregnant? Knowing the right time to have intercourse.

**The fertile window**
The fertile window is the days in a woman’s menstrual cycle where pregnancy is possible. Technically, pregnancy is only possible during the five days before the woman ovulates to the day of ovulation itself. This is because the lifespan of sperm is only five days maximum, while the lifespan of the ovum is 24 hours.

The best chance of conceiving is from having intercourse in the two to three days preceding ovulation and including the day of ovulation. Once ovulation has occurred the probability of pregnancy declines rapidly, and within 12 to 24 hours the woman will no longer be able to get pregnant during that cycle.

If a woman has sex on any of these three days, she has a 15-25% chance of becoming pregnant.

**What is ovulation?**
Ovulation is when a mature egg is released from the ovary, moves down the fallopian tube, and is available in the fallopian tube to be fertilised.

**Tracking your ovulation**
- Work out the length of your average menstrual cycle. Day one is the first day of the menstrual period and the last day is the day before the next period begins.
- Ovulation happens about two weeks before the next expected period. So if your average menstrual cycle is 28 days, you should ovulate around day 14.

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**Estimated Likelihood of Conceiving On Days of the Menstrual Cycle Relative to the Day of Ovulation**

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Women’s Guide to Ovulation

Remember the ‘fertile window’ is the six days leading up to and including ovulation. The three days leading up to and including ovulation are the most fertile. Depending on your cycle length the most fertile days in the cycle varies:

- If you have 28 days between periods ovulation typically happens on day 14, and the most fertile days are days 12, 13, and 14.
- If you have longer cycles, say 35 days between periods, ovulation happens on day 21 and the most fertile days are days 19, 20, and 21.
- If you have shorter cycles, say 21 days between periods, ovulation happens on day 7 and the most fertile days are days 5, 6, and 7.

How do you know you’re ovulating?
Women’s cycles can vary, so to know that you are ovulating and on which day of your cycle you are ovulating, observe your fertility signs throughout your cycle and record them on a chart.

The most accurate methods of working out when ovulation is about to occur are:

- Keep an eye out for changes in your mucus. Around the time of ovulation, you may notice your vagina’s mucus is clear, slick and slippery, the consistency of egg white. This is the best sign of when ovulation is actually happening.
- Use an ovulation predictor kit. You can start testing with your ovulation predictor kit a few days before your estimated day of ovulation. Subtract 17 days from your average cycle length and start testing from this day of your cycle, e.g. if you have a 28 day cycle, you would start testing from day 11. A positive result means you are going to ovulate within the next 24 to 36 hours.
- Record your basal body temperature (BBT) each day before getting out of bed. A special basal body temperature thermometer will ensure accurate measurement. Your BBT rises about half a degree Celsius after ovulation has occurred. By charting your temperature, it’s easy to see when the rise in temperature and ovulation happens. This can help you work out your own pattern of ovulation. However, because at that stage ovulation has already passed, it does not help you pinpoint the fertile window but may guide you for next month.

The best time to try and conceive is during the ‘fertile window’ of the menstrual cycle; this is different for different women.

Anovulation
Anovulation is the failure of the ovary to release an egg (oocyte) over a period of time generally exceeding 3 months. Normal ovulation occurs monthly from alternating ovaries. The normal functioning ovary releases one ovum every 25-28 days. The oocyte develops in a small fluid collection in the ovary called a “follicle” and ovulation occurs when this follicle ruptures. Usually one oocyte is released every month. A small gland in the base of the brain called the "pituitary gland" regulates ovulation. This average time between ovulation events is variable, especially during puberty and the peri-menopause period. For non-pregnant women aged 16–40 anovulation is considered abnormal and a cause of infertility in approximately 30% of fertility patients.

Usually, women with anovulation will have irregular periods. Or, in the worst case, they may not get their cycles at all. If your cycles are shorter than 21 days, or longer than 36 days, you may have ovulatory dysfunction. Also, if your cycles fall within the normal range of 21 to 36 days, but the length of your cycles varies widely from month to month, that may also be a sign of ovulatory dysfunction. (For example, one month your period is 22 days, the next it's 35). It is possible to get your cycles on an almost normal schedule and not ovulate, though this isn't common.

How Does Anovulation and Ovulatory Dysfunction Cause Infertility?
For a couple without infertility, the chances of conception are about 25% each month in women under 35 years of age. So even when ovulation happens, conception is not guaranteed.

When a woman is anovulatory, she can't get pregnant because there is no egg to be fertilised. If a woman has irregular ovulation, she has fewer chances to conceive, since she ovulates less frequently.
Women’s Guide to Ovulation

Plus, it seems that late ovulation doesn't produce the best quality eggs, which may also make fertilisation less likely.

It's also important to remember that irregular ovulation means the hormones in the woman's body aren't quite right. These hormonal irregularities can sometimes lead to other issues, like lack of fertile cervical mucus, thinner or over thickening of the endometrium (where the fertilised egg needs to implant), abnormally low levels of progesterone, and a shorter luteal phase.

What Causes Anovulation?
Anovulation and ovulatory dysfunction can be caused by a number of factors. The most common cause of ovulatory dysfunction is polycystic ovarian syndrome, PCOS. Other potential causes of irregular or absent ovulation include:
• Obesity
• Too low body weight
• Extreme exercise
• Hyperprolactinemia
• Premature ovarian failure
• Perimenopause, or low ovarian reserves
• Thyroid dysfunction (either hyperthyroidism or hypothyroidism)
• Extremely high levels of stress

What are the Potential Treatments for Anovulation?
Treatment will depend on the cause of the anovulation. Some cases of anovulation can be treated by lifestyle change or diet. The most common treatment for anovulation are fertility drugs. Usually, Clomid (clomiphene citrate) is the first fertility drug tried. Clomid can trigger ovulation in 80% of anovulatory women, and help about 45% get pregnant within six months of treatment. For women with PCOS, insulin sensitising drugs such as Glucophage (metformin) that may help a woman start ovulating again. Usually, six months of treatment is required before you'll know if the particular drug you have been prescribed will work.

If the cause of anovulation is premature ovarian failure, or low ovarian reserves, then fertility drugs are less likely to work. In that case, your doctor may suggest using an egg donor, or an alternative family building option like adoption.

How is Anovulation Diagnosed?
You may be slightly confused by the outcome of your self-assessment of ovulation. Do not despair even your doctor may be uncertain when you present the results of especially the basal body temperature chart. Special investigations will shed more light in doubtful cases.
• Serum progesterone assessment: The pathologist takes blood on request from your doctor approximately 7 days after ovulation for progesterone assessment. There are different views on what the minimum normal ovulatory levels are. Usually a level of more than 30 nmol/l is regarded as an optimal result.
• Ultrasound evaluation: Examination of your ovaries before and after ovulation to detect the presence of a follicle and its subsequent disappearance is the best way of assessing ovulation since ovulation day can be accurately predicted once the size of the follicle is known. However, you will only find adequate ultrasound equipment for this purpose at infertility Clinics and some Gynaecologists' consulting rooms.
• Endometrial biopsy: This relatively painful procedure is only rarely performed by your doctor to identify subtle hormonal disorders associated with ovulation abnormalities. A small sample of the uterine lining is obtained by means of a thin plastic needle and is assessed by a Pathologist.

Important Facts
• Ovulation does not equal pregnancy. If everything is normal and you have intercourse at exactly the right time the chance of pregnancy is roughly 25%!!!
• The best way for you to determine the optimal time for conception is by evaluating your cervical mucus by means of the Billings method. Your finger is placed through the vagina until the cervix is touched (feels like the tip of your nose). The mucus is then examined by rolling your forefinger and thumb together and stretching the mucus as far as possible. When the mucus is clear, stretchable and slippery ovulation is close.
• Do not think that by abstaining in order to “get the sperm build up” will improve your chances. Indeed, abstinence for more than 2 – 3 days may be disastrous for sperm quality in certain circumstances.
Easy for you to say God needed another angel—
since God didn’t ask you for yours.
Easy for you to say God has a plan—
if all of God’s plans for you have precisely tailgated your own like a lovely fairy tale.
Easy for you to say everything happens for a reason—
please tell me one good reason my son is forever buried deep underground?
Easy for you to say trust God—
if you’ve never felt betrayed by the heavens themselves.
Easy for you to say hang on to hope—
if you can still find your rope.
Easy for you to say time heals all wounds—
if time has already made perfect heart-shaped scabs of yours.
Easy for you to say be thankful for what you have—
would you like to switch places with me and feel how little I have left?
Easy for you to say God needed another flower for his garden—
if none of your ‘flowers’ have ever been plucked before their time.
Easy for you to say find peace and move on—
if you haven’t had to hold your dead child’s hand inside the curves of your living one.
Easy for you to say he’s in a better place—
if you still get to hold your child in the best place there is.
Easy for you to say you’re young, you can have more—
would you be willing to exchange your living child for those you might someday have?
Easy for you to say every cloud has a silver lining—
if you haven’t been asked to walk through this never-ending storm of mine.
Easy for you to say it was God’s will—
if the plan you got currently includes all of your children rambunctiously romping around your living room.

by Angela Miller
Tubal disease can cause infertility due to a blockage of one or both of the fallopian tubes. These tubes are the "roadway" for the sperm to find and fertilise the egg. Tubes can be damaged and blocked due to a variety of reasons. Infection from either a gynaecologic infection (such as Chlamydia) or gastrointestinal source (such as appendicitis, infection in the intestines, etc.) can block one or both tubes. Also prior surgery can create adhesions (scar tissue) that prevent the tubes from working properly. Other conditions such as endometriosis can also damage the tube(s).

In natural unassisted conception, the fallopian tubes play an integral part in establishing pregnancy. First, an egg which is ovulated from the adjacent ovary must be picked up by the finger-like projections at the end of the tube. The ovulated egg is safe-guarded in the ampullary segment of the tube until it is fertilised by sperm. The tube nurtures the resulting embryo for the next five days as it traverses the length of the tube before entering the uterus. Tubal factor infertility pertains to tubal damage which precludes interaction between egg and sperm and/or prevents the proper movement of embryos along the tube for uterine implantation.

The fallopian tubes are delicate structures of only about the same thickness as the lead of a pencil. Because of this they can easily become blocked or damaged. This can interfere with the sperm reaching the egg, and a proper embryo development and implantation in the uterus. Blockages may arise as a result of scarring due to infection or previous abdominal surgery.

Pelvic inflammatory disease (PID) is usually the main cause of tubal infertility. In addition PID is associated with an increased risk of subsequent ectopic pregnancy (when the fertilised egg implants in the fallopian tube instead of the uterus).

What the Fallopian tubes do
- To "grab" the oocyte as soon as it is released from the ovary at the time of ovulation. To perform this function the fallopian tubes must be freely movable and must not be stuck to the pelvic wall, uterus or ovaries by adhesions.
- To function as an incubator where the oocyte and sperm meet and the initial stages of embryo development takes place. For this function the tubes must be patent (open).

The inside lining of the fallopian tubes act as a conveyor system moving the developing embryo to the uterus where it implants 3 - 5 days after ovulation.

Causes of Fallopian Tube damage
- The use of the intra-uterine contraceptive device (contraceptive "loop") especially when there is more than one sexual partner.
- Sexually transmittable disease such as gonorrhoea resulting in infection of the fallopian tubes.
- Previous pelvic surgery especially when the fallopian tubes or ovaries were involved.
- Endometriosis.

Diagnosis
The diagnosis of tubal damage is established with a pelvic x-ray called a hysterosalpingogram (HSG). The test involves the injection of dye into the uterine cavity and a simultaneous x-ray of the uterus and tubes, which illustrates the dispersion of dye through the pelvic organs.

Treatment
- Tubal surgery: When tubal surgery is indicated the laparoscopic route is also usually more preferable to "open surgery". The feasibility for the surgery depends on the severity of tubal damage and the position where the Fallopian tube is damaged. A competent infertility specialist is absolutely essential to perform tubal surgery effectively.
- In Vitro-Fertilisation: If tubal surgery is not feasible due to extensive tubal damage, In Vitro-Fertilisation is the only option. Please read about IVF under infertility treatments.

Damage to the Fallopian Tubes includes:
- Total blockage preventing sperm and oocytes to meet and to produce an embryo.
- Reduced mobility which results in the inability of the fallopian tube to pick up the egg when it is released from the ovary.
- Damage to the inside wall of the fallopian tube which results in the inability of the embryo to move down to the uterus. This may result in an ectopic pregnancy if the embryo attaches to the side wall of the fallopian tube resulting in rupturing of the tube at about seven weeks pregnancy duration.

Medfem Fertility Clinic offers both advanced microsurgical treatments as well as in vitro fertilisation as therapy for tubal factor infertility.
Most people take it for granted that they’ll have children one day. Yet one in six couples is infertile. Approximately 40% of this unfortunate event is due to male factor infertility. Azoospermia (no sperm present) may exist from birth or may have developed later on in life due to illness, injury, or surgery (including cancer treatments, hormonal problems, cystic fibrosis, mumps, obstruction to the ducts leading out from the testis, ejaculation issues, paralysis, sperm antibodies, and much more).

Assisted reproductive treatment (ART) using donor gametes, has provided new opportunities for treating infertile couples, single women and same-sex couples. Sperm banking or more formally referred to as sperm cryopreservation has become one of the major assisted reproductive treatments.

As a sperm donor you are only allowed by law to donate at any one institution, and can have only five live births resulting from your sperm. You have the right to indicate to whom you would like to donate your sperm to e.g. marital status of the receiving couple, ethnic grouping, sexual preference, and religion.

Non-smoking men, between the ages of 21 and 40, who hold a matric qualification and higher are invited to donate their sperm. We require sperm donations from all ethnic groups. If you would like to become a sperm donor at Medfem Fertility Clinic, we invite you to set up an appointment with us.

Medfem Fertility Clinic is currently recruiting sperm donors from all ethnic groups. If you are a healthy non-smoking male between the ages of 21 – 40, give us a call! (011) 463 2244

Inside Every Hero, There’s a Million More.

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Endometriosis

South Africa is a national organisation providing information and support to those living with this chronic condition. Endometriosis South Africa has been created especially for South African women living with this chronic disease and hopes to soon become a recognised and credible organisation whose major goal is to provide education and build a network of support.

http://www.endpain.co.za/

Endometriosis Warriors South Africa is a Facebook support group for women suffering from endometriosis. If you or a loved one suffer from endometriosis this group may add much needed support and understanding.

IFAASA, the Infertility Awareness Association of South Africa NPC, is a non-profit organisation that aims to break the silence for those suffering from infertility by supporting Southern Africans living with reproductive health issues through education and advocacy, and by educating the public about reproductive diseases.

IFAASA is the only South African NPC dedicated to educating and advocating for those suffering from infertility.

Endometriosis

South Africa

We Can Do It!

Volunteers Required

Do you have a passion for anything infertility related? If yes, we may just need your assistance!

We really need help with the following (but not limited to):

- Public Relations
- Graphic Design
- Legal Work
- Events Management
- Sponsorship
- Website Development
- Finance/Accounting

Email megan@ifaasa.co.za

"Strength doesn't come from what you can do. It comes from overcoming things you thought you couldn't."

#Manyfacesofendo South Africa
When to Test for Infertility

We believe that anyone worried about their fertility should take immediate steps to have their situation assessed. Immediate evaluation and treatment of infertility is warranted in cases of known problems such as anovulation, tubal occlusion, and severe male factor infertility. Otherwise the standard guideline is that an evaluation of infertility is warranted for a couple when the female partner is older than 35 and has been trying to conceive for 6 months without success. It is also indicated if the female partner is 35 years of age or less after the couple has been trying to conceive for one year. We also must be aggressive in evaluating and treating women 40 years and greater because of the increased potential for significant loss of ovarian reserve in this age group.

For further information on Infertility Testing visit http://www.medfem.co.za/where-to-start

Facebook? Blog? Pinterest?

Social media is changing how Medfem Fertility Clinic connects with the world. We can now be found on Facebook, Pinterest, Youtube, Linked-In and Google+. Along with our new website, we’ve launched a blog to talk about current fertility topics. Visit www.medfem.co.za for quick links to our social media pages and our informative blog. Following us on Facebook will allow you to stay informed about our latest articles, events and more.

Latest Blog Posts

- World Infertility Awareness Month
- Men’s Health Awareness Month
- Tips to Increase Fertility for Men
- International Cancer Survivors Day
- Infertility Treatments Raise Relapse Rates in Women with Multiple Sclerosis
- Smoking Causes Infertility
- Poor Thyroid Function Could Be Impacting Your Fertility

Patient Testimonials

Tell us your Medfem Fertility Clinic story! We would love to share your experience of how Medfem helped grow your family. Please know that all testimonials will be posted anonymously, unless you give us permission to use your name. Email us at: communications@medfem.co.za

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Medfem Fertility Clinic
Cnr Nursery and Peter, Bryanston, Gauteng, South Africa
Telephone: +27 11 463 2244
Email: info@medfem.co.za
Website: www.medfem.co.za