

# Reproductive Care Center

## OOCYTE (EGG) DONATION RECIPIENT INFORMED CONSENT

### INTRODUCTION

In vitro fertilization (IVF) resulted in the world's first human birth reported in 1978. Donated female gametes (oocyte/egg donation) to treat certain types of female reproductive failure were used to produce a birth in 1984. The recipient couple must be married and the wife must be 18-55 years old without medical contraindications to pregnancy or labor and delivery of a pregnancy.

The egg donation process involves several steps for both the egg donor and the egg recipient.

- Recruitment and screening of egg donors followed by matching donors with recipients. In some cases, we perform screening tests after matching the donor with a recipient.
- Preparation of wife's uterus to achieve synchrony with the egg donor's stimulated cycle.
- IVF treatment of the egg donor.
- Sperm collection from the recipient woman's husband or sperm donor followed by insemination of eggs.
- Embryo culture and transfer into the recipient woman's uterus.
- Cryopreservation of surplus/excess embryos.
- The IVF process induces psychological stress and we refer patients for psychological counseling whenever patients request help or we feel it would be useful.

### EGG DONOR MATCHING

Reproductive Care Center (RCC) provided you with a list of egg donors available from our center. Information regarding the donors includes non-identifying medical, genetic and physical characteristics. Alternatively, recipients choose egg donors from other donor agencies or they bring their own known donor into the program. RCC cannot guarantee the accuracy of the information provided by the egg donors.

RCC's donor program includes sole-match cycles or split-match cycles. Each cycle type has different fees, responsibilities and obligations. A sole-match cycle matches one egg donor with one recipient woman. All eggs retrieved in that cycle become the property of the recipient woman and her husband. A split-match cycle matches one egg donor simultaneously with two recipient women. The retrieved eggs from a single split-match cycle are divided between the two recipient women and their husbands. In the event of very few eggs from retrieval, the recipient designated as the primary recipient becomes the owner of all the eggs.

### RISKS AND COMPLICATIONS

#### PREPARATION OF RECIPIENT WOMAN'S UTERUS

Hormone manipulation achieves synchrony between the donor and recipient's menstrual cycles. Controlled endometrial development (CED) describes the use of oral contraceptives (OC), GnRH agonists, estrogen, and progesterone hormones to achieve synchrony with the egg donor's cycle and stimulation of the endometrium to prepare it for implantation of an embryo. Transvaginal ultrasound and blood hormone levels monitor the endometrial response to CED. Occasionally, the endometrium does not respond to hormone stimulation and all the embryos must be cryopreserved.

#### DONOR IVF PROCEDURE

The IVF/ET process occurs in stages through outpatient visits. While the egg donor assumes the physical risks of IVF, you assume the risks associated with IVF that lead to low or poor egg formation. Consequently, the following summary of IVF focuses on aspects of the egg donors IVF cycle that affects you.

**Ovarian Stimulation:** The drugs and doses used for ovarian stimulation vary depending on medical and related factors. Most side effects are minor but an allergic reaction to any of the drugs is always possible. Rarely, a side effect could lead to cycle cancellation. RCC cannot guarantee the number or quality of eggs produced from stimulation.

Following embryo transfer (ET), we require progesterone supplements until the pregnancy test or for an additional 8 weeks if the woman is pregnant. Progesterone administration by injection often causes discomfort and swelling at the injection site for some weeks after stopping the injections. Vaginal progesterone may cause irritation and/or discharge. Despite some product labeling, all progesterone products recommended by our clinic are generally considered safe and effective during pregnancy. Only one of the products has received specific approval by the FDA for use during pregnancy.

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**Monitoring:** Transvaginal ultrasound examinations (TVE) determine the number and size of ovarian follicles (cysts) for the donor's cycle. Together with blood hormone levels, the medical staff determines whether to adjust the hormone dose and the correct time for egg retrieval. TVE also monitor the development of the recipient's endometrial lining. TVE does not usually hurt. Blood draws (phlebotomy) and injection of medications may cause mild discomfort and bruising, bleeding, infection, or scarring at the needle sites.

**Egg Retrieval:** We remove the eggs from the donor's body using ultrasound-guided egg retrieval. We do not guarantee that the ovaries contain any healthy eggs or that we will successfully retrieve them. We may not recover eggs because ovulation occurred before the time of retrieval (an unusual event).

## **IVF PROCEDURE - EMBRYOLOGY AND EMBRYO TRANSFER**

**Sperm collection:** The husband provides a semen specimen by masturbation on the day of the egg retrieval. Our staff processes the sperm for insemination of the eggs. We label each sperm specimen with several identifying marks such as name and chart number to ensure the correct sperm fertilizes the donor eggs.

If the man does not or cannot provide a semen specimen within a reasonable time on the day of egg retrieval, he must decide how to proceed. We can sedate the man and aspirate the sperm directly from the testicle or epididymis, use donor sperm or discard the eggs without insemination. The man assumes all responsibility for providing us with a sperm sample on the day of egg retrieval. We recommend that you notify the medical staff before you begin the treatment cycle if you believe that you may have trouble producing a sperm sample so that we can freeze a sample in advance.

**IVF Embryology:** Our staff combines the sperm and eggs following retrieval and then places them into an incubator to allow fertilization. If preliminary tests determine that the sperm will not naturally fertilize an egg, we insert the sperm directly into the egg (intracytoplasmic sperm injection - ICSI). We cannot guarantee fertilization regardless of the technique used to inseminate the eggs. Occasionally, eggs die in the incubator, other eggs fertilize abnormally resulting in embryos that cannot be transferred, and very rarely, none of the eggs fertilize or progress into embryos. When patients elect blastocyst transfer, they assume the risk that none of the embryos will become blastocysts; although, an embryo transfer of morula stage embryos may occur.

Equipment failure, infection, human error or other unforeseen factors may result in loss or damage to eggs, semen, and/or embryos. Unforeseen conditions (natural weather disasters, etc.) may make RCC facilities or other medical or laboratory support unavailable at the appropriate time for egg recovery.

**Embryo Transfer:** The patient(s) indicate in writing the number of embryos to be transferred and/or cryopreserved after discussion with a physician on the day of transfer. We transfer embryos into the uterus using a small catheter inserted through the cervix. Rarely, technical difficulties prevent ET requiring embryo freezing or the embryos are lost in the process of attempting a difficult ET. If more than one embryo is transferred, there is a risk of multiple gestations.

ET occasionally causes slight discomfort, a small risk of infection and/or bleeding. We recommend bed rest for the rest of the day following the ET. Intramuscular or intravaginal progesterone supplements enhance implantation of the embryos in the uterus. We recommend cryopreserving (freezing) excess embryos so that you have additional opportunities to become pregnant or to have another child if the fresh ET results in a successful pregnancy. You must sign a separate consent for embryo cryopreservation.

**Pregnancy:** We cannot guarantee implantation or a successful pregnancy from any IVF/ET procedure. Most infants born following human IVF appear normal at birth. Yet, congenital abnormalities, birth defects, genetic abnormalities, mental retardation, and/or other possible deviations from normal occur in children born following IVF as they do in children resulting from natural fertilization. Some studies suggest that IVF leads to greater risk of congenital anomalies than in natural conceptions.

Pregnancy following IVF/ET may end in a miscarriage, ectopic (tubal) pregnancy, or stillbirth. Multiple pregnancies (twins, triplets, etc.) occur with greater frequency than natural conceptions. Some pregnancy complications may occur more frequently following IVF than natural impregnation such as preterm labor and early delivery.

## **ALTERNATIVES TO EGG DONATION:**

Most clinicians recommend egg donation when the recipient woman is unlikely or unable to become pregnant with her own biologic child. Consequently, alternatives to egg donation include adoption, donor embryo transfer (if available), surrogacy, or childless living.

