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Optimising model of care for female oncology patients needing urgent fertility preservation

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Introduction

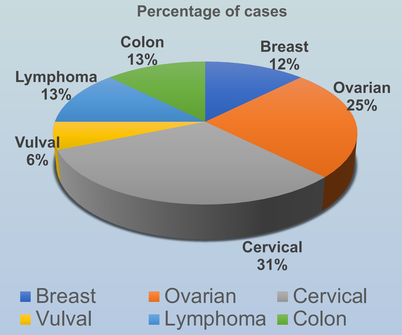
Modern anti-cancer treatments have led to a significant improvement in survival, but early loss of fertility. Procreation is a basic human instinct, so the inability to conceive is devastating for most women. The standard of care for fertility preservation for these patients is variable and often inadequate. Various elements of care have been identified. The next step is to develop a reproducible and structured model of care to improve oncofertility experience, patient satisfaction and overall treatment outcome. Continued collaboration among oncologists, fertility specialists, counsellors and other support providers is crucial.

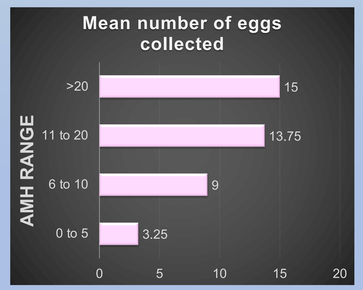
Aim

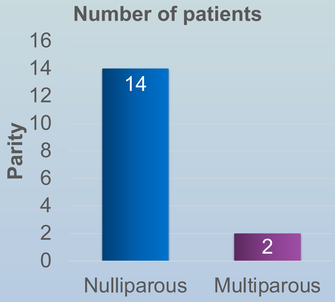
To optimize outcome and treatment experience of female oncology patients undergoing fertility preservation by developing a structured pathway that includes a standardized referral process, IVF coordination, a standard operating procedure, rapid access and one-stop management, MDT approach and other specific elements of care.

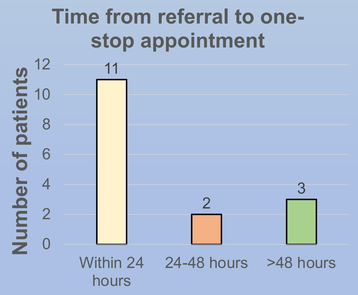
Method

A prospective observational study was conducted on patients referred to the Fertility Centre at Chelsea and Westminster Hospital, London, UK over the period of last one year.
A standard operating procedure, information leaflets and forms for referrers and the receiving team, dedicated IVF coordination slots and training were developed for a one-stop fertility preservation service to complete consultations and investigations all in one appointment with a view to starting ovarian stimulation within 48-72 hours of referral. NHS funding was secured urgently for most cases. Professional counselling was offered to all. Data was collected to assess feasibility and outcome of this structured pathway.









Results

18 patients with a recent diagnosis of cancer were referred to our fertility unit in the last one year. Two patients attended the initial consultation to gain further understanding of their fertility options and treatment process but ultimately did not pursue fertility preservation. The remaining 16 patients received fast-track treatment through the newly introduced one-stop service. The mean age of patients in the study was 31 years. 87.5% patients were nulliparous. A majority of the patients had a diagnosis of gynaecological cancer, ovarian and cervical being the commonest. The median AMH in this group was 10pmol/L (lowest 0.2pmol/L and highest 44.7pmol/L). The median number of eggs collected after ovarian stimulation was 9, with the lowest being 0 for patient with AMH <0.2pmol/L and highest being 22 with AMH of 36.7pmol/L. The median time between referral to the fertility team and completion of fertility preservation treatment was 17 days. 68.8% patients were seen in the one stop clinic within 24 hours of referral and in 81.3% cases we successfully managed to provide a one-stop service for investigations and consultations all at the same appointment. Three patients that could not complete all investigations were medically complex that required input from other specialties.

Conclusion

Potential treatment-related infertility can be a very distressing diagnosis on top of an initial cancer diagnosis. A rapid-access, one-stop fertility preservation service included several distinct elements of success. The quality of experience can be further improved and standardised by digitalization of the pathway, which is our current direction.

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