Feedback

We appreciate and encourage feedback. If you need advice or are concerned about any aspect of care or treatment please speak to a member of staff or contact the Patient Advice and Liaison Service (PALS):

Freephone: 0800 183 0204
From a mobile or abroad: 0115 924 9924 ext 65412 or 62301
E-mail: pals@nuh.nhs.uk
Letter: NUH NHS Trust, c/o PALS, Freepost NEA 14614, Nottingham NG7 1BR

www.nuh.nhs.uk

If you require a full list of references for this leaflet please email patientinformation@nuh.nhs.uk or phone 0115 924 9924 ext. 67184.

The Trust endeavours to ensure that the information given here is accurate and impartial.

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The Information Standard Certified Member

Nottingham University Hospitals NHS
NHS Trust

Donor Insemination

Information for patients

Fertility Unit

This document can be provided in different languages and formats. For more information please contact:

The Fertility Unit
Queen's Medical Centre
Derby Rd, Nottingham, NG7 2UH
East Block, B Floor
Tel: 0115 970 9238

Public **information**

We are here for you

What is donor insemination?

More than one couple in seven have difficulties in conceiving and seek medical help. A significant proportion of fertility problems are associated with sperm, either a problem with the sperm number or function or indeed a complete absence. In all of these cases, patients may choose to use donor sperm in order to achieve a pregnancy. In rare cases the use of partners' sperm carries a risk of an inheritable condition and a decision is made by the couple to use donated sperm in order to prevent disease to their baby. Lastly, the use of donor sperm also offers a route to genetic parenting for single women and single sex couples.

The simplest option for treatment using donor sperm is DI, sometimes called DIUI.

Is there a charge for DI?

Treatment funded by the NHS is dependent on a number of factors (eligibility criteria) which do change slightly from year to year and depend on which CCG (Clinical Commissioning Group) you come under. If you do not have any existing children NHS funding may be available for at least the first few treatments, but those patients returning for a sibling pregnancy would definitely be asked to fund this themselves.

How do I get access to treatment with donor sperm?

Like most hospital treatment, accessing DI usually starts with a visit to your GP for a referral to the Fertility Unit. Although some units allow you to see them directly if you are self funding, we think that its important that your GP is aware of the treatment and are involved in the welfare of the child assessment. Your GP will also be able to organise some basic investigations prior to your appointment so that the results are available at your initial consultation.

Notes

- The British Infertility Counselling Association (www.bica.net) is an organisation set up specifically for guidance and support for infertility issues.

- ParentLine Plus (www.parentlineplus.org.uk) is a national charity offering support to parents in the UK.

Confidentiality

All patient files are kept separately from your general hospital notes and are kept locked away when not in use. There are only a limited number of personnel who have access to your file. The identity of the donor is kept strictly confidential 'Parents to be' do not need to inform other healthcare professionals of how conception occurred unless genetic issues arise.

Emergencies

If you have an urgent enquiry during the normal office hours contact the Fertility Clinic using the telephone number above. In an emergency out of hours please contact the Nottingham University hospital on 0115 924 9924 ext. 69023. A contact number will be given on an individual basis depending which member of staff is on duty.

Fertility Unit
Queen's Medical Centre
Nottingham University Hospitals NHS Trust
Nottingham
NG7 2UH
Tel: 0115 970 9238
Fax: 0115 919 4497
Email: fertility.enquiries@nuh.nhs.uk

www.nuh.nhs.uk/fertility

What tests are required before starting DI?

Before any form of treatment can be pursued there are a number of investigations which may need to be carried out. These include:

1. **Check ovulation:** This is confirmed by ultrasound scanning or measuring the hormone progesterone in a blood sample and is usually on about day 21, if the cycle is around 28 days long but should be seven days before the start of the next period.

2. **Assessment of the Fallopian Tubes:** This is to check the tubes are fully open (patent) and there is no blockage or evidence of disease. This can be done using either a laparoscopy and dye test, hysterosalpingogram (HSG) or HyCoSy (Hystosalpingo Contrast Sonography). A laparoscopy involves a general anaesthetic and is an operation during which a small telescope is passed through an incision under the belly button. A dye is injected up through the cervix from below and passes through the fallopian tubes providing there is no blockage. Hysterosalpingogram or HSG is a specialized X-Ray of the uterus and tubes, where a dye is then injected slowly into the uterine cavity and detected using X-Ray pictures. A HyCoSy is similar to the HSG but uses ultrasound instead of X-Rays to examine the tubes.

The decision as to which tubal patency test will be used will depend largely on individual diagnosis, history and sometimes personal preference.

Infection screening: Rubella (German measles) is an infection, which if contracted during pregnancy can cause damage to the unborn child. If you are found non-immune then it is essential that you be immunised. Titres (blood levels) would then be re-checked three months after immunisation to confirm immunity before any treatment is commenced.

DIUI treatment how does it work?

DIUI is a form of artificial insemination, where the donor sperm are washed and placed directly into the womb using a fine catheter. In doing so more sperm will find their way to the site of fertilisation than by insemination into the vagina. It is an outpatient procedure with little discomfort or complication and only takes a few minutes. DIUI is often combined with some sort of ovarian stimulation, which uses drugs to produce one or even two good quality eggs and ensures that they are released at around the same time as the insemination.

Ovulation induction

The principle of ovulation induction is to stimulate the ovaries (with fertility drugs) to produce at least one follicle which will contain a single egg or oocyte. Often more than one follicle is produced, although if there are more than two, treatment is likely to be abandoned because of the high risk of multiple pregnancy (see later in this leaflet). A good response to ovulation induction aims to ensure that good quality eggs are released allowing appropriate timing of donor insemination (DI). There are two main types of drug treatment used to induce ovulation: one Clomid and the second Gonadotrophins.

Each growing follicle contains a single egg (oocyte) and is considered ready for ovulation when it has grown to a diameter of between 1.7-2.4cm. At this time an injection of Human Chorionic Gonadotrophin (hCG) is given and ovulation takes place between 36 and 48 hours later.

Further reading and information

Donor Conception Network – information booklets
The Donor Conception Network (DCN) has produced a series of booklets called ‘Telling and Talking’. These aim to prepare and support parents of donor-conceived people to tell their children about their origins.

The booklets can be downloaded free of charge from the DCN website

http://www.donor-conception-network.org/

The DCN is a self-help network comprised of:

- Over 1,000 families created with the help of donated eggs, sperm or embryos.
- Couples and individuals seeking to find a family through assisted reproduction.
- Adults conceived using a donor.

Professional support

You may wish to seek counselling, or similar support services, on best methods of discussing donor conception with your child. In addition it is worth bearing in mind that although it is a limited resource, you can access our counselling service before, during and after treatment.

There are a number of organisations set up to offer counselling services and advice:

- The Human Fertilisation and Embryology Authority (HFEA) (www.hfea.gov.uk)

- The British Association for Counselling and Psychotherapy (www.bacp.co.uk) can help you find counselling services in your area.

Telling the child

All parents of donor-conceived children are encouraged to talk to their child about their origins. Telling them about their origins can be a sensitive topic to discuss. However, if done honestly and if discussed at the right time, the issue need not be a difficult one to broach. Finding out suddenly, later in life, may be emotionally damaging to donor-conceived people and their family. This, coupled with the donor conceived people's legal right to find out about their genetic origins, means that it is advisable for parents to be open with their children from an early age.

Evidence from the experience of adoption, as well as studies of donor-conceived people, suggest that it is best for donor conceived people to be told about their origins in childhood. Family secrets can undermine trust and lead to conflict and stress. They can also suggest to donor-conceived children that their parents are ashamed of how they were conceived. If you, as the parent, are open about how your child was conceived there is no reason they should feel any different to any other child. If donation has been part of the family story for as long as your child can remember, their genetic origins needn't be an issue. Some donor-conceived children are likely to want to know more about their donor, while others won't be particularly interested.

1. Clomid (Clomiphene Citrate)

This drug is a mild ovarian stimulant and acts by stimulating the pituitary gland to release the woman's own hormones (FSH and LH) which cause the growth and maturity of follicles in the ovary. Clomid tablets are taken from day two of the cycle (day two of the period) for five days. The starting dose is usually 50 milligrams, which may be adjusted according to the ovarian response. Results show that four out of five women given Clomid do ovulate but less than half become pregnant. If Clomid does not work well then the next step may be to try Gonadotrophins (see below).

Monitoring

The ovarian response to Clomid is monitored using ultrasound scanning during the first treatment cycle, although later treatment cycles may also be monitored especially if Ovitrelle (hCG) is also being taken – see later.

Side effects

Common side effects include headache, flushing, breast tenderness and nausea and some patients find it better to take the tablet just before bedtime. If any blurring of vision is noticed then the tablets should be stopped immediately and the clinic informed. Clomid can be taken for no more than twelve ovulatory cycles, due to an increased risk of ovarian cancer.

2. Gonadatrophins

Gonadotrophins are hormones from the pituitary gland in the brain FSH (follicle stimulating hormone) and LH (luteinising hormone). These drugs are administered in injection form by use of an auto-injector pen or with a syringe and needle. This injection is given just under the skin (subcutaneous) so the needle is very short and fine. Gonadotrophin treatment (sometimes called GTs) is usually started between day three and five of the menstrual cycle (day one classed as the first day of bleeding) with most starting on day five. All patients have a base-line ultrasound scan before starting to check that the endometrium (lining of the womb) is thin and the ovaries are inactive. Occasionally cysts or unruptured follicles can be seen and treatment may need to be delayed or modified. Patients who have irregular periods may require a course of progesterone to induce a bleed prior to starting.

Initial treatment involves a daily single injection with the dose of drug tailored to the individual for five days. Administration of the injection should be at approximately the same time each day. Patients are encouraged to alternate injection sites on a daily basis to reduce local reaction or bruising. Any drugs stored in the fridge should be removed from the fridge up to an hour before administration to reduce the stinging sensation on injection. After the first five days of the treatment, a follow-up scan will be performed to see how the ovaries are responding. On the day of the scans, no injection should be given until the scan is reviewed by one of the nurse specialists.

The aim of the treatment will be to achieve one to two mature follicles a mature follicle is one that has a diameter of between 1.7 and 2.4cm. The length of time and dosage of drugs to achieve this will differ from patient to patient and is adjusted on an individual basis. When maturation of the follicle or follicles has been achieved then the injection of hCG will be administered to initiate ovulation (rupturing of the follicle).

The centre is also required to satisfy itself that the GP of each prospective parent knows of any reason why either might not be suitable for the treatment to be offered. GPs will be asked to provide factual information, medical or otherwise that might have implications for the health and welfare of any resulting child. Written consent will be sought before any contact with a GP is made. This should be given after discussion about these issues and prior to the reading of the letter/questionnaire that will be sent to the GP's. If any of these enquiries give cause for concern, the centre will make further inquiries of any relevant individual, authority or agency it can. Consent will be sought before any contact with these bodies is made. However, failure to give consent will be a factor that may be taken into account in considering whether or not to offer treatment.

Ultimately the consultant responsible for the HFEA license is responsible for making the final decision about whether or nor treatment will be offered. Treatment may be refused on clinical grounds or, if the centre believes that it would not be in the interests of any resulting child, or any child already existing, to provide treatment, or is unable to obtain sufficient information or advice to reach a proper conclusion. If treatment is refused for any reason, the centre should explain the reasons for this and the factors, if any, which may persuade the centre to reverse it's decision. It should also explain the options that remain open and where counselling can be obtained.

The assessment will involve the centre taking a detailed medical and social history covering the patient's:

- Commitment to having and bringing up a child.
- Ability to provide a stable and supportive environment.
- Medical and social family history.
- Current health, age and consequent ability to look after or provide for a child's needs.
- Ability to meet the needs of any child or children arising from a multiple pregnancy.
- Any risk of harm to the child or children who may be born, including the risk of inherited disorders or transmittable diseases, problems during pregnancy and of neglect or abuse.
- The effect of a new baby or babies upon any existing child of the family.
- In addition, where treatment involves the use of donated gametes, the following will be taken into account:
- A child's potential need to know about their origins and whether or not the prospective parents are prepared for the questions which may arise while the child is growing up.
- The possible attitudes of other members of the family towards the child and towards their status in the family.
- The implications for the welfare of the child if the donor is personally known within the child's family and social circle.
- Any possibility known to the centre of any dispute about the legal fatherhood of the child.

Monitoring by Ultrasound Scanning (USS)
Monitoring the ovarian response to gonadatrophins is essential and requires regular attendance for ultrasound scanning during the treatment cycle. These are carried out by trained sonographers/nurse specialists. The scan is reviewed and, if necessary the drug dosage adjusted depending on the response. The number of scans depends on the individual and on the ovarian response. The nurse specialists discuss the results with you and will let you know when ovulation will take place.

Side effects
Local mild reaction from the injection site may occur and occasionally patients experience headache following administration. Abdominal discomfort is common and is associated with following ovulation.

Human Chorionic Gonadotrophin (hCG) - Ovitrelle
hCG encourages the final maturation and release of the dominant follicle and is given usually when it reaches a diameter of at least 1.7cm. This is given via an injection just under the skin (subcutaneous) so the needle is very short and fine. If however too many follicles bigger than 1.7cm have developed, hCG administration is withheld in order to prevent side effects such as ovarian hyper stimulation syndrome and multiple pregnancy.

All patients should be aware that hCG can cause you to have a false positive pregnancy test result. It is therefore recommended that pregnancy testing is not performed within three weeks of the injection.

How do I start my treatment cycle?

When you have completed all of the required screening, counselling and tubal patency tests, a donor allocation form is completed and given to our donor co-ordinator. This form has your personal phenotypes (eye colour, hair colour, height etc) and any preferences that you may have for matching with a suitable donor. Please note that it can take up to eight weeks to be allocated a donor, although every effort is made to match you as quickly as possible.

After a suitable donor has been allocated, you will be able to commence treatment on your next menstrual cycle. Prior to this you will need to contact the Fertility Clinic on 0115 970 9238 to discuss commencing treatment and to ensure you have any necessary drug prescription.

You are then asked to call the unit on the first day of your menstrual cycle to book in for a follicle scan – this is generally around Day 12 of your cycle if you are being treated on a natural or Clomid cycle or Days two to five if you are using gonadotrophins.

How does the insemination take place?

Insemination will be timed to take place to coincide with ovulation (usually 24-36 hours post hCG injection). A date and time will be arranged with the Andrology Laboratory to prepare your sperm sample. The insemination is performed by the fertility nurse-specialist. A speculum is inserted into the vagina. The cervix (neck of the womb) is located and a fine flexible catheter is passed through this into the uterus. The prepared sperm are introduced via the catheter. Patients are encouraged to rest for 15-20 minutes before leaving the unit but may experience slight discomfort or cramping pains at which can continue for 24-48 hours. Occasionally slight spotting (of blood) may also occur.

A woman who carries and gives birth to a child as a result of treatment will be the legal mother of that child. However, there are cases where a woman's partner may not automatically be the legal parent of the resulting child – for example if the woman is **not married or in a civil partnership** with her male or female partner, and the woman is being treated using donor sperm (or embryos created using donor sperm), the consent of both the woman **and** her partner is needed for the partner to be recognised as the child's legal parent.

Welfare of the child

The HFE Act (1990) requires that the welfare of the child must be taken into account before any treatment can commence at a licensed centre. This includes the welfare of any child born as a result of the treatment, and of any other existing children who may be affected by the birth. Many factors need to be taken into consideration in this assessment, including who would be legally responsible for any child born as a result of treatment, and who it is intended will be bringing up the child.

People seeking treatment are entitled to a fair and unprejudiced assessment of their situation and needs. This is conducted with skill and sensitivity appropriate to the delicacy of the case and the wishes and feelings of those involved. The HFE Act does not exclude anyone from being considered for treatment. However, in situations where the child will have no legal father the clinic will pay particular attention to the prospective mother's ability to meet the child's needs as it grows up and, where appropriate, will consider whether there are others within the mother's family and social circle willing and able to share the responsibility for meeting those needs, and for bringing up, maintaining and caring for the child.

Legal aspects - The Human Fertilisation and Embryology Authority (HFEA)

The HFEA are the fertility regulators or watchdog and ensure that all clinics follow the law according to the HFE act. Every clinic is therefore inspected and licensed according to the HFEA's code of practice and has to be very careful how it conducts its business. All the consent forms completed and other assessments such as the welfare of the child are requirements of the HFEA and must be carried out with great care. The HFEA must also be informed of the outcome of all pregnancies so every couple must keep the clinic informed no matter where they are in the country. There are a number of individual areas in relation to this code that all patients need to be aware of and, if necessary, ask questions of the clinic staff or counsellor to ensure full understanding.

Any child born from sperm donated through a clinic is the legal child of the mother and her partner, if she has one. The donor has no legal rights or responsibility for the child. If donated sperm is used in treatment outside a licensed clinic e.g. via an internet company - the donor is considered by law to be the father of the child, with the rights and responsibilities this involves.

Legal parenthood

When using a licensed clinic, all patients seeking fertility treatment and their partners must carefully consider the issue of legal parenthood and complete the required consent forms. This can be a complex area to understand and you will be given a separate information leaflet to help you complete the forms. Please read it carefully and ask any questions you may have before you complete your consent forms.

Follow up

Blood tests will be carried out seven days following insemination, which should confirm ovulation. If the treatment is unsuccessful, the period would normally be expected seven days later (14 days after insemination). If however no bleed occurs, patients are asked to take a pregnancy test and inform the clinic of the result. If it is negative, appropriate support and follow-up will be arranged. If however the test is positive, an ultrasound scan will be arranged to confirm the pregnancy.

Abandoning treatment

Treatment may be abandoned if no ovarian follicles develop or indeed if too many develop and there is an increased risk of **multiple pregnancy or** ovarian hyper stimulation syndromes (**OHSS**) which are described below.

Success rates

Success is dependent on a number of factors including age, quality of ovulation and sperm quality. If DI is performed in the natural cycle i.e. with no drugs to induce ovulation, approximately 15-20% of treatments will result in pregnancy. If drugs are used to induce ovulation and sometimes to produce more than one egg, the chance of pregnancy increases to around 20-25% but of course there is also an increased risk of multiple pregnancy – (see below)

What if DI fails?

DI is usually successful after the first few attempts. If however for some reason it does not work, it may be recommended that you attempt a more hi-tech form of treatment such as in vitro fertilisation (IVF). This is where the sperm are put together with the eggs in a dish outside the body. The eggs become fertilised and form an embryo, which is then replaced inside the body a few days later. IVF is more complicated, costs more and is more invasive than DI - but can be up to twice as successful.

Risk and treatment complications

There are two major complications of fertility treatment but really only apply if a patient receives stimulation of the ovaries.

1. Multiple pregnancy

When the ovaries are stimulated by drugs to increase the number of eggs produced, there is always an increased risk of a multiple pregnancy. Usually twin, sometimes triplet but very rarely quadruplet may occur. The risk to the pregnancy increases with increasing numbers of babies. Therefore we aim to minimise this risk as far as possible. Multiple pregnancy carries risks to the mother and the developing babies and include: pregnancy-induced hypertension (raised blood pressure), pre-eclampsia, premature delivery, and bleeding problems. The risks are increased with higher order multiples. There are higher risks associated with prematurity and problems associated with delivery. Babies born early often require intensive care and can be hospitalised for long periods of time and may develop serious physical and mental illness. Parents are asked to consider the effects of multiple pregnancy on existing children, their own relationship and the financial burden that can understandably arise in this situation.

2. Ovarian Hyperstimulation Syndrome (OHSS)

The individual woman's response to the drugs may vary and it can be difficult to predict the number of follicles that will develop. The use of the fertility drugs we use (clomid, and gonadatrophins) are carefully monitored but they can sometimes lead to over stimulation of the ovaries. Occasionally, cysts may appear in the ovaries and fluid collects in the abdominal cavity, causing discomfort. If this does happen, it is important that you tell us so that we can monitor the size of the cysts. You would be advised to rest, drink plenty of fluid and take simple painkillers.

The donor register

Every donor is registered with the HFEA and both identifying (name, address, date of birth etc) and non-identifying (eye/hair colour, height/weight) information is stored on a database.

As parents are in the best position to pass information to children at an age when they can understand it, they are entitled to details of the child's donor and may apply for further information from the HFEA. The HFEA permits parents to access some information about their child's donor and donor-conceived genetic siblings. Parents can ask the HFEA, or the clinic where they received treatment, for anonymous information about their child's donor. Only information which could not, on its own or in conjunction with any other information, be used to trace or identify the donor will be given. Different donors will have provided different amounts and types of information. Some donors may have only provided a small amount of information – for example, their height, hair colour and occupation. Others will have provided more detailed information about themselves as a person.

What can offspring find out about their biological origin?

Since April 2005, identifying information about sperm donors has been held on the HFEA Register. When any child born as a result of donation reaches 18 years old they may approach the HFEA to open the register and obtain the information that the donor provided to the clinic when he first attended.

Cytomegalovirus (CMV)

CMV, is a very common virus which infects over 40% of the population. In most people the CMV does not cause any symptoms and they will not know they are infected. However, it can be hazardous during pregnancy as it can cause problems for unborn babies. It is estimated that a third of women who become infected by CMV for the first time during pregnancy will pass the infection on to their unborn baby and in 10% of cases, the babies infected with the virus will go on to develop problems and unfortunately some of these problems can be serious. The risk from acquiring CMV from donor treatment is extremely low. However we ensure that no donors with an active infection donate. In the majority of cases we also take the extra precaution of only treating CMV negative women with a donor who is also CMV negative. However in exceptional circumstances, CMV positive donors may be used in CMV negative women if there is a need to offer more donor choice and where we can be assured that there is little risk of infection. Of course, any amount of screening cannot prevent a female patient coming into contact with a member of the public who has a CMV infection.

How is the donor selected for my treatment?

In general, donor choice is up to the recipient (patient receiving DI). For heterosexual couples the physical characteristics of the donor are often matched to the male partner, yet ultimately it is up to personal preference. A close match cannot be guaranteed if donor numbers are low and choice limited. For the same reason, a different donor may have to be used for subsequent sibling treatments. If a pregnancy occurs we will always try to reserve sperm (from the same donor) so that any subsequent brothers or sisters are genetically related. We would advise that this request be made as soon as possible as there is no guarantee that stock will be available. There is an annual reservation fee payable to reserve stock for sibling use. Please ask for further details if required.

Some treatment cycles actually have to be cancelled or postponed because the ovaries have over-responded to such an extent that proceeding with treatment would endanger your health. Very rarely, in less than 1% of cases, a more serious reaction to the drugs causes a very large number of eggs to develop and the ovaries swell greatly. Symptoms such as nausea and vomiting, abdominal pain and swelling, and shortness of breath can occur. The woman may feel faint and notice that she is only passing small amounts of urine. If these complications occur, urgent admission to hospital is required to give intravenous fluids and to monitor the condition until recovery is complete. If you experience any of the above symptoms and feel concerned, report the matter to the Fertility Unit.

Other risks

Ectopic (Tubal) pregnancies
Ectopic pregnancies (where the egg is fertilised outside of the womb) occur in 1-2% of pregnancies. In gonadotrophin cycles the rate is slightly increased to 1-3%. An ectopic pregnancy can be treated using drugs or by surgery but can sometimes result in the loss of the tube.

Ovarian Stimulation and Ovarian Cancer
Research which has linked the use of ovulation induction agent to ovarian cancer is controversial. However, as we are unsure of the risk, we follow current guidance which is to limit patients to a maximum of six cycles of clomid before attempting to use gonadotrophins.

Birth defects
The rate of birth defects after ovulation induction is no higher than in the general population, at 2-3%, and children born after such treatment are developmentally no different to their peers.

Counselling

It can be both distressing and confusing for a couple to find that using donor sperm is their only option to have their own child and very careful consideration must be given to the implications of the use of donated sperm. Accepting treatment is a very personal and private matter and the decision is one which can only be made by the individuals concerned. As the issues involved in using donor sperm are complex, we are required by law to offer independent counselling to all patients wishing to embark on the treatment programme. Any topics pertaining to treatment, legal requirements and possible future problems may be covered, along with any particular queries. Approximately an hour is needed for each session and couples are seen initially together, although may be seen as individuals at a later stage. Additional appointments for counselling can be organised for you at any time before, during or after treatment. Refusal to attend the counselling session will prevent couples proceeding with treatment.

Choosing a donor

Who donates sperm?

Sperm donors come forward voluntarily and are paid only 'out of pocket' expenses. Each is carefully counselled about their motives and to ensure that their medical, social, family and genetic history is satisfactory. The decision to donate is not taken lightly, particularly in the light of changes in the law, requiring donors to be identified on a national register. This register may be accessed by children born as a result of the donation (when they reach the age of 18), possibly with a view to contacting their biological father. Most of our donors are recruited here in Nottingham, although you could source a donor from another UK clinic and have it transferred to our clinic if you wish. This is likely to incur a fee even if your treatment is funded by the NHS as donors can be very expensive.

Occasionally couples wish to use a family member or friend as a sperm donor. However under these circumstances, the cost of screening the individual and processing his donated specimens have to be met by the couple. Careful thought must also be given to the process and careful counselling is required of the donor (and his partner) as well as the couple to ensure that they all understand that the situation can give rise to some very unique and complex family issues.

What screening is performed by donors?

All donors undergo a physical examination and are screened for a number of diseases, which may be passed on either sexually or genetically. Donor screening at NUH is in line with current national guidelines and includes: sexually transmitted diseases including HIV, Hepatitis, Syphilis, Chlamydia and Gonorrhoea. Donors from certain non-caucasian ethnic groups are additionally tested for blood disorders including sickle-cell anaemia, Thalassaemia and Tay Sachs disease.

All such screening cannot completely eliminate all risk of infection and genetic disease (including Cystic Fibrosis) but enormously lowers the chances of them occurring as far as possible.

Genetics and cystic fibrosis (CF) screening

Every donor has what we call a 'karyotype' to check both the number and structure of his chromosomes. We also check to see if the donor carries the CF gene which is present in approximately 1 in 23 individuals. CF can occur when both genetic parents are carriers of the gene and for this reason we cannot accept donors who are carriers.