

Egg Sharing Information

Below is some general information to help you. We hope that you will contact us if there is anything further we can do. We can put you in touch with both donors and recipients who have been involved with egg sharing.

This information should be read in conjunction with the Human Fertilization and Embryology Authority (HFEA) leaflets “Donating Sperm, Egg and Embryos” and “Using Donated Sperm, Egg and Embryos”. The HFEA can be contacted on 0207 291 8200. www.hfea.gov.uk for more information.

The law changed on the 1st of April 2005 to remove anonymity from donors and allow donor-conceived children to access the identity of their donor when they reach the age of 18. The new legislation will not be retrospective.

There are many women who need IVF but for economic reasons find it is beyond them. The inequality of funding for infertility treatments in the UK has resulted in many couples being unable to access treatment and has led in part, to the development in egg sharing.

Egg sharing is where a woman undergoing fertility treatment, 'shares' her eggs with someone who needs them. In a typical stimulated IVF cycle a number of eggs are generally produced rather than one or two that may be released in an unstimulated cycle.

The women giving her eggs can often receive her treatment free of charge or at a reduced rate and is often seen by couples as a way to have treatment that they could not otherwise have accessed.

Criteria for acceptance on the scheme;

The egg provider should

- Be between the ages of 18-35
- Have no previous history of severe endometriosis or having had one ovary removed.
- Have no history of transmissible diseases
- Have no personal or family history of inheritable disorders
- Complete relevant consent forms
- Undergo a thorough clinical assessment (including family history) and full laboratory screening for transmissible conditions
- Undertake free independent counselling.

The HFEA does not set a lower limit for the minimum number of eggs required for sharing, it does however require that both the minimum number and the allocation of eggs are agreed by the provider and recipient prior to beginning treatment.

Although the HFEA guidance is designed to ensure that the egg provider's treatment should not be compromised if she does not produce a sufficient number of eggs, it is acceptable for clinics to have more specific policies on these matters, but these must be consistent with the guidance.

In most clinics, if the egg provider produces fewer eggs than the minimum needed for sharing, she could choose either to go ahead, using all the eggs herself at no extra cost and with no further commitment, or donate all her eggs to the recipient in that cycle and subsequently she will be offered another, free IVF cycle using all the eggs that she produces for herself.

If the IVF cycle is abandoned because of poor ovarian response, it is unlikely that the provider will be accepted into the scheme again.

1. How does the clinic match up the donor and the recipient?

In addition to both parties fulfilling the standard requirements for IVF treatment, clinics may also take into consideration:

- a) CMV (Cytomegalovirus) status (see below for explanation),
- b) locality - to maintain confidentiality, and
- c) physical characteristics.

Donor

What are the implications of donating?

- a) Recipient's cycle may succeed when donor's fails.
- b) Giving away half of her eggs means that there are statistically fewer chances of the donor achieving a pregnancy, as fewer embryos will be available for subsequent frozen embryo transfers (FETs). This may mean that the donor has to go through additional stimulated cycles compared to standard IVF, although the likelihood of success in any one cycle will depend on a large number of factors and cannot be predicted accurately in advance.
- c) Donor's child/ren may have half siblings of similar age with whom they could potentially come into contact.

2. What extra tests do I need to have in addition to those required for routine IVF?

a) CMV (Cytomegalovirus)

Cytomegalovirus (CMV) is a common virus and a member of the herpes family. It affects more than half of all adults but rarely causes significant disease unless there is damage to the body's immune system.

b) CF (Cystic Fibrosis)

Cystic Fibrosis (CF) is the commonest inherited disorder in the UK; one in twenty-five people carry the recessive gene. In CF a defective version of a protein is produced, this is responsible for the transportation of salts and waters across the cell membranes. This means that certain parts of the body lack water and secretions become thick and sticky.

c) Karyotype

The microscopic appearance of a set of chromosomes, including their number, shape and size.

3. To what extent do I retain control of the stored embryos?

The egg donor retains an absolute power to withdraw her consent to embryos being used at any time up to the moment they are placed in a recipient.

4. If I am CMV positive, can I still donate my eggs?

Yes, but only to a CMV positive recipient which restricts the choice of recipient for matching.

5. If there are an odd number of eggs produced who receives the extra egg, the donor or the recipient?

Usually the donor. The minimum number of eggs required for sharing and the allocation of those eggs between donor and recipient should be agreed by all parties before any treatment begins.

Recipient

6. Can I bring in my own donor?

Yes, providing she is willing to be screened and undergo counselling. It would then be treated as "known donation." The implications of your egg donor being personally known to you should be discussed prior to the treatment.

7. How soon can I go through for treatment?

Each individual clinic varies, but it's approximately 14 months.

8. Do we have any say about the type of donor we would want to use?

Recipients can specify physical characteristics although clinics will not select donors for reasons that are incompatible with, or not relevant to, the welfare of any resulting child. You should be aware that no guarantees can be given where an attempt is made to match physical characteristics. If keen to specify upper age limit of donor, you must be aware that this could restrict choice and delay treatment.

9. If the treatment cycle is unsuccessful, how soon can I try again?

If sharing did not go ahead because too few eggs were obtained from the donor then the recipient would go through the process again as soon as possible (usually 2-3 months).

If only a single embryo was available for transfer, the wait should not be longer than six months.

If the cycle was unsuccessful despite a 2-embryo transfer, the recipient would have to rejoin the waiting list for another donor.