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Newsletter FPSI
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Preserving Futures

A Newsletter by Fertility Preservation Society (India)

Welcome to the much awaited edition of this years' Fertility Preservation Society of India (FPSI) Newsletter. FPSI continues to raise awareness about the importance of fertility preservation among healthcare professionals, patients, and the general public through educational campaigns, workshops, and advocacy initiatives. This months' newsletter serves as a platform to share updates, resources, and insights related to the recent trends in fertility preservation.

The first article outlines the recent trends and advancements in offering Fertility Preservation for Benign Indications.

We also delve a little deeper into the long term reproductive and pregnancy outcomes in female survivors of childhood Hodgkins lymphoma. We highlight a recent article, which brings about a comparison between the outcomes of heterotopic and orthotopic autologous Ovarian Tissue Transplantation.

Lastly,we have a case presentation and an interesting quiz to tickle your neurons.

As the field of oncofertility continues to evolve, it is imperative to prioritize the integration of fertility preservation into comprehensive cancer care and support systems. Through collaborative research, innovative strategies, and patient-centred initiatives, we strive to empower cancer patients with the opportunity to preserve their fertility and envision a future beyond cancer. Thank you for your commitment to advancing oncofertility in India. Stay tuned for our next edition as we continue to explore the latest developments and initiatives in this vital area of healthcare.

Dr. Neeta Singh
Editor, FPSI Newsletter

Dr. Jasneet Kaur
Joint Editor, FPSI Newsletter

Contents

Fertility Preservation Society (India) FPSI

Phone: +91 98103 17131
Email: fertilitypreservationsociety@gmail.com
Address: D-59, Defence Colony, New Delhi 110024
Website: www.fpsind.com

President's Message

Dear Members,

Greetings form the Executive Team 2023-24 of the Fertility Preservation Society (FPSI). It is absolutely wonderful to see the FPSI grow to a strength of more than 250 members now! Today the awareness for fertility preservation is gradually increasing amongst the oncologist as well as the patients.Our society stands as a beacon of support and guidance for those seeking fertility preservation options with our commitment to advocate accessible fertility preservation services, and providing education and creating awareness. Together, with the oncologist we strive to break down barriers, challenge stigmas, and ensure that everyone has the opportunity to build the family they desire. As we embark on another year of progress, let us reaffirm our dedication to the noble cause of fertility preservation. Together, with the valuable suggestions and support from each one of you, look forward to taking FPSI to the next pedestal!Please save your dates for the annual conference of FPSI on 28th and 29th September 2024 at Hyderabad and for ISFP at JP tower Hall and Conference, Tokyo, Japan between 15th and 17th November 2024. Hoping to see you all in large number at Hyderabad and Tokyo.

Warm regards,

Dr. Madhuri Patil
President,
Fertility Preservation Society(India)

Secretary's Message

Dear Esteemed Members,

Welcome to the latest edition of the Fertility Preservation Society of India (FPSI) Newsletter! We are excited to bring you updates and insights into the dynamic field of fertility preservation. I congratulate the newsletter editors Dr. Neeta Singh and Dr. Jasneet Kaur for their effort to bring forth this newsletter In this edition, we aim to provide valuable insights into the evolving landscape of fertility preservation, with a particular focus on the advancements made in offering fertility preservation for benign indications. We recognize the increasing importance of catering to individuals seeking fertility preservation beyond cancer treatment, and our newsletter endeavours to shed light on how healthcare professionals are adapting to meet these evolving needs.

Furthermore, we will delve into the critical topic of long-term reproductive and pregnancy outcomes in female survivors of childhood Hodgkin's lymphoma. Understanding these outcomes is vital for ensuring comprehensive care for survivors and guiding future treatment decisions effectively.

Additionally, we will explore a recent comparison between the outcomes of heterotopic and orthotopic autologous ovarian tissue transplantation. This comparison promises to provide valuable insights into the effectiveness of different transplantation techniques, thus informing clinical practice and enhancing patient care.

We are happy to present a case presentation and an engaging quiz in this edition. These interactive features aim to stimulate discussion and further enhance our collective understanding of fertility preservation practices.

As we continue to navigate the dynamic landscape of oncofertility, I urge each of you to remain actively engaged in our efforts to advance fertility preservation in India. Through collaborative research, innovative strategies, and patient-cantered initiatives, we can empower individuals facing fertility-related challenges and enable them to envision a future beyond their medical conditions.

I look forward to your continued support and participation in our future endeavours.

Warm regards,

Dr. Shobhana Patted
Hon. Secretary
Fertility Preservation Society of India

Fertility preservation in Benign Gynaecological conditions

Director & Senior Consultant : Dr. Umesh N Jindal
Jindal IVF and Sant Memorial Nursing Home, Chandigarh

Introduction

Recently, we did oocyte preservation for a 20 year old girl who underwent unilateral oophorectomy and ovariopexy for second ovary for recurrent torsion of ovary. Another, recently married 26 year women requested embryo preservation because her mother had early menopause. She had low anti Mullerian Hormone (AMH) and was scared of decreased ovarian reserve. She did not want immediate pregnancy but wanted to have at least two babies. Role of fertility preservation (FP) in women undergoing treatment for malignant conditions is clearly established and has become a standard of care. Potential for decreased ovarian reserve is well recognized in many benign Gynaecological conditions (BGC) and these are more prevalent than malignant diseases. Fear of infertility is of equal concern to families even in benign conditions especially in young unmarried girls. Currently, the only advice given to the patient is early marriage and early childbirth which may not be a feasible option for many. Highly successful FP techniques are usually never discussed with these women. Few of such conditions are discussed in this short review.

Techniques

Oocyte, embryo and ovarian tissue cryopreservation are all successful techniques and can be employed in benign conditions. The benefits of each technique need to be weighed upon in all cases depending upon age, marital status, underlying disease and desires of the patient and families. Ovarian tissue cryopreservation facilities may not be available at all places.

Pros

1. May be of great importance for some women for their social and psychological well being
2. Even in so called fertility sparing surgery there is enough evidence of loss of some ovarian function and highly operator dependent.
3. One can catch the window of opportunity

Cons

1. There is no real test which can predict pathological decline in ovarian function in absence of iatrogenic interventions
2. There is no clarity at what stage of the disease and chronological age when the FP should be advised
3. Low ovarian reserve does not directly related to low fertility
4. There is paucity of data of successful pregnancies after oocyte cryopreservation in women with low reserve
5. One may have to do two-three cycles to get “reasonable” number. There is no clear answer to this question at this moment based on the scant evidence in the available literature.
6. The medical and psychological complications of these procedures need to be considered.
7. Problem of unused frozen material is also there with host of ethical and legal issues
8. Cost benefit analysis is not in favour of a universal recommendation
9. May create a false sense of security

Benign conditions in which there may be serious risk of Fertility Loss

It is very difficult to make an exhaustive list of BGC in which FP may be offered. Few common conditions are discussed.

1. Decreased ovarian reserve (DOR): Diagnosis of DOR is based on decreased AMH, antral Follicle count (AFC) on ultrasound and a high FSH level. Discussing FP may be a better option than to wait for serious decline in ovarian function and premature ovarian insufficiency (POI). Indeed there is a window of opportunity which may be missed.
2. Genetic conditions: Nearly 10% of patients with POI are of genetic origin. Mosaic Turner’s syndrome, FMR gene permutation and BRCA gene carriers are some examples. In addition to Fertility preservation options these women also need genetic counselling regarding health impact of these diseases, risk of transmission and preimplantation genetic testing of embryos and option of ovum donation.
3. Ovarian cysts and tumours: Recurrent, bilateral or large cysts may compromise ovarian reserve by

themselves. Surgical interventions definitely further aggravate the situation. Recurrent torsion may require oophorectomy or ovarian fixation.

4. Endometriosis: Relationship of endometriosis with infertility is clearly established. Ovarian reserve in endometriosis may be severely compromised because of progressive nature even in absence of surgery, surgical interventions, frequent recurrences after surgery and poor surgical techniques. The best FP is to optimize surgical techniques and prevention of recurrences by medical management. In selected cases oocyte preservation can be offered.

Conclusion

To address FP concerns in benign conditions is a natural corollary of universal acceptance for need of FP counselling in women undergoing gonadotoxic therapy for malignant conditions. Although no general guidelines can be given at this moment because of the paucity of data regarding diagnosing potential risk of serious fertility decline, cost benefit ratio and safety and efficacy of such approach. All cases need to be individualized and counselled in detail.

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For inquiries, membership information, or contributions to the newsletter, please contact us

Fertility Preservation Society of India

Registered Office & Secretariat: D-59, Defence Colony, New Delhi-110024.

- 9810317131/9599915122
- www.fpsind.org
- fertilitypreservationsociety@gmail.com

Thank you for your continued support and dedication to advancing fertility preservation in India.

In India, oncofertility is a slowly evolving field that requires collaborative efforts from healthcare professionals, researchers, policymakers, and patient advocates. By harnessing local expertise, adapting global best practices, and prioritizing patient-centered care, we can continue to advance oncofertility initiatives and improve outcomes for cancer patients nationwide.

Together, we can empower individuals to preserve their fertility and fulfill their dreams of parenthood.

Ovarian reserve, Reproductive function and Pregnancy outcomes among female survivors of childhood Hodgkin lymphoma: Results from the DCOG LATER-VEVO Study

S Broer, K Drechsel, F Stoutjesdijk, J Twisk, M Van den Berg, E Van Dulmen - den Broeder, G Kaspers, M Veening
Human Reproduction, Volume 38, Issue Supplement 1, June 2023
https://doi.org/10.1093/humrep/dead093.097
Compiled by: Dr Jasneet Kaur
Clinical Director and Consultant, Milann Fertility Centre,Chandigarh

Study question:

What is the impact of treatment for Hodgkin lymphoma (HL) on clinical reproductive markers and pregnancy outcomes?

Summary answer:

Impaired markers of ovarian reserve in childhood HL survivors substantiate risk of a reduced fertile life span. Pregnancy outcomes seem reassuring at a young age.

What is known already:

Childhood Hodgkin Lymphoma (HL) is nowadays highly curable with survival rates over 90%. Chemotherapy and radiation are associated with late adverse effects including risk of reduced ovarian function and reserve.

Study design, size, duration:

This study was embedded within the DCOG ,LATER-VEVO study, a nationwide, multicentre, retrospective cohort study performed between 2004 and 2014, in which the reproductive ability of 1106 female childhood cancer survivors was studied and compared to 798 controls (siblings and females from the general population).

Participants/materials, setting, methods:

The current analysis included all female childhood HL survivors, treated between 1963 and 2002, and controls who provided written informed consent to participate in the LATER-VEVO study. Data collection consisted of a questionnaire and timed clinical measurements (blood sample and transvaginal ultrasound). Serum antimullerian hormone (AMH), FSH, inhibin B, the antral follicle count (AFC) and self-reported (first) pregnancy rates and outcomes were evaluated in linear and logistic regression models .

Main results and the role of chance:

84 HL survivors and 798 controls were included, aged 29.6 (IQR 19.8-36.6) and 32.7 (IQR 19.7-49.6) years old at time of assessment. Median age at HL diagnosis was 13.4 years (IQR 6.4- . 16.4), with median time since diagnosis of 16.5 (IQR 8.4;36.6) years. Cyclophosphamide equivalent dose (CED-score) exceeded 6000mg/m2 in 56 women and 14 survivors received pelvic irradiation. **All clinical markers were significantly deteriorated in survivors** (odds-ratio for low AMH (<p10) 10.1 . [95%CI 4.9;20.6]; low AFC (<p10) 4.6 [95%CI 2.1;9.9]; elevated FSH (>10IU/l) 15.3 [95%CI 5.7;41.1], low Inhibin B (<20ng/l) 3.6 [95%CI . 1.7;7.7], all p<0.001, 45 survivors and 413 controls).

Pregnancy and live birth rates were comparable between survivors and controls

(80% live birth, 20% miscarriage). However survivors were significantly younger of age at first pregnancy (27.0 years vs 29.0 yrs, p-0.04, 42 survivors and 389 controls). Time to first pregnancy seemed to be increased in survivors (adjusted odds-ratio for time to pregnancy >12 months was 2.5 [95% CI . 1.1;5.6] in survivors, p 1⁄4 0.031). No significant differences in birth weight or gestational age were observed.

Gonadotoxicity was specifically present after treatment with procarbazine and higher CED-score.

No clear effect of age at diagnosis was observed.

Limitations, reasons for caution:

The studied cohort comprised a relatively young population. Risk of premature ovarian insufficiency could not be assessed and a considerable number of women indicated they considered themselves too young to aim to achieve pregnancy. Heterogeneity in received . treatment and sample size issues complicated the extent of the analyses.

Wider implications of the findings:

HL survivors appear to have an impaired ovarian reserve, however chance to achieve pregnancy seems reassuring at a young age. Additional studies are needed to assess fertile life span and reproductive potential of HL survivors, in particular for current HL treatments that are hypothesized to be less gonadotoxic.

Acknowledgement:

This article is a compilation from 'Ovarian reserve, Reproductive function and Pregnancy outcomes among female survivors of childhood Hodgkin lymphoma: Results from the DCOG LATER-VEVO Study. Broer, K Drechsel, F Stoutjesdijk, J Twisk, M Van den Berg et al.Human Reproduction 2023 ,38(1) .

Comparison of orthotopic and heterotopic autologous Ovarian Tissue Transplantation Outcomes

Kutluk H. Oktay, Loris Marin

Fertility and Sterility January 2024,121(1);72-79
https://doi.org/10.1016/j.fertnstert.2023.10.015

Compiled by Dr Jasneet Kaur
Clinical Director and Consultant Milann Fertility Centre, Chandigarh

Objective:

To compare the outcomes of orthotopic and heterotopic ovarian tissue transplantation (OTT) techniques.

Design:

Mixed prospective-retrospective cohort study.

Setting:

Academic hospital.

Patients:

A total of 14 recipients of autologous OTT.

Interventions:

Of the 14 women, 12 who received orthotopic (n = 6) or heterotopic (n = 6) transplants met the inclusion criteria. All orthotopic transplants and one heterotopic ovarian tissue transplant were performed laparoscopically. Although 5 of the 6 remaining heterotopic transplants were performed subcutaneously under local anesthesia or intravenous sedation, one was performed with robotic assistance. With the exception of one recipient who solely desired restoration of endocrine function, all underwent oocyte retrieval either to cryopreserve oocytes and embryos before the graft function ceased or because they could not otherwise conceive (hysterectomy, radiation damage, and heterotopic transplant).

Main Outcome Measures:

Primary outcome measures were graft function and longevity, and the number of embryos generated per retrieval.

Results:

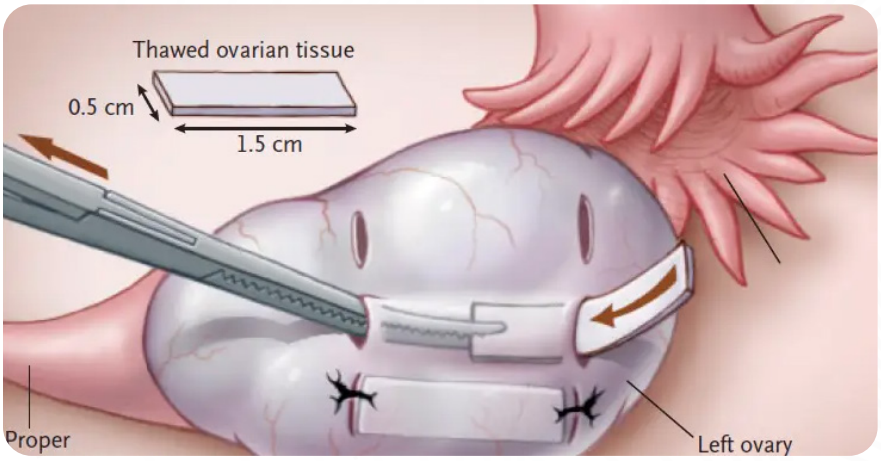
The mean age at ovarian tissue harvesting and transplantation was lower in patients with orthotopic vs. heterotopic transplants, although the proportion of transplanted ovarian cortex was lower in heterotopic transplant cases. All grafts restored ovarian endocrine function. **Fertilization rates, the number of embryos generated per retrieval, and the mean number of non arrested embryos were significantly lower in heterotopic OTT. However, time to function and graft longevity were similar between the groups.** Although 4 of the 6 women conceived and delivered 7 children among orthotopic ovarian tissue recipients, one recipient had 3 spontaneous live births after heterotopic OTT, presumably because of the induction of function in the remaining menopausal ovary.

Conclusions:

It appears that **orthotopic OTT results in higher gamete and embryo quality. However, the endocrine function restoration rate and longevity are similar between the 2 approaches.** When feasible, orthotopic OTT should be preferred for those who intend to conceive, although a less invasive heterotopic OTT can be performed for those who primarily desire ovarian endocrine function.

Acknowledgement:

This article is a compilation from 'Comparison of orthotopic and heterotopic autologous ovarian tissue transplantation outcomes.'Kutluk H. Oktay, Loris Marin. Fertility and Sterility January 2024,121(1);72-79.



Case Study

Random Start Protocol For COS In A Cancer Patient For Fertility Preservation - Case Study

Dr Shilpa Ellur, Consultant -Reproductive Medicine, Milann Fertility Centre, Whitefield, Bangalore &
Dr Shristi Raj FRM Resident, Milann Fertility Centre, Whitefield, Bangalore

Case Report

Mrs X aged 29 years and Mr Y aged 28 years came to our clinic Milann Fertility, Whitefield on 22 Jan 2024 for counselling on Fertility preservation. Mrs X was recently diagnosed with Oestrogen positive receptor Stage 3 invasive breast carcinoma of right breast with metastasis to right axillary lymph node. The oncologist after discussing the treatment as Neoadjuvant chemotherapy followed by surgery and later with chemo and radiotherapy had advised for the fertility preservation before the chemotherapy session.

The couple was counselled and explained about the cancer treatment and its effect on fertility and the feasible fertility preservation methods. Mrs X came to our clinic on Day 8 of menstrual cycle, and as the oncologists were keen on starting chemotherapy as soon as possible, she was counseled for OTC/Random start stimulation and gave consent for controlled ovarian stimulation and IVF with embryo freezing using Random start protocol.

On her baseline assessment, she had an AFC of 14, AMH of 2.3 ng/ml her E2 109.7 pg/ml, Lh 4.11 mIU/L and P4 0.1 ng/ml on start of stimulation.

She was started on a Random protocol for COS with oestrogen suppression with GT dose of 300 IU along with Tab letrozole 2.5 mg in step up manner (for oestrogen suppression). Total dose of GT and total days of stimulation were 2700 IU and 9 days respectively. Oocyte retrieval was scheduled after 35 hours of agonist trigger. 11 follicles were aspirated and 5 mature (M2) oocytes were retrieved, out of which 5 fertilized and resulted in 5 day 3 embryos. Letrozole was continued post OPU till E2 levels dropped to less than 50pg/ml. She was then referred for Neoadjuvant chemotherapy. In view of her young age at diagnosis she was also counseled for BRCA mutation testing

Discussion:

Breast cancer(BC) treatment leads to a reduction in reproductive lifespan due to the use of gonadotoxic agents and prolonged hormonal treatment. With the increasing incidence of BC in the young and better survival rates, fertility issues have come into focus. Pregnancy does not appear to have a detrimental effect and may even improve survival rates. Fertility counseling and offering FP therefore is the standard of care. Advances in ART have made FP a more viable option for patients with cancer. One of the main concerns of oncologists and oncosurgeons however is that FP might have a deleterious effect on tumor progression as a result of ovarian stimulation, especially if treatment is delayed. In particular, estrogen-dependent tumors theoretically could grow and progress as serum estradiol levels rise with gonadotropin treatment. However, stimulation protocols that add letrozole, an aromatase inhibitor, have been successfully implemented and keep serum estradiol close to physiologic levels during the cycle. The preservation of fertility in women of childbearing age with breast cancer in urgent need of Neoadjuvant chemotherapy is however challenging because the time for ovarian stimulation is restricted before gonadotoxic therapies begin.

It has been shown that random-start stimulation resulted in Oocyte yields comparable with conventional protocols and similar numbers of retrieved oocytes in either the early follicular, late follicular or luteal phase subgroup within random-start protocols. This protocol allows GTs to be started on any day of the cycle by recruiting a second wave of developing follicles, without compromising outcome. GnRH antagonist is started when the second wave of follicles reaches 12 mm in size, the dominating follicle in the follicular phase or the corpus luteum in luteal phase is discounted

A recent study has shown that use of a random start stimulation protocol in FP patients who undergo Neoadjuvant chemotherapy does not affect the outcomes.The steady rise in the number of patients treated with Neoadjuvant cemotherapy demands a closer look at OTC and Random start protocol for these patients. That this regimen is considered to have better results with higher survival rates highlights the need to provide the patient with realistic fertility prospects after aggressive treatment that is likely to induce permanent damage to her ovaries. Advances in ART enable patients to bank eggs and embryos with a high level of confidence that they will have excellent chances to conceive after they complete treatment and are disease free. In cases where a cancer gene mutation is identified, PGT-M allows us to shield the next generation from inheriting it. FP is possible with Neoadjuvant chemotherapy and will not significantly delay treatment if the referral is made promptly after diagnosis

Taken together, the combination of random start protocol with addition of aromatase inhibitor/Tamoxifen is vital in a successful oncofertility preservation for estrogen-sensitive breast cancer patients in urgent need for Neoadjuvant chemotherapy.

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https://doi.org/10.1016/j.rbmo.2021.08.003

Put your thinking caps on and challenge yourself!!!!

1

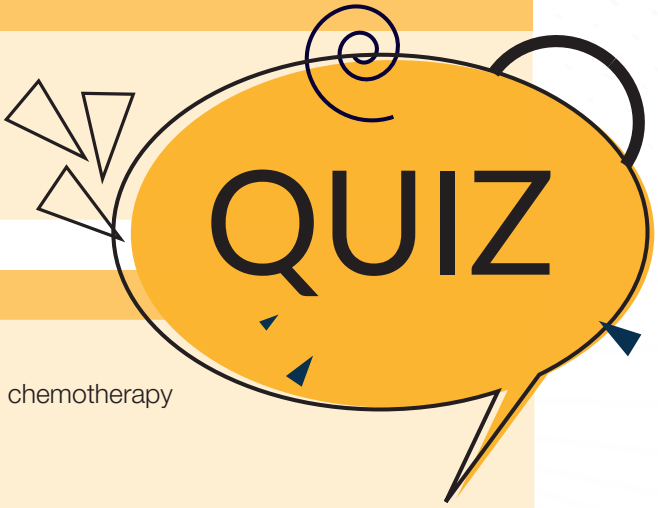
The GnRh agonist when given for ovarian protection shouldbe started:

a. At least a week prior to CT and it should be continued till 2 weeks after completion of therapy
b. At least 4 weeks prior to CT and it should be continued till 2 weeks after completion of therapy
c. Should be started on the day of chemotherapy
d. At least a week prior to CT and it should be stopped on the day of completion of therapy

2

The risk of reseeding during OTC is considered to be high in the following malignancies:

a. Leukemia
b. Burkitt's lymphoma
c. Neuroblastoma
d. All of the above



3

Ovarian transposition can be offered to:

a. Patients requiring local pelvic radiation
b. Patients requiring local pelvic radiation and chemotherapy
c. Patients requiring chemotherapy
d. All of the above

4

OTC can be offered in which patients?

a. Advanced maternal age>36 years
b. Decreased ovarian reserve AMH<0.5ng/ml or AFC<5
c. Prior history of Chemotherapy
d. None of the above

5

Which of the following statements are true?

a. Ovarian stimulation can be performed immediately after OTC.
b. OTC at the time of oocyte pick-up after ovarian stimulation should not be performed unless in a research context.
c. Ovarian transposition can be performed at the same time as OTC in patients planned for pelvic irradiation.
d. All statements are true

ANS: 1-a, 2-d, 3-a, 4-c, 5-d

FPSI Membership Request Form

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Please attach two recent passport size photographs

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1. Fertility preservation-Social indication ☐
2. Fertility preservation-Oncology ☐
3. Fertility preservation male ☐
4. Fertility preservation-Childhood ☐
5. Fertility preservation-Adolescence ☐
6. Others ☐

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Eligibility for Associate members: Non clinical members which include, embryologist, psychologists, counsellors, NGS's, social workers, lawyers

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SECRETARIAT
Fertility Preservation Society (India)
No 1, Uma Admirality, First Floor, Bannerghatta Road, Bangalore 560029.
Website: www.fpsind.com
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Save the Dates!

Mark your calendars and stay tuned for the opportunities to learn, connect, and engage at the Upcoming International Conferences.

Category	Early until 15 September, 2024	Late until 14 November, 2024	Onsite 15-17 November, 2024
Currency	JPY	JPY	JPY
Physicians, Scientists, and Industry Representatives	¥80,000	¥90,000	¥100,000
Junior doctors(under 30 years old), Affiliated Health Professionals and Students	¥50,000	¥60,000	¥60,000
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Join the Movement for Fertility Preservation!!

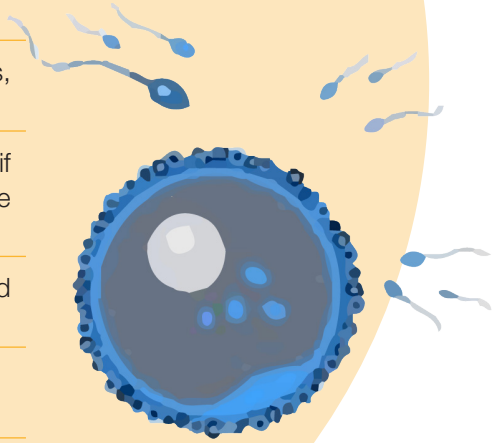
Interested in becoming a member of FPSI or contributing to our initiatives?

Get involved today by joining FPSI as a member, participating in our events, or volunteering for advocacy efforts.

Together, we can make a difference in the lives of individuals facing fertility-threatening conditions and promote access to fertility preservation for all.

Benefits

- As a member, you will have access to scientific news, as well as, up-to-date articles written by renowned specialists in the field.
- You will also have access to news from the most recent and, if possible, slides presented during the official CMEs and conference of the Society.
- There will be a conference registration discount for members in good standing with annual membership.
- Members will also get an opportunity to be invited as a faculty in academic meetings of the Society.



Kindly find attached our membership form and link to our TOFG Journal

The Onco Fertility Journal

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