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Newsletter FPSI
Volume 1 | Issue 2 | May - August 2024

Preserving Futures

A Newsletter by Fertility Preservation Society (India)

Dear Colleagues and Friends,

It gives us immense pleasure to present this edition of our newsletter. As members of the Fertility Preservation Society of India, we are united by a shared vision to empower countless patients, offering them hope and choice in their fertility journeys.

In recent years, there has been significant progress in fertility preservation strategies for patients with gynecological cancers. We present here guidelines formulated by a collaborative effort by ESGO, ESHRE, and ESGE which provide evidence-based recommendations to optimize fertility outcomes for patients diagnosed with cervical cancer, ovarian cancer, and borderline ovarian tumors.

We discuss the latest study published in the Journal of Clinical Oncology, providing promising data on the safety of interrupting adjuvant endocrine therapy in women with hormone receptor-positive breast cancer to attempt pregnancy and another study emphasising the role of Tamoxifen in COS.

We also discuss a case of fertility preservation in a patient with endometrial cancer highlighting the complexities and challenges faced.

As a community of dedicated professionals, we have a crucial role in supporting these advancements and fostering awareness, education, and collaboration across the country.

With this vision in mind, we are delighted to extend a warm invitation for our upcoming FertiProtect Conference to be held in the vibrant city of Hyderabad.

I encourage each of you to mark your calendars. Let us come together to share knowledge, inspire innovation, and reinforce our commitment to advancing fertility preservation in India.

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.org

President's Message

Dear Members and Colleagues,

I am honoured to address you through this edition of our Fertility Preservation Society (India) Newsletter. We launched our society in 2014 and we are in the 11th year now. As we move forward in advancing fertility preservation, our mission remains to provide hope, choices, and solutions to individuals and families facing reproductive challenges. In this context, the Fertility Preservation Society (India) (FPSI) is organising CME's across India to create awareness among our fellow colleagues specially the oncology fraternity.

The incredible strides made in research, technology, and patient care in this field offer renewed opportunities for those who wish to preserve their fertility. As I reflect back on what FPSI has done as a team over the last year, I am truly proud. Together, we have expanded awareness about the importance of fertility preservation by having our annual conference in Anand, Gujarat and 4 CMEs in collaboration with the oncologist. The CMEs were held in Delhi, Mumbai, Barely and Madurai. We are planning to create information videos for social media to strengthen our commitment to improving the quality of life for individuals who require and seek fertility preservation options.

In the months ahead, we will continue to focus on expanding access and creating awareness. The CMEs planned for the next 3 months are in Bhubaneshwar, Belgaum, Lucknow, Chennai and Guwahati. We encourage each of you to participate in our upcoming events and contribute to the shared vision that drives our society forward. Thank you for your dedication and passion. Together, we are shaping the future of reproductive health, ensuring that fertility preservation becomes a viable and accessible option for all.

Warm regards,

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

Secretary's Message

Dear Members,

I am delighted to connect with you through our newsletter as we continue our shared mission of advancing fertility preservation in India. The Fertility Preservation Society of India (FPSI) has made several strides in fostering awareness and enhancing patient care in this important field.

I congratulate the newsletter editors Dr Neeta Singh and Dr Jasneet Kaur for their effort to bring forth in this newsletter the latest guidelines formulated by a collaborative effort by ESGO, ESHRE, and ESGE which provide evidence-based recommendations to optimize fertility outcomes for patients diagnosed with cervical cancer, ovarian cancer, and borderline ovarian tumours and also for compilation of several interesting studies published in the Journal of Clinical Oncology.

Our upcoming Annual Conference in Hyderabad will continue to build on this momentum. We invite you to actively participate in our annual conference, where leading experts will discuss cutting-edge technologies and offer valuable insights into best practices.

As a society, we remain committed to fostering collaboration, education, and support for those navigating the complexities of fertility preservation. Together, let's continue to shape a future where individuals can preserve their reproductive potential and achieve their family-building dreams.

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-sparing treatment and follow-up in patients with Cervical cancer, Ovarian cancer, and Borderline ovarian tumors: Guidelines from ESGO, ESHRE, and ESGE- by Philippe Morice, et al: A Policy Review: Lancet Oncology August 2024

Summary Review by: Prof.Neeta Singh, All India Institute of Medical Sciences, New Delhi

The European Society of Gynaecological Oncology, the European Society of Human Reproduction and Embryology, and the European Society for Gynaecological Endoscopy jointly developed clinically relevant and evidence-based guidelines focusing on key aspects of fertility-sparing strategies and follow-up of patients with cervical cancers, ovarian cancers, and borderline ovarian tumours.

Optimization of fertility results and infertility management Reproductive medicine specialist consultation

Individuals who wish to preserve their fertility should be offered reproductive counselling before the beginning of any oncological treatment. The reproductive medicine specialist should be part of the treatment decision process and be consulted when treatment plans are changing or family planning starts. Creation of a specific multidisciplinary team is encouraged.

Evaluating ovarian function in patients before cancer treatment. The assessment of ovarian reserve should be done with the same methods as in women without cancer (serum anti-Müllerian hormone and antral follicle count), although the interpretation of results might be difficult in patients with ovarian tumours. The age of the patient is more important than AMH and AFC in planning fertility sparing treatment. Pretreatment ovarian reserve markers alone should not be used as treatment guide for fertility sparing surgery.

Oncological aspects of fertility-sparing strategies during the initial management of cervical cancer Oncological selection criteria:

The mandatory imaging tests to assess oncological criteria are pelvic MRI (preferred; evaluated by a dedicated gynaecological radiologist) or expert sonography.

Radiological assessment by CT or PET-CT could be performed to exclude any distant metastatic disease (II, B). Cervical conization is the method of choice for staging in early cervical cancer and could be associated with lymph node staging according to the ESGO– ESTRO–ESP guidelines (II, B). Conization should be performed if no gross lesion is noted (III, B).

Surgical and pathological criteria

Radical trachelectomy with removal of a part of parametria is not recommended for stage IB1 disease fulfilling all the strict inclusion criteria of staging system, squamous cell at any grade or adenocarcinoma at grade 1 or 2, tumor size ≤2 cm, no lympho-vascular space invasion [LVSI], negative imaging for metastatic disease, depth of invasion ≤10 mm, and conization margins and endocervical curettage negative for malignancy or high-grade dysplasia. Radical trachelectomy is recommended for stage IB2 disease by use of an abdominal approach .Lymph node staging strategies for stage IB1 and IB2 diseases should follow the ESGO–ESTRO–ESP guidelines. A non-fragmented cone is crucial for pathological evaluation. The base of the cone should encompass the visible gross lesion on the ectocervix with at least 1 mm histological margin.

Favourable oncological selection criteria:

The following seven criteria should be met before considering fertility-sparing management.

- Assignment of patients to favourable selection criteria is based on all clinicopathological variables.
- Confirmed histology on cervical biopsy or conization is consistent with squamous cell carcinoma (all grades) or usual-type HPV-associated adenocarcinoma (all grades) with no more than 10 mm stromal invasion.
- Absence of LVSI is a favourable pathological biomarker.
- No evidence of any metastasis is required.
- Largest measurement of a tumor is 2 cm by imaging or clinical exam.
- Free margins on final pathology are mandatory.
- No evidence of tumor involvement of the internal cervical orifice and cranial extent of cervical tumor is 1 cm or more from the internal cervical orifice on imaging (IV, B).

COS in Cervical cancers

For all patients with cervical cancer eligible for fertility sparing management, ovarian stimulation followed by oocyte retrieval can be discussed for women without ovarian involvement treated by radiotherapy, brachytherapy, or hysterectomy in accordance with the

legal country-specific regulations regarding surrogate pregnancy. Special attention is needed for ovarian stimulations and transvaginal oocyte retrieval in the presence of active cervical neoplasia. Transvaginal puncture and retrieval might be possible in selected cases with minimal tumor involvement. However, it should be avoided in cases with extensive upper vaginal disease to minimize the theoretical risk of iatrogenic cancer spread during the procedure. A transabdominal laparoscopic approach or open approach might be an option. Transabdominal approach for oocyte retrieval has been suggested as a safe and efficacious

Oncological aspects of fertility-sparing strategies during the initial management of ovarian cancer: General recommendations:

If bilateral oophorectomy is needed, uterine-sparing surgery can be considered assuming normal endometrial (preferably evaluated by hysteroscopy) and serosal evaluation (IV, B).

Favourable oncological selection criteria for ovarian preservation

One of the following criteria should be met

- Borderline ovarian tumour all stages (non-invasive peritoneal implants) regardless of ovarian microinvasion
- Germ cell tumours (all stages)
- Granulosa cell tumors stage IA and IC1;
- Sertoli-Leydig cell well-and-moderately differentiated tumors stage IA;
- low-grade serous and low grade endometrioid carcinomas stage IA and IC1;
- high-grade serous carcinoma stage IA;
- Mmucinous carcinoma expansile subtype stage IA and IC1;8. mucinous carcinoma infiltrative stage IA; or clear-cell carcinoma

Salpingo-oophorectomy versus cystectomy in selected cases of borderline ovarian tumours. Bilateral ovarian cystectomy with macroscopic healthy ovarian tissue sparing in bilateral serous and seromucinous borderline ovarian tumors can be considered (IV, B). Unilateral salpingo-oophorectomy and cystectomy with macroscopic healthy ovarian tissue sparing are both acceptable strategies for unilateral serous and seromucinous borderline ovarian tumour. In case of cystectomy, patients should be counselled about the risk of local and ovarian recurrence of up to 30% with no effect on overall survival, but better fertility results.

Fertility preservation methods in first-line treatment settings of Ovarian tumours

Ovarian stimulation followed by egg retrieval can be offered to patients with ovarian cancer with favourable prognostic factors considering histological diagnosis, hormone sensitivity, cancer stage, and oncological prognosis. Ovarian stimulation followed by egg retrieval for fertility preservation is not recommended before final histological confirmation of a possibly malignant or borderline ovarian mass. For primary ovarian neoplasms, it is recommended that ovarian stimulation and oocyte cryopreservation be performed after completing staging surgery and determining the histological diagnosis, hormone sensitivity, cancer stage, and oncological prognosis. Ovarian tissue freezing and immature oocytes retrieval for ex vivo in vitro maturation and further mature oocyte vitrification during surgery in case of bilateral oophorectomy could be offered. The timing of ovarian stimulation and egg retrieval when adjuvant chemotherapy for ovarian cancer is planned depends on multidisciplinary discussion and can be performed ideally before chemotherapy or in rescue at least 6 months after chemotherapy (post-treatment fertility. In cases of borderline ovarian tumour, biomarkers of the tumour (BRAF, estrogen receptor, KRAS, etc) should not be used as a contraindication for considering ovarian stimulation. In cases of low-grade serous or ovarian endometrioid adenocarcinoma or granulosa cell tumour, the ovarian stimulation protocol based on co-treatment with aromatase inhibitors should be a first choice.

Evaluating ovarian function

Regular measurement of serum AMH concentrations after cancer treatment can be used to indirectly estimate the degree and evolution of the ovarian follicular pool and ovarian response to stimulation. Desire for immediate pregnancy if fertility-sparing surgery did not affect the possibility of unassisted conception, patients are advised to attempt spontaneous conception for at least 6 months before being referred to a reproductive medicine specialist. Patients with a history of infertility or inability to conceive spontaneously should be referred to a reproductive medicine specialist as soon as possible.

Conclusion

These evidence-based guidelines are to help clinicians propose consensual management and harmonizing treatments to try to give the best chances to patients with ovarian cancers, borderline ovarian tumors, or cervical cancers to become pregnant. They also provide recommendations for patient follow-up timelines after such treatment and when completion surgery is required and also emphasize the crucial role of multidisciplinary methods, reflecting the need for centralization of care in highly skilled teams to optimize the results of complex management of fertility-sparing treatments.

Fertility Preservation and Assisted Reproduction in Patients With Breast Cancer Interrupting Adjuvant Endocrine Therapy to Attempt Pregnancy

Hatem A. Azim et al. Samuel M. Niman, Ann H. Partridge, Isabelle Demeestere, Monica Ruggeri, Marco Colleoni et al
Journal of Clinical Oncology,Volume 42, Number 23,May 2024
https://doi.org/10.1200/JCO.23.02292

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

Purpose

We investigated time to pregnancy, efficacy and safety of fertility preservation, and assisted reproductive technologies (ARTs) in women with early hormone receptor–positive breast cancer (BC) desiring future pregnancy.

Patients and Methods

POSITIVE is an international, single-arm, prospective trial, in which 518 women temporarily interrupted adjuvant endocrine therapy to attempt pregnancy. We evaluated menstruation recovery and factors associated with time to pregnancy and investigated if ART use was associated with achieving pregnancy. The cumulative incidence of BC-free interval (BCFI) events was estimated according to the use of ovarian stimulation at diagnosis. The median follow-up was 41 months.

Results

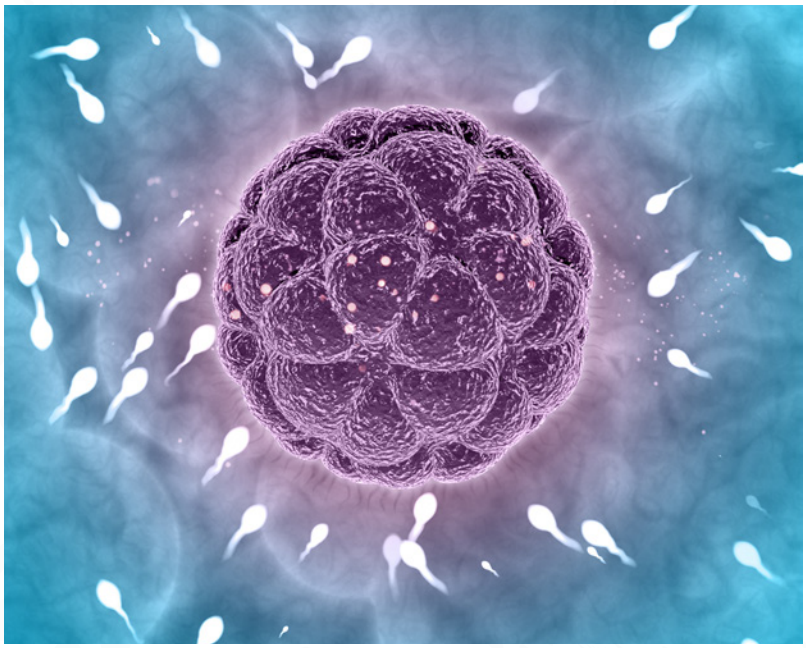
Two hundred seventy-three patients (53%) reported amenorrhea at enrollment, of whom 94% resumed menses within 12 months. Among 497 patients evaluable for pregnancy, 368 (74%) reported at least one pregnancy. Young age was the main factor associated with shorter time to pregnancy with cumulative incidences of pregnancy by 1 year of 63.5%, 54.3%, and 37.7% for patients age <35, 35-39, and 40-42 years, respectively. One hundred and seventy-nine patients (36%) had embryo/oocyte cryopreservation at diagnosis, of whom 68 reported embryo transfer after enrollment. Cryopreserved embryo transfer was the only ART associated with higher chance of pregnancy (odds ratio, 2.41 [95% CI, 1.75 to 4.95]). The cumulative incidence of BCFI events at 3 years was similar for women who underwent ovarian stimulation for cryopreservation at diagnosis, 9.7% (95% CI, 6.0 to 15.4), compared with those who did not, 8.7% (95% CI, 6.0 to 12.5).

Conclusion

In POSITIVE, fertility preservation using ovarian stimulation was not associated with short-term detrimental impact on cancer prognosis. Pregnancy rates were highest among those who underwent embryo/oocyte cryopreservation followed by embryo transfer.

Acknowledgement:

This article is a compilation from " Fertility Preservation and Assisted Reproduction in Patients With Breast Cancer Interrupting Adjuvant Endocrine Therapy to Attempt Pregnancy Hatem A. Azim et al. Samuel M. Niman, Ann H. Partridge, Isabelle Demeestere, Monica Ruggeri, Marco Colleoni et al.Journal of Clinical Oncology,Volume 42, Number 23,May 2024..



Planned oocyte cryopreservation: A Systematic Review and Meta-regression analysis

Ayala Hirsch, Bruria Hirsh Raccah, Reut Rotem, Jordana H Hyman, Ido Ben-Ami, Avi Tsafrir
Human Reproduction Update, Volume 30, Issue 5, September-October 2024
doi.org/10.1093/humupd/dmae009

Compiled by:Dr Priyanka Thakur,Senior Consultant and Fertility Specialist, Kullu, Himachal Pradesh

Background

Awareness of the age-related decline in fertility potential has increased the popularity of planned oocyte cryopreservation (POC). However, data regarding outcomes of POC, including rates of women returning to thaw oocytes, as well as pregnancy and live birth rates, are scarce and based mostly on small case series.

Objective And Rationale

POC was defined as cryopreservation exclusively for prevention of future age-related fertility loss. The primary outcome was live birth rate per patient. The secondary outcomes included the return to thaw rate and laboratory outcomes. A meta-regression analysis examining the association between live birth and age above 40 or below 35 was conducted.

Search Methods

We conducted a systematic database search from inception to August 2022. The search included PubMed (MEDLINE) and EMBASE. Our search strategies employed a combination of index terms (Mesh) and free text words to compile relevant concepts. The systematic review and meta-regression were undertaken following registration of systematic review (PROSPERO registration number CRD42022361791) and were reported following guidelines of Preferred Reporting Items for Systematic Review and Meta-Analyses 2020 (PRISMA 2020).

Outcomes

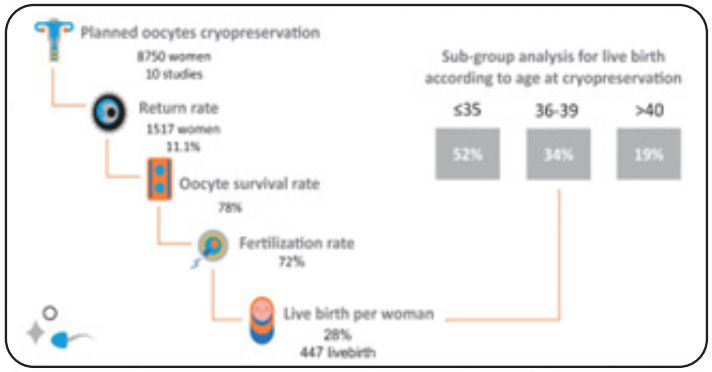
The database search yielded 3847 records. After the selection process, 10 studies, conducted from 1999 to 2020, were included. Overall, 8750 women underwent POC, with a mean cryopreservation age of 37.2 (±0.8). Of those, 1517 women returned to use their oocytes with a return rate of 11.1% (± 4.7%). The mean age at the time of cryopreservation for women who returned to use their oocytes was 38.1 (±0.4), with an average of 12.6 (±3.6) cryopreserved oocytes per woman. In a meta-analysis, the oocyte survival rate was 78.5% with a 95% CI of 0.74–0.83 (I2 = 93%). The live birth rate per patient was 28% with a 95% CI of 0.24–0.33 (I2 = 92%). Overall, 447 live births were reported. In a sub-group analysis, women who underwent cryopreservation at age ≥40 achieved a live birth rate per patient of 19% (95% CI 0.13–0.29, I2 = 6%), while women aged ≤35 years old or younger had a higher live birth rate per patient of 52% (95% CI 0.41–0.63, I2 = 7%).

Wider Implications

POC emerges as a feasible option for women aiming to improve their chances of conceiving at a later reproductive age. Nonetheless, it must be acknowledged that the overall success rates of POC are limited and that the likelihood of successful live birth declines as the age at cryopreservation rises. With increasing interest in POC, the collation of comprehensive and high-quality data is imperative to clearly define the outcomes for various age groups.

Acknowledgement:

This article is a compilation from “Planned oocyte cryopreservation: A Systematic Review and Meta-regression analysis. Ayala Hirsch, Bruria Hirsh Raccah, Reut Rotem, Jordana H Hyman, Ido Ben-Ami, Avi Tsafrir.Human Reproduction Update, Volume 30, Issue 5, September-October 2024.”



Fun Fact

Increasing patient age correlates to decrease in oocyte competency, leading to greater challenges in successful fertility treatment. Clinically, patient age and number of oocytes is used to estimate probabilities of success. However, oocyte quality may vary widely between patients of the same age, and even within each cohort of oocytes. VIOLET is an AI tool that assesses images of mature denuded oocytes to provide an analysis shown to significantly correlate with subsequent blastocyst development and quality.

Use of Tamoxifen-Controlled Ovarian Hyperstimulation for fertility preservation before breast cancer treatment: a prospective cohort study with a 5-year follow-up.

Dezellusa, S. Mirallieb, F. Leperlierb, B. Sautereya, P.-E. Bouetc, A. Dessaintd et al
Breast. 2024 Aug 3;77:103776. doi: 10.1016/j.breast.2024.103776.
Compiled by: Dr Neera Mehta,Consultant,Mehta Nursing Home,Kharar,Punjab

Purpose:

Fertility issues are of great concern for young women undergoing treatment for breast cancer (BC). Fertility preservation (FP) protocols using controlled ovarian stimulation (COS) with letrozole have been widely used with overall good results. However, letrozole cannot be used in every country in this context. This study aimed to assess the efficacy of tamoxifen for COS in women with early BC undergoing FP.

Methods:

This multicentric prospective study included patients aged 18–40, diagnosed with stage I, II and III invasive BC, undergoing tamoxifen-COS before adjuvant or neoadjuvant chemotherapy (NAC). The primary endpoint was the efficacy of tamoxifen-COS protocol evaluated by the number of oocytes collected and vitrified. Secondary endpoints included the time interval before chemotherapy, breast cancer (BC) recurrence rates, and reproductive outcomes.

Results:

Ninety-five patients were included between 2014 and 2017, aged 31.5 ± 4 years on average. 37.9 % received NAC and 62.1 % received adjuvant chemotherapy. FP procedure was successful in 89.5 % of the cycles. The mean number of collected and vitrified oocytes was 12.8 ± 7.9 and 9.8 ± 6.2, respectively. The mean duration of COS was 10.4 ± 1.9 days. Median time before chemotherapy initiation was 3.6 weeks (IQR 3.1; 4.1) for women receiving NAC. Five-year relapse-free and overall survival rates were in-line with those expected in this population. Twenty-one women had spontaneous full-term pregnancies, while 5 underwent IVF cycles with frozen-thawed oocytes, without pregnancy.

Conclusion:

Tamoxifen-COS protocols appear to be feasible before adjuvant or NAC treatment in young BC patients and efficient in terms of oocyte yield.

Acknowledgement:

This article is a compilation from 'Use of Tamoxifen-Controlled Ovarian Hyperstimulation for fertility preservation before breast cancer treatment: a prospective cohort study with a 5-year follow-up. Dezellusa, S. Mirallieb, F. Leperlierb, B. Sautereya, P.-E. Bouetc, A. Dessaintd et al.Breast. 2024 Aug 3;77:103776. '

Probable future of Onco-fertility

Chemoprotection of the ovary

Role of CHEK point inhibitors

CHEK1/2 inhibitors prevent the apoptosis of human oocytes induced by chemotherapeutic agents and even enhanced its anti-tumour effects.

This protective effect appeared to be mediated by inhibiting DNA damage via the CHEK-TAp63a pathway and by generation of anti-apoptotic signals in the oocytes.

Case Report:

RANDOM START PROTOCOL FOR COS IN A CANCER PATIENT FOR FERTILITY PRESERVATION-CASE STUDY

Fertility Preservation in a Patient with Endometrial Cancer

Dr Jasneet Kaur, Clinical Director and Consultant,Milann Fertility Centre,Chandigarh
Dr Sanjana,FRM Resident,Milann Fertility Centre,Chandigarh

Mrs X, 35 years old, presented to our fertility clinic with an inability to conceive for the past 5 years. Her menstrual history was suggestive of anovulatory cycles. She had received multiple cycles of ovulation induction prior to being diagnosed with a tubal factor on HSG. Laparoscopy was suggestive of a bilateral fimbrial block and her endometrial curettings were positive for Kochs on DNA PCR. She was started on ATT for 6 months. She also had a history of impaired glucose tolerance and took metformin 500 mg twice daily on and off. Both her parents were diabetic, on oral hypoglycaemic agents. She was obese, with a BMI of 27kg/m2 and was borderline hypertensive. An endometrial biopsy done a year prior was suggestive of simple endometrial hyperplasia without atypia.

Transvaginal ultrasound done on day 12 of her cycle, revealed an echogenic endometrium measuring 15 mm, with an ill-defined 8 mm polyp at the fundus, with bilateral polycystic ovarian morphology and no dominant follicle.

With these USG findings, and her previous HPE report,a repeat EB was done. It revealed the presence of atypical complex hyperplasia, with foci of well-differentiated endometrioid adenocarcinoma Grade 1. Findings were reviewed by another pathologist, who concurred. MRI done was suggestive of an ill-defined, hypointense T2 lesion at the fundus, measuring 8x6 mm, without myometrial invasion.

The patient was advised to undergo definitive surgery. However, she expressed a strong desire to preserve her fertility. She was referred to a gynae oncologist for further evaluation. A repeat hysteroscopic guided biopsy was done and a polypoidal lesion was identified in the fundal region. The HPE confirmed well-differentiated adenocarcinoma Grade 1 with molecular profiling showing p53 mutant positivity.

The patient was started on megestrol acetate 80 mg three times daily, and a levonorgestrel intrauterine contraceptive device (LNG-IUCD) was inserted. Metformin 500 mg twice daily was restarted , and she was encouraged to lose weight. The patient was also offered genetic counselling.

Repeat hysteroscopic guided endometrial biopsies done at 3 and 6 months post-treatment were negative for malignancy, allowing for cessation of megestrol. The patient was then referred back to the fertility clinic and was planned for controlled ovarian stimulation (COS) with the progestin-primed ovarian stimulation (PPOS) protocol. Ovarian stimulation was started with recombinant follicle-stimulating hormone (follitropin-alfa Gonal-f®, EMD Serono, Inc.,) for the first 5 days followed by Menopur (highly purified HMG-Ferring Pharmaceutical Ltd.) for the next 6 days along with MPA 10 mg once daily. Letrozole 2.5 mg twice daily was administered throughout the stimulation. ET was illdefined with the LNG-IUS in situ. Decapeptyl 0.2 mg subcutaneously was given as the trigger and OPU performed 35 hours later under general anaesthesia, using transvaginal ultrasound guidance.

Only four mature oocytes (M2) were retrieved, out of which all fertilised and cleaved and two 4AA blastocysts were cryopreserved on day 5. A diagnosis of partial empty follicle syndrome (EFS) was made. Post OPU, Letrozole was continued till E2 levels dropped below 50 pg/mL. The LNG-IUCD was removed on the day of oocyte retrieval.

A frozen embryo transfer (FET) was planned in a stimulated cycle with letrozole. However, due to suspicious findings on ultrasound, a pre-FET hysteroscopic guided endometrial biopsy was done, which revealed a well-differentiated endometroid adenocarcinoma. MRI findings also indicated disease progression with an increased lesion size with a possible myometrial invasion. The patient now opted for definitive surgery. The postoperative pathology confirmed a well-differentiated adenocarcinoma confined to the uterus, with clear lymph nodes and parametrium. Postoperatively, she chose to pursue surrogacy, and an application has been submitted to the appropriate authorities for the same .

Conclusion: This case underscores the importance of close surveillance when managing patients with endometrial cancer undergoing fertility preservation . Despite initial favourable treatment responses, the risk of relapse and disease progression remains significant, necessitating vigilant monitoring and timely intervention.

First report on successful delivery after re-transplantation of vitrified, rapid warmed ovarian tissue in Germany,Europe by Dr Nicole Sangers group.

This complements the successful deliveries reported by the groups of Suzuki (Japan) and Silber (USA) on using vitrified tissue, the current results confirm the high potential of this cryopreservation method as an alternative approach to the widespread slow freezing method.

MCQs

1

Which of the following statements are true?
In patients with endometrial cancer planned for fertility sparing treatment

a. A combined approach consisting of hysteroscopic tumour resection, followed by oral progestins and/or levonorgestrel-intra-uterine device, is the most effective

b. Orally administered megestrol acetate at a dose of 160–320 mg/day or medroxyprogesterone acetate at a dose of 400–600 mg/day is recommended

c. Weight control during fertility-sparing treatment is highly recommended to increase the chance of response

d. All statements are true

2

According to the ESHRE Fertility Preservation guidelines 2020 which of the following is not an established /innovative method of fertility preservation

a. Oocyte cryopreservation

b. Ovarian Tissue cryopreservation

c. OTO-IVM

d. All are experimental

3

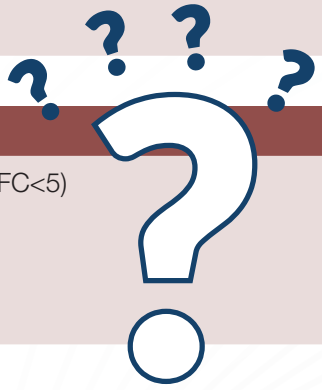
Which of the following statements are true?

a. Pregnancy is generally safe in women who are breast cancer survivors independent of estrogen receptor status of the tumour.

b. It is recommended to stop tamoxifen for at least 3 months before attempting pregnancy.

c. Pregnancy after treatment for breast cancer should be closely monitored, as there is an increased risk of preterm birth and low birth weight.

d. All are true.



4

OTC should not be offered in which patients?

a. Patients with a low ovarian reserve(AMH<0.5ng/ml and AFC<5)

b. Patients who have had prior exposure to chemotherapy

c. Patients younger than 25 years

d. Can be offered to all the above.

5

Which of the following statements is true?

a. Ovarian reserve should be assessed before cancer therapy by measuring AMH and AFC

b. AMH levels should be done before and 1 year after gonadotoxic therapy to predict recovery of ovarian function

c. Pre treatment AMH should not be used as an indicator of post treatment fertility

d. All the above are true

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

Invitation

28th-29th September, 2024
at **Vivanta Hyderabad Begumpet**
1-10-147 & 148, Mayur Marg, Begumpet,
Hyderabad, Telengana, 500016, India

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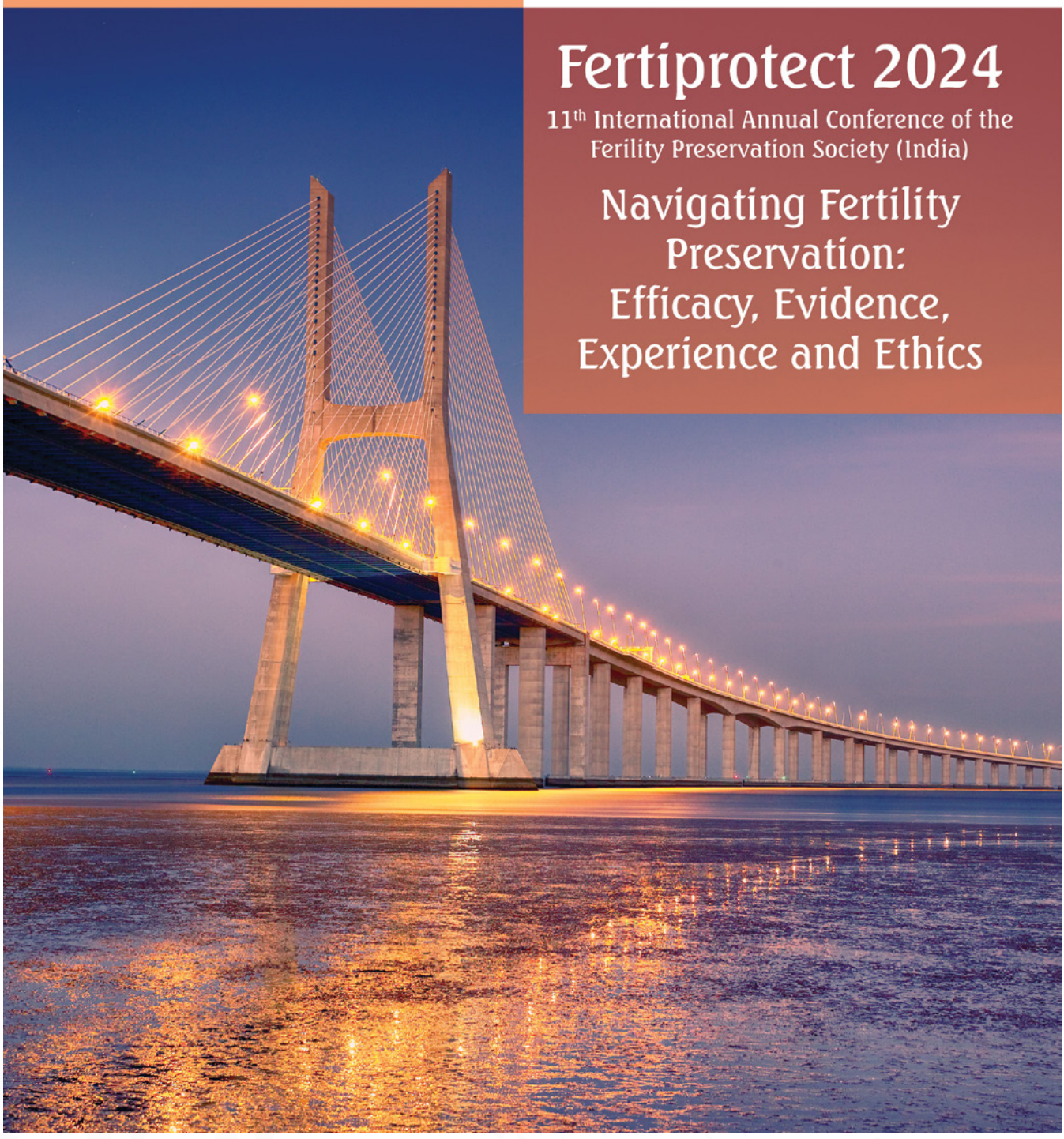

Fertiprotect 2024

11th International Annual Conference of the Ferility Preservation Society (India)

Navigating Fertility Preservation: Efficacy, Evidence, Experience and Ethics

Welcome Message

Dear Friends and Colleagues,

It is our pleasure to welcome you all to this global fertility preservation event organized by the Fertility Preservation Society (India). Fertility preservation plays a critical role in the lives of many young couples who are struggling with the possibility of current or future reproductive compromise. The ever-expanding horizon of fertility preservation encompasses young women and men with varying conditions – be it social or disease-related. The theme of this conference "Navigating Fertility Preservation: Efficacy, Evidence, Experience and Ethics" embodies this aspect of fertility preservation. We believe that Fertility Preservation is not only about cancer anymore. We have a diverse group of experts from various fields who will be sharing their expertise and research findings with us. We encourage gynaecologists, embryologists, oncologists, and reproductive medicine specialists to join us for this incredibly informative event.

The conference provides a unique opportunity to network and collaborate with peers and explore innovative solutions that will help patients in our own country. We welcome young investigators looking to share their research. Please mark your calendar for this exciting event!

We look forward to welcoming you to this conference at Hyderabad, and we wish you all a productive and enjoyable experience.

Thank you!

Dr. Madhuri Patil
President FPSI

Dr. Shobhana Patted
General Secretary

Dr. Nalini Kaul (Mahajan)
President ASFP

Dr. Vyjayanthi S
Organising Chairperson

Mr. P Durai
Organising Secretary

Scan QR Code to Register

FPSI Membership Request Form

FPS(I)
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Fertility Preservation Society (India)

Registered Office & Secretariat: No 1, Uma Admirality, First Floor,
Bannerghatta Road, Bangalore 560029.

Name: _____

Qualification: _____ Date of birth: _____

Designation: _____

Address:

Workplace: _____

Residence: _____

Address to be used for correspondence ☐ Workplace ☐ Residence

Telephone No. : Workplace: _____ Residence _____

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Date: Bank:

Signature: _____ Name: _____ Date: _____

Please make Cheque / Draft in Favor of

FERTILITY PRESERVATION SOCIETY
A / C No: 914020019747855 (Axis Bank)
IFSC Code: UTIB0001358
Branch: Safdarjung Enclave, New Delhi

Please attach two recent passport size photographs

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

Journal **Website:**

www.tofjonline.org

Manuscript **Submission:**

https://review.jow.medknow.com/tofj

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