See we are talking. Generally about the topic of uncle fertility, and more specifically about reproductive endocrinology and infertility. Referral for fertility preservation and patients undergoing chemotherapy or Granada. Toxic therapy as the poster said. And we’re joined by two members of the OB GYN department, both who are relatively young in their careers. I don’t actually know who’s going first, and I’m going to introduce both of them together as we start.
and they can decide that.

So we have two speakers.

We have Tanya Glenn, who’s originally from Rochester, MN and went to college at Truman State University in Missouri and then went on to attend medical school at Saint Louis University School of Medicine. She’s in her final year of REI training at Yale and is going to be taking a position at Brooks Army Medical Center.
After completing her fellowship this year. And she is joined by Gabriella Barouch Kim, who is from Los Angeles, originally received her undergraduate degree at UCLA, where she received a number of honors and went on to medical school at UCSF. She is a third year resident in OBGYN and is also interested in REI. And is in the process of applying for reproductive endocrinology and infertility fellowships as the parent of a child who went through the Yale OBGYN Residency.
It’s always nice to interact with the Yale OBGYN and residents, so they’re here today and I’m not entirely sure what order. I’m not entirely sure who’s talking. You’re both on one screen and I think you can figure it out.

Welcome, thank you for joining us.

So I’m Gabriella. I’m here with Doctor Glenn. We’re actually going to be Co presenting and Doctor Glenn is going to help answer
questions at the end as well.

OK, your slides. They look perfect.

Perfect thank you so much.

So today as you already mentioned, we’re going to be talking about fertility preservation for patients undergoing gonadal toxic therapy.

Our objective with this talk is to try to raise awareness for fertility preservation. So our objective with this talk is to try to raise awareness for fertility preservation.

Encourage patient and provider discussions surrounding the implications of cancer.

Treatment on future reproductive capacity, improve multidisciplinary collaboration.
between providers caring for these patients and reproductive specialists, and discuss options for fertility preservation for patients who hope to preserve their reproductive capacity. So first I’d like to start with a little bit of background on this topic. The term oncofertility was coined by Doctor Woodruff and it refers to a field of medicine concerned with minimizing the negative effects of cancer treatment on the reproductive system and fertility, with assisting individuals with reproductive impairments resulting from cancer therapy. So what population are we referring to when we discuss fertility preservation?
For patients undergoing cancer therapy?

So over 200,000 people under the age of 49 are diagnosed with cancer annually and 85% of patients less than 39 years old will survive for five years.

70,000 new cases a year of cancer are diagnosed in adolescence and young adults of these patients, more than 90% of them, will survive for at least five years, and these patients tend to be healthier and tolerate more intense therapies, which is relevant because more intense therapies can drastically reduce the reproductive lifespan.
Certain cancer treatments such as radiation, chemotherapy, and surgery, can lead to sterility and subfertility. So next I’d like to briefly discuss what some of the morbidities of these therapies. Specifically regarding radiation therapy, there are acute morbidities, including primary hypogonadism, premature ovarian insufficiency, central hypogonadism, and then there are late morbidities, specifically for patients who are undergoing radiation to the brain, and then there are late morbidities.
including secondary cancers that can result from radiation therapies,
hypothalamic pituitary ovarian access deficiencies.
Spinal cord dysfunction,
which can potentially lead to impotence among males and infertility or ovarian insufficiency.
Regarding the effects of chemotherapy,
there are the effects of late morbidity,
including infertility,
premature ovarian insufficiency and primary hypogonadism,
and there are increased risks specifically with people who are
receiving alkylating agents or patients with Hodgkin’s lymphoma or breast cancer with undergoing adjuvant therapy where at increased risk of premature ovarian insufficiency.

Regarding stem cell therapies and the effects of those, those can lead to gonadal dysfunction and the late morbidity associated with those include secondary cancers and endocrine dysfunction. For example, if somebody would...
need to undergo removal of their ovaries or fallopian tubes. So different therapies have different reproductive risks associated with them, so high risk therapies include high dose pelvic radiation, radiation to the brain, hematopoietic stem cell transplantation, total body radiation or chemotherapy with high dose alkylating agents, whereas low risk therapies include low dose radiation to the pelvis, non alkylating chemotherapeutic drugs. Or antimetabolites.
So now I’d like to transition a bit to discuss the importance of counseling these patients. All patients of reproductive age who will undergo potentially gonadal toxic therapies should be receiving fertility counseling. This is in line with guidelines from the American Society of Clinical Oncology, which reports that all oncologic healthcare providers should be prepared to discuss infertility as a potential risk of therapy. The NCCN practice guideline also says that fertility preservation is an essential element of management of
adolescents and young adults with cancer. That being said, less than half of US doctors inform cancer patients of childbearing age about fertility preservation, and only 47% of US doctors routinely refer cancer patients of childbearing age to reproductive endocrinologist. 54% of oncologists do not discuss fertility, according to the JNC that was published in 2013, whereas specifically pediatric oncologists tend to do a bit better and 94% of pediatric oncologists discuss fertility. And what basically this highlights
is that there is a discrepancy between the current guidelines and the reality regarding counseling, and this is something for all of us to work on and an area for improvement to increase access to fertility preservation.

So what about Yale? What is going on? How are you doing with counseling at Yale regarding fertility preservation for patients undergoing therapy for their cancer? So we do have one study that looks into how what percentage of patients are being counselled specifically for patients who are prescribed cyclophosphamide. The study included 236 reproductive age women between December of 2019 and October of 2021.
And of these 236 patients, 33% received family planning counseling and 9% were offered ovarian tissue cryopreservation. There were certain factors which modified a patient’s likelihood for receiving counseling and those included Caucasian race, age less than 40, and those who had living children were less likely to receive this counseling. So how can we improve access for fertility preservation? There are several things that need to happen for us to achieve that goal.
One is to increase awareness.

Next would be to assess patient’s interest in receiving fertility preservation treatment, as well as the provider providing basic counseling regarding fertility preservation.

Placing a referral when indicated, and then ensuring that a patient is able to access this care.

So how do we increase awareness?

Well, patients are often overwhelmed by a cancer diagnosis, especially when they first receive that diagnosis. They can be worried about delays in cancer treatment,
00:11:40.830 --> 00:11:44.662 or they could just be unaware of the potential effects of their therapy on their reproductive capacity.

00:11:44.662 --> 00:11:47.543 The medical team already has a considerable amount of counseling to do when a patient receives this diagnosis, and oftentimes that the discussion of fertility preservation cannot be prioritized.

00:11:49.980 --> 00:11:52.614 The medical team already has a considerable amount of counseling to do when a patient receives this diagnosis, and oftentimes that the discussion of fertility preservation cannot be prioritized.

00:11:52.614 --> 00:11:55.219 However, the onus really falls on the medical team to be able to identify these patients who are at risk and to be able to provide basic counseling and place the referral to reproductive endocrinology when indicated.

00:11:55.219 --> 00:11:57.535 when a patient receives this diagnosis, and oftentimes that the discussion of fertility preservation cannot be prioritized.

00:12:00.996 --> 00:12:04.380 However, the onus really falls on the medical team to be able to identify these patients who are at risk and to be able to provide basic counseling and place the referral to reproductive endocrinology when indicated.
optimize this awareness so one is just through education and collaboration,
which is why doctor Glenn and I are here is to try to promote that and something else that we that we proposed was epic optimization,
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00:13:12.900 --> 00:13:16.260 to reproductive endocrinology or not.
00:13:16.260 --> 00:13:18.570 Facing a referral or acknowledging that
00:13:18.570 --> 00:13:21.238 this is not applicable for this patient.
00:13:23.850 --> 00:13:27.082 After a provider is met with
00:13:27.082 --> 00:13:29.910 this alert they would then when
00:13:29.910 --> 00:13:32.863 indicated either place a consult to
00:13:32.863 --> 00:13:36.263 gynecology when a patient is in the
00:13:36.263 --> 00:13:39.170 if they are in
00:13:39.170 --> 00:13:40.995 the outpatient setting they would
00:13:40.995 --> 00:13:43.229 simply just place an REI referral.
00:13:43.230 --> 00:13:46.830 I just want to highlight here that when
00:13:46.830 --> 00:13:49.682 patients are in the inpatient setting,
00:13:49.682 --> 00:13:53.280 that console is a general consult to
00:13:53.280 --> 00:13:56.140 gynecology. Once that console is placed,
00:13:56.140 --> 00:13:58.920 the guide, the inpatient gynecology
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responder team will contact reproductive endocrinology. This can also be done for preservation. For male patients, it would still be a gynecology consult in that case as well. So now regarding education, the Oncofertility Conservatorium was developed in 2007 to address the lack of knowledge concerning fertility, preservation and the National physicians cooperative includes 83 institutions, including oncologists, surgeons, endocrinologists, reproductive endocrinologist, urologist, rheumatologist, geneticist, and mental health providers,
and below are also different links. That can be used by both providers and patients to promote education on this topic. And then regarding counseling. So there are several steps involved in counseling patients, including informing patients of the potential risks to fertility. Referring patients to REI if they are interested as well as following up on those patients. At this point I want to just.
00:15:30.290 --> 00:15:32.661 transition a bit to discuss to
00:15:32.661 --> 00:15:34.481 discuss patient perspectives and
00:15:34.481 --> 00:15:36.889 hopefully this will help highlight
00:15:36.889 --> 00:15:39.369 again the importance of this topic.
00:15:42.680 --> 00:15:46.397 So in a study that looked at
00:15:46.397 --> 00:15:50.280 female cancer survivors. Umm?
00:15:50.280 --> 00:15:52.992 There was an increased rate of
00:15:52.992 --> 00:15:54.800 pregnancy termination among female
00:15:54.873 --> 00:15:57.489 cancer providers due to a fear of the
00:15:57.489 --> 00:15:59.973 effect of their therapies on their
00:15:59.973 --> 00:16:02.173 future on their future children,
00:16:02.180 --> 00:16:03.820 and what this really highlights
00:16:03.820 --> 00:16:05.460 is a gap in education.
00:16:07.800 --> 00:16:10.619 This study also showed that 91%
00:16:10.619 --> 00:16:12.614 of female cancer survivors felt
00:16:12.614 --> 00:16:15.334 that their quality of life was
improved after receiving counseling
and treatment about fertility.
There was also a cross sectional study
concerning fertility after cancer,
where the primary outcome was use of
fertility treatment and in this study,
75% of participants reported that having
a biological child was important to them.
15% of these participants actually used fertility services.
And survivors were less likely to pursue
infertility treatment due to a fear of adverse effects on their personal health,
which again highlights a gap in their education.
Other patient perspectives include a survey from the Journal of Clinical Oncology. In this survey, 81% of teen girls and 93% of their parents would be interested in fertility preservation, even if that method were to be experimental. In a survey from the Journal of Assisted Reproduction and Genetics, 12.5% of patients reported that they would regret if they were unable to use the tissue that they preserved for ovarian tissue preservation. In these patients and parents felt more in control of their decision with receiving this counseling.
There are studies and surveys that indicate that 26% to 80% of individuals remember discussing fertility. This range really highlights the variability in each practice. 68% of males and 14% of females remembered being offered a referral for fertility preservation. And then this last statistic reports that female survivors were less likely to be prescribed infertility medications after seeking help, and that relative risk was 0.57. And what this shows us is that there’s also a lack of education among providers.
So next, I’d like to speak about the different methods that can be offered to patients for fertility preservation. There are many proven as well as experimental methods for preserving fertility. These include gamete or embryo cryopreservation, ovarian tissue, or whole ovary preservation, suppression of damage which can include decreasing the dose of a certain therapy or using an alternative therapy. Decreasing the dose to the gonads, or steel or shielding the gonads, or avoidance of damage entirely.
which could entail. Removing the gonads or using an alternative therapy.

So to discuss some of the proven methods, the gold standard is considered embryo cryopreservation. This process includes stimulating the ovaries with gonadotropins, surgically retrieving oocytes, inseminating the O sites, culturing them for three to five days, and then cryo preserving them. This tends to have a high success with 90% survival of embryos and live birth rates between 22 to 35.
Percent, this whole process takes about two to three weeks, and some of the cons include exposure to high dose hormones, the time involved, and the fact that the patient would need either partner or donor sperm. Another option is mature O site cryopreservation. This tends to have slightly lower success rates between 50 and 90% survival. That’s likely due to attrition of the O sites, as they need to be frozen, thawed, then inseminated. And sorry it fertilized and matured.
This process takes essentially the amount the same amount of time as.

Embryo choir preservation.

There are fewer ethical objections and no partner is required for oversight chair preservation.

Another proven method includes O for praxy. This has a success rate between 16 and 90% and involves fixing the ovary to the pelvic brim with a surgical clip. This is typically used for patients who will be exposed to, for example, radiation therapy to the pelvis and what it’s essentially doing is moving.
the gonads away from that site.

There are no ethical obligations,

I’m sorry there’s no ethical objections

to over prexy and enables a patient

to be able to use their own O sites

and there’s no stimulation required.

Some of the cons include that.

It really depends on a

patient’s vascular system.

It depends on their age.

It depends on the dose of

radiation that they’re receiving,

and it can also be affected if

the area is not shielded. The.

Other methods for.

For fertility preservation,
include ovarian tissue cryopreservation. This was previously thought to be experimental and is now a proven method and involves obtaining ovarian cortical tissue prior to ovarian failure. The tissue is obtained via laparoscopy or laparotomy. The tissue is dissected into small fragments, cryopreserved, and then can later be transplanted. Most typically, that’s done as an orthotopic transplant. Live birth rates are between 23 and 25% and this is particularly...
00:22:44.065 --> 00:22:46.797 useful for prepubescent girls,
NOTE Confidence: 0.759999091666667
00:22:46.800 --> 00:22:48.824 and it can also be used as a
NOTE Confidence: 0.759999091666667
00:22:48.824 --> 00:22:50.809 form of endogenous hormones.
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00:22:50.810 --> 00:22:54.700 Once this tissue is retransplantation.
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00:22:54.700 --> 00:22:58.210 Some of the cons include.
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00:22:58.210 --> 00:23:02.919 That reimplantation of potential
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00:23:02.919 --> 00:23:05.988 cancer potential cancer.
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00:23:05.990 --> 00:23:08.348 Once the tissue is removed and
NOTE Confidence: 0.759999091666667
00:23:08.348 --> 00:23:09.920 then reimplanted the uncertain
NOTE Confidence: 0.759999091666667
00:23:09.988 --> 00:23:11.598 life span of this tissue.
NOTE Confidence: 0.759999091666667
00:23:11.600 --> 00:23:14.384 The fact that it requires surgery
NOTE Confidence: 0.759999091666667
00:23:14.384 --> 00:23:17.532 and may require IVF down the line
NOTE Confidence: 0.759999091666667
00:23:17.532 --> 00:23:20.211 and the age limit such that patients
NOTE Confidence: 0.759999091666667
00:23:20.211 --> 00:23:22.459 who are typically over the age of 40
NOTE Confidence: 0.759999091666667
00:23:22.459 --> 00:23:24.537 will have less benefit in this case.
NOTE Confidence: 0.759999091666667
00:23:29.480 --> 00:23:31.643 Next, I'd like to go over just
a few experimental methods which include whole ovary, including pedicle cryopreservation. This is typically reserved for very young patients whose ovaries are very small, for which ovarian tissue, cryo. Location would be very difficult. Another experimental method includes GNRH agonist therapies. The thought process with this is that we shut down the ovaries while a patient is receiving their cancer therapy, and the thought is that when these ovaries are less active, they’ll be less susceptible to the
harmful effects of the therapies.

Some alternative options for patients include the use of donor eggs, donor ombria embryos, surrogates or adoption.

Lastly, to go over what happens post treatment for these patients.

So regarding evaluation of their fertility down the line, most reproductive endocrinologists or gynecologists would look for patients to resume their menstrual cycle as well as test their anti mullerian hormone level to get a proxy of their ovarian reserve.

Regarding the use of medications
and outcomes for these patients, generally we use the same medications. However, as already mentioned, if a patient has an estrogen sensitive cancer, we can consider adding letrozole and aromatase inhibitor or tamoxifen to reduce the exposure to high levels of estradiol. There are lower pregnancy rates in the first five years with autologous samples. The lower pregnancy rate is 60%. However, notably, if someone were to use donor O sites, the lower pregnancy rate is 60%. However, notably,
pregnancy rates tend to be fairly comparable.

Regarding pregnancy complications, pregnancy does not affect recurrence of any cancer and generally pregnancy complications tend to be very low.

The one exception to this is that some patients who receive very high dose of radiation to the uterus, especially at a young age, can potentially have a bit higher risk.

Pregnancy outcomes and pregnancy complications.

Regarding risk to offspring, there is no increased risk of anomalies.

However, a provider may consider referring a patient to a genetic
counselor specifically, if there is a genetic predisposition to cancer. Some other concerns that I'd like to briefly discuss include some safety concerns so. It should be determined by a multidisciplinary team, including the medical oncologist and reproductive endocrinologist. As to a discussion of the risks, benefits, preferences, and prognosis of this patient to discuss whether pursuing fertility preservation would be safe for the patient.
There should also be consideration paid to trying to prevent any delays in oncologic treatment.

Regarding the legal implications, we should acknowledge the legal implications of not following the standard of care as well as the medical liability and potential malpractice with omission of information specifically regarding the risks of cancer therapies on reproductive capacity.

Additionally, the ethical considerations to consider that every patient has the right to know their options concerning fertility preservation as well as the risks and costs associated with that.
Posthumous utilization.

This typically will depend on a patient’s advance directive.

Minors who are diagnosed with cancer will typically require a surrogate decision maker.

And of course, the cost of these therapies.

Just to briefly discuss the cost.

There is legislation regarding costs specifically in Connecticut.

In general, in 1942, the US Supreme Court acknowledged that procreation is a basic civil right and then specifically in Connecticut.
We do have the fertility preservation bill. This was an acted, and basically it ensures that patients are covered for fertility preservation. If they have a medical necessity and having prior cancer treatment is considered, makes fertility preservation a medical necessity, and so patients who have private insurance. Have have this cost covered under this bill. Unfortunately, that bill does not cover the cost for people without insurance or for people with Medicaid, and so there are other means to try to reduce that cost for those patients,
and they are listed below.

So for example, with repro tech,
they provide discounted long term storage of ovarian tissue as well as O sites and embryos,
specifically regarding the cost of ovarian tissue prior preservation that one tends to be a bit costly.
And can be between 12 to 24,000.

However, this can also vary based off of the patient’s income.

And so, to summarize, some of the things that we discussed today.
Certain cancer treatments such as chemotherapy, radiation and surgery can lead to sterility and subfertility all patients of reproductive age who will undergo potentially genotoxic therapies should receive appropriate counseling. Some of the methods to try to optimize access to fertility preservation include increasing awareness, promoting education and counseling, and collaboration, and methods. To preserve fertility, include embryo 4 O site cryopreservation, for paxi, ovarian tissue cryopreservation, or experimental methods.
Thank you so much for your attention.

Here are some of our references and we’re happy to answer any questions.

There’s.

OK, so we have a question here regarding oh for proxy.

The range of success rates listed are quite wide, from 10 to 90%.

I had heard roughly a 50% chance of damaging the ovary directly from the procedure itself, which seems a high risk since since the risk from radiation is also probabilistic.

Does Yale offer this option?

What do the success rates look like?
00:31:01.526 -- 00:31:03.868 in modern practice and what patients?
NOTE Confidence: 0.92788757142857
00:31:03.870 -- 00:31:06.537 Do well versus poorly with this approach.
NOTE Confidence: 0.92303708
00:31:15.430 -- 00:31:17.978 I actually have not seen any
NOTE Confidence: 0.92303708
00:31:17.978 -- 00:31:19.488 perplexity done here at Yale,
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00:31:19.490 -- 00:31:21.205 but it is actually a simple procedure.
NOTE Confidence: 0.86569425
00:31:21.210 -- 00:31:22.110 It’s the same thing.
NOTE Confidence: 0.86569425
00:31:22.110 -- 00:31:23.890 If we had some with ovarian torsion,
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00:31:23.890 -- 00:31:26.130 it’s actually the same procedure to be done,
NOTE Confidence: 0.86569425
00:31:26.130 -- 00:31:28.210 so it’s something that we can actually do.
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00:31:28.210 -- 00:31:30.260 I haven’t seen a whole lot of public
NOTE Confidence: 0.86569425
00:31:30.260 -- 00:31:31.750 radiation patients come through. I
NOTE Confidence: 0.90801173
00:31:31.760 -- 00:31:33.160 couldn’t give you the exact
NOTE Confidence: 0.90801173
00:31:33.160 -- 00:31:36.450 statistics, mainly because
NOTE Confidence: 0.75860985511111
00:31:36.450 -- 00:31:40.653 the problem is is like it varies on dose.
NOTE Confidence: 0.75860985511111
00:31:40.660 -- 00:31:41.659 Where it’s located?
NOTE Confidence: 0.75860985511111
00:31:41.659 -- 00:31:43.324 Are they shielding or not?
And so that's why you see that wide range. So even with Uber, Paxi would probably still recommend doing an additional. Fertility preservation procedure like tissue or embryo cryopreservation. Just to make sure that if there is any scatter from the radiation we're still protecting them as much as possible. So I have a question for you, so, U, Obviously these issues come up with a fair amount of frequency, and I'm struck that you gave a great talk, but one of you is going off to take
00:32:21.030 --> 00:32:24.596 a job in Texas and and Gabriella,
NOTE Confidence: 0.91166512
00:32:24.600 --> 00:32:26.628 you’re going off to do a
NOTE Confidence: 0.91166512
00:32:26.628 --> 00:32:27.980 fellowship in another year.
NOTE Confidence: 0.91166512
00:32:27.980 --> 00:32:31.500 So who on the in the REI?
NOTE Confidence: 0.91166512
00:32:31.500 --> 00:32:34.188 Faculty is interested in these issues,
NOTE Confidence: 0.91166512
00:32:34.190 --> 00:32:35.438 who we should approach?
NOTE Confidence: 0.669570777333333
00:32:36.810 --> 00:32:38.975 Well, Gavin, be here for
NOTE Confidence: 0.669570777333333
00:32:38.975 --> 00:32:41.620 another year and so I
NOTE Confidence: 0.701417034
00:32:41.660 --> 00:32:43.510 understand that. But you know,
NOTE Confidence: 0.701417034
00:32:43.510 --> 00:32:46.358 again. So in training
NOTE Confidence: 0.809797005454545
00:32:46.710 --> 00:32:48.670 no, absolutely. And so we’re
NOTE Confidence: 0.809797005454545
00:32:48.670 --> 00:32:51.040 working with Doctor Callan as well,
NOTE Confidence: 0.809797005454545
00:32:51.040 --> 00:32:53.343 and she does mainly the probably the
NOTE Confidence: 0.809797005454545
00:32:53.343 --> 00:32:55.980 most of the fertility preservation.
NOTE Confidence: 0.809797005454545
00:32:55.980 --> 00:32:58.997 But the fellows all work together too,
NOTE Confidence: 0.809797005454545
00:32:59.000 --> 00:33:00.132 so it’s everything’s just
kind of passed down for. So my second year fellow, who’s a rising third year now Eric Kahn, would be another good point. Of reference as well.

There’s another chat. The questions. Can you talk a little bit more about your outpatient services? How quickly can these patients be seen, particularly those who need to start anti cancer treatment quickly? Absolutely. So usually the third year fellow actually does all of the at least the Medicaid referrals and other referrals as well.
If you just mark them urgent, we usually can see them within a week if not faster inpatient. Of course we see within 24 hours a lot of times it’s just be like video chat so we can just talk about the options. And start getting things set up on our end, but usually we see people very quickly and you know we manage to squeeze them in somewhere because we know how important this is and. You know the hard part is when patients know are not stable enough, and those are probably the hardest patients, and so usually if they have to undergo cancer treatment immediately,
00:34:10.880 --> 00:34:12.392 we want to make sure that they know how
NOTE Confidence: 0.77724546125
00:34:12.392 --> 00:34:14.155 to find us afterwards so we can start
NOTE Confidence: 0.77724546125
00:34:14.155 --> 00:34:17.370 planning after their treatment as well.
NOTE Confidence: 0.77724546125
00:34:17.370 --> 00:34:18.100 Ohh Kurt,
NOTE Confidence: 0.77724546125
00:34:18.100 --> 00:34:20.655 is there any movement to extend reproductive
NOTE Confidence: 0.77724546125
00:34:20.655 --> 00:34:22.590 coverage to patients with Medicaid?
NOTE Confidence: 0.77724546125
00:34:22.590 --> 00:34:25.814 I wish I’ve not seen any movement from.
NOTE Confidence: 0.77724546125
00:34:25.820 --> 00:34:27.041 Fortunately for that,
NOTE Confidence: 0.77724546125
00:34:27.041 --> 00:34:29.890 I think there’s this an ongoing struggle.
NOTE Confidence: 0.77724546125
00:34:29.890 --> 00:34:31.410 The hard part too is.
NOTE Confidence: 0.77724546125
00:34:31.410 --> 00:34:33.210 I’m not originally from East Coast,
NOTE Confidence: 0.77724546125
00:34:33.210 --> 00:34:34.810 but since all the states are so small
NOTE Confidence: 0.77724546125
00:34:34.810 --> 00:34:36.526 each time you move states we see a
NOTE Confidence: 0.77724546125
00:34:36.526 --> 00:34:38.470 lot of patients from Rhode Island and
NOTE Confidence: 0.77724546125
00:34:38.470 --> 00:34:40.290 Massachusetts and New York and all of
NOTE Confidence: 0.77724546125
those states have different policies

when it comes to fertility preservation,

and so it makes it very difficult

I think, but I have not seen any

improvement in that area.

Can you clarify if the quality

of life statistic is independent

of whether or not the patient

used preservation strategies?

I think the stress is the

importance of referral,

regardless of whether or

not you have time. Yes,

Patients, even if they

cannot pursue the treatment.
Especially they can’t pursue it immediately.

Still appreciate the counseling that they receive so that they’re aware of it.

It’s not 10 years down the road that they’re.

Surprised by this outcome.

Something as well as that we’re doing a lot more ovarian tissue crime preservation.

I’m doctor ate. Who’s a Yale physician, but recently has been working a little bit more with us.

we’re doing a lot more ovarian tissue crime preservation.

a little bit more with us.

He does the ovarian tissue crime preservation, he kind of based out of New York when he comes down and does ovarian just require preservation,
and does a lot of research on fertility, and so we're lucky to have him and that we can kind of continue. Still other areas that we're trying to improve on is, you know, testicular tissue prior preservation. Hopefully we will get more. There's only like 1 area, I think in Philadelphia or Pittsburgh around here. That does that for prepubescent boys, that is still experimental, but there's a lot of different things that we're just trying to bring more to Yale so that we can ensure that we kind of cover...
NOTE Confidence: 0.828731549230769
00:36:20.431 --> 00:36:21.947 everyone for fertility preservation.
NOTE Confidence: 0.828731549230769
00:36:21.950 --> 00:36:24.540 When it comes to male fertility preservation.
NOTE Confidence: 0.828731549230769
00:36:24.540 --> 00:36:27.000 It’s usually if they’re postural,
NOTE Confidence: 0.828731549230769
00:36:27.000 --> 00:36:27.834 very straightforward.
NOTE Confidence: 0.828731549230769
00:36:27.834 --> 00:36:30.336 If there’s any problem with ***********
NOTE Confidence: 0.828731549230769
00:36:30.340 --> 00:36:31.876 or the patients are unable to do so,
NOTE Confidence: 0.828731549230769
00:36:31.880 --> 00:36:34.456 we just have our colleague from Urology, Dr. Honig,
NOTE Confidence: 0.828731549230769
00:36:34.456 --> 00:36:36.536 help us with that,
NOTE Confidence: 0.828731549230769
00:36:36.540 --> 00:36:38.742 but we have our own andrology
NOTE Confidence: 0.828731549230769
00:36:38.742 --> 00:36:40.660 lab and store sperm here.
NOTE Confidence: 0.911451026666667
00:36:46.120 --> 00:36:47.539 Any other questions?
NOTE Confidence: 0.888016965714286
00:36:51.450 --> 00:36:52.650 Well, thank you both.
NOTE Confidence: 0.888016965714286
00:36:52.650 --> 00:36:55.276 It was really great and we
NOTE Confidence: 0.888016965714286
00:36:55.276 --> 00:36:56.848 look forward to interacting
NOTE Confidence: 0.888016965714286
00:36:56.848 --> 00:36:59.117 with your colleagues in the in
NOTE Confidence: 0.888016965714286
the years ahead and good luck.