

## **Elective Report: Obstetrics and Gynaecology in Athens, Greece, with a focus in the area of Reproductive Medicine**

As part of my elective, I chose to explore the area of reproductive medicine, a field of O&G that fascinates me, both for the complicated combination of ethics and science that governs it, but also for the satisfaction it offers assisting patients with conceiving and fulfilling their wishes. I chose to go to Athens as I am fluent in Greek, and was lucky to be accepted in a well known specialist centre accommodating patients from Europe and the whole world, the EMBIO medical centre.

### **Objectives: 1. What is the prevalence and major causes of infertility in the Greek population?**

Working at EMBIO medical centre, made me realise that a great number of couples in Greece deal with infertility. This of course is not a problem exclusive to Greece. As EMBIO is a centre attracting patients from all over the world, it was early evident that infertility is a big health issue globally. The World Health Organisation quotes the prevalence of infertility as 8-10%. This is higher in Europe and therefore in Greece ranges from 10-15%. This may be found lower in the general population and as I was following the activities in a specialist centre there is potential of selection bias.

There is not a specific cause of infertility that is particularly common in Greece. A major contributor to the increase in couples facing infertility is the fact that women decide to have their children at an older age, which in Greece is quite commonly above 40. Subsequently the majority of women seeking assisted reproduction treatment are above 35. To my surprise multiple women in their early 30's were also seeking treatment for multiple reasons.

In Greece, just as elsewhere, infertility is a problem affected by multiple aspects. Some female factors that I encountered include: PCOS which is particularly common in the Mediterranean (ovulation disorders), the rarer Asherman's syndrome causing adhesions within the uterus, endometriosis, fibroids, bilateral oophorectomy secondary to carcinoma, post chemotherapy. On the other hand on the male side there were occasions of oligospermia and decreased motility. There were however occasions where the exact cause of infertility could not be established.

### **2. How are the reproductive health services organised and offered in Greece and how do these differ from the UK?**

Reproductive health is a specialist service in Greece. People who after one year have been unable to conceive, while having regular unprotected intercourse, contact the assisted reproduction centres and organise a private assessment including a package of history, examination, ultrasound and blood tests for the females and history, examination, semen analysis for the males. Once these results are available then the doctor is able to make an assessment of the situation and carry out further investigations such as a hysterosalpingogram or a testicular biopsy.

Once the cause of infertility in the specific case is established then the doctor proceeds with suggesting a protocol that is appropriate for the case.

Compared to the UK, in Greece there is no unifying primary care, where the patient will have their GP to consult and who will in turn send them to secondary care should they require specialist treatment. Additionally the number of IVF cycles is not limited to 3 as it is on the NHS.

### **3. What are the rules and regulations related to IVF treatment?**

In Greece, the legal framework surrounding assisted reproduction is very tolerant, which is one of the reasons Greece attracts patients from abroad seeking treatment. There is an age

limitation for women, set at the age of 50 and single women are also allowed to receive treatment. There is however, no age limitation for men. In Greece, legislation allows the use of donor sperm or donor eggs, should the test results and the doctor suggest it is required. A woman can become a donor of eggs up to three times. The above mentioned regulations enhance the number of people who can have a successful treatment and therefore become parents.

In cases where a child is conceived with the use of an unknown sperm donor from a bank, the donor does not have a legal status as a parent. When the child turns 18 however is allowed to access information about the donor.

Our main priority as clinicians is to ensure the wellbeing of the child to be born, and therefore all patients need to go through a series of medical tests including HIV and Hepatitis serology. Additionally one of the parents needs to be tested for heterozygosity of sickle cell disease and cystic fibrosis. If it is deemed necessary pre-implantation diagnosis can take place for inherited disorders and known mutations within a family.

#### **4. Further my understanding and knowledge of reproductive medicine as well as develop experience in healthcare provision in a different cultural setting.**

I feel very lucky to have had the opportunity to shadow the services provided in a big and world known specialist fertility centre such as EMBIO. Here it was interesting to come across patients both from Greece and other European countries and compare their experiences and medical journeys to each other and to ones I had encountered in my medical school career in the UK.

I became aware of the process associated with assisted reproduction throughout the procedure. I sat in consultations and followed the assessment of the patients. I was explained how different protocols exist for IVF treatment and the medications and length of treatment associated with each one. I followed intrauterine insemination procedures, oocyte retrievals and micro-fertilisation in the lab as well as embryo transfers following in vitro fertilisation and growth for 2-3 days. I became aware of the medication and process following embryo transfers. I experienced the satisfaction that couples experience with a positive pregnancy test and the disappointment of an unsuccessful cycle.

On top of Assisted Reproduction I was able to follow laparoscopic and hysteroscopic theatre lists where the surgeons managed common gynaecological conditions such as fibroid and polyp removals. Opportunities were abundant. In clinics I developed a better understanding of the gynaecological ultrasound scanning and I feel more confident and competent in identifying common conditions such as fibroids, adenomyosis, PCOS and polyps.

I had the opportunity to work alongside both the doctors but also the midwives at the unit. Everyone was particularly helpful and made me feel part of the team. I found that working in Greek, even though it is my native language and the source of the majority of medical words was at some points particularly challenging. With repetition it became easier and I felt more efficient in communicating. In summary, this experience enhanced my interest in O&G as well as deepened my knowledge and understanding of assisted reproduction. I had a well rounded and rich experience. What I really treasure in this speciality is the satisfaction it offers both the patient and the doctor when offering the greatest gift of them all: life!