The Process of Uterine Transplantation

Patient Information Sheet

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

1) What is the purpose of the study?

Uterine or womb transplantation has been proposed as a cure of absolute uterine factor infertility. It is a surgical process whereby a womb is transplanted from one woman to another. The aim of this procedure would be to allow the woman with previous womb-related infertility to have a baby when she has not been able to do so previously.

The term “absolute uterine factor infertility” is used to refer to women who either do not have a uterus or whose uterus does not work. There are multiple causes of absolute uterine factor infertility as demonstrated in the diagram below. Many women are born without a womb (MRKH) whilst others have undergone hysterectomy (surgical removal of the womb) as a consequence of cancer, fibroids (myoma) or excessive bleeding during or after pregnancy. Causes of non-functioning wombs include womb malformations, scar tissue within the womb (adhesions), previous radiation damage, fibroids and adenomyosis.

There are many thousands of women in the UK who have absolute uterine factor infertility:
One in every 4000 women in the UK is born without a womb. In 2007 alone there were 2,200 women aged between 15 and 44 who were born without a womb. In the 15 to 24 year old age group in the UK, around a thousand young women have hysterectomies every year. Hysterectomy is still a commonly performed procedure for the treatment of cervical cancer - many of these cancer victims have not completed their families when they have their wombs taken away. At the time of birth to prevent life threatening bleeding (post-partum haemorrhage) one or two women in every hundred have their womb taken away.

Historically, there have been very few options available for women who have absolute uterine factor infertility to have children of their own. Surrogacy or adoption have been the only options available, however these options are fraught with emotional, social and legal issues.

Why have I been chosen?

You have been chosen for this trial because you have absolute uterine factor infertility and expressed an interest in uterine transplantation. You will need to meet our selection criteria for the trial to ensure you are a suitable candidate. The inclusion and exclusion criteria include the following:

**Inclusion criteria:**
1) Aged 24 - 38 years (or 40 if eggs frozen before aged 38)
2) No significant medical problems
3) BMI <30kg/m²
4) Able to reside in the UK as a resident as long as the grafted uterus is in-situ post-operatively
5) Has a long-term partner
6) Has own ovaries and eggs i.e. no donor eggs
7) Fluent in the English language

**Exclusion criteria:**
1) Previous children
2) Previous major abdominal/pelvic surgery
3) Previous severe endometriosis
4) If history of cancer, cancer-free for less than 5 years
5) History of psychiatric illness involving hospital admission
6) Requirement of donor egg or donor sperm
7) Insufficient embryo quality/quantity (<10 satisfactory embryos)

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

This trial is made up of many components. The details of each component are described below:

1. **Physical Assessments**

Those patients who meet the selection criteria will meet with Mr Benjamin Jones, the clinical research fellow for the trial, who will perform various physical assessments to ensure you would be suitable for uterine transplantation. They will go through your previous medical history, check any regular medications, discuss various lifestyle factors and discuss any previous operations you may have had. They will check your blood pressure, measure your height and weight and perform a routine general examination. Baseline blood tests
will be performed including checking your haemoglobin, iron levels, blood group, kidney function and liver function. Screening for infectious diseases such as HIV, Hepatitis B & C will also be performed and further investigations will be arranged if necessary.

2. Psychological Assessments

Potential patients and their partners would subsequently undergo psychological assessments to assess their attitudes, motivations and feelings towards uterine transplantation with Dr Maria Jalmbrant. It is important that other options such as surrogacy and adoption have been considered and the benefits and disadvantages over uterine transplantation have been contemplated. Your previous mental health history will be assessed along with your capacity to consent to the procedure to ensure you have the ability to fully understand the plan proposed, the reasons behind it, the potential risks involved and the suitable alternatives. You will be asked to fill in a number of questionnaires about your mood, your well-being, and your relationship every few months during the study. You will also be asked to participate in interviews at various stages throughout the study. These will mostly be done over the phone but some will require you and your partner to meet with us face to face.

Some challenges that you may face during the trial could include stressful life events or symptoms, intrusive media interest, graft rejection and poor fertility outcomes, etc. The aim of these interviews and questionnaires will be to primarily identify any stressors and difficulties that you may be having and offer support for these as necessary to ensure that you and your partner are feeling supported throughout the trial.

3. Consent

Once selected for uterine transplantation you will be fully informed about the proposed plan. Sufficient time will be given to allow you to explore any issues, discuss with your support network and raise any questions with any of the research team. Once you are fully informed about the risks, benefits and alternatives of every aspect of the proposed plan, written consent will be obtained. It is important that you have considered the alternatives, weighed up the potential risks versus the benefits, and that you have not been coerced in your decision-making in any way.

4. Fertility treatment - Embryo collection and freezing

Prior to uterine transplantation it will be necessary to undergo fertility treatment to ensure that your ovaries have a sufficient number of eggs available for assisted conception following transplantation. Initially this involves medical treatment to suppress your naturally occurring monthly cycle hormones for the first two weeks. After this period you will be given daily injections of gonadotrophin for approximately 12 days to increase the number of eggs you produce. Over this time you will be monitored with ultrasound and blood tests. Approximately 34-38 hours prior to egg collection you will have a different injection to help your eggs mature. Egg collection will be carried out under ultrasound guidance under sedation using a thin, hollow needle. During and after the procedure you may experience some abdominal cramping and have a little vaginal bleeding. Whilst serious complications rarely occur, the risks include adverse drug reactions to sedation, pelvic infection and damage to bowel, bladder and blood vessels. There is also a risk of ovarian hyperstimulation syndrome (OHSS), which occurs in women who are very sensitive to the fertility drugs used to increase egg production. This can cause the ovaries to increase in size and cause bloating and abdominal pain. Severe cases are rare but can cause damage to organs such as the kidneys or lungs and increases the risk of blood clots in legs or lungs. These will be minimised by using the expert fertility team at the Lister Hospital, London.
Following this your eggs will be cultured, together with an optimised sample of your partner’s sperm, and checked for signs of fertilisation. Those that fertilise will be then grown in an incubator until they are of suitable quality to be frozen in tanks of liquid nitrogen for future use. A minimum of 10 good quality embryos will be needed to go ahead with the transplant procedure.

5. The Donor Process

The uterus used for transplantation will be donated from deceased donors. These are generally from women who have been recently declared brain dead and whose organs are kept viable by ventilators until they can be excised for transplantation. After receiving consent from the family of the donors then the uterus and its blood supply will be excised and preserved until transplantation. The uterus will be appropriately matched to you individually, using a number of selection parameters, to reduce the chances of rejection.

6. Uterine Transplantation

Once the donor uterus has been retrieved then we will be ready to proceed with uterine transplantation. You may need to come in at short notice, given the time constraints related to the donor organ so it is best to have your bag packed ready in advance. You will be joined by the surgical team and have the chance to answer any last minute questions. An anaesthetist will subsequently discuss the proposed anaesthesia and pain management plan during and after the operation. Repeat blood samples will be taken before the operation. You will then be taken to theatre where you will be put to sleep under general anaesthesia. The transplant is a major operation that will be performed by a midline incision from your belly button down to just above your pubic bone. Dissection will be performed to access the pelvis and the blood vessels that the donor uterus will subsequently be joined to. The vaginal vault, where the uterus will be attached, will be freed from the surrounding structures such as the bladder and rectum. Once the blood vessels and vaginal vault have been prepared, the donor uterus and its blood vessels will be implanted into the pelvis. The uterine blood vessels will be joined to your existing blood supply in the pelvis and, once the blood flow to the uterus is confirmed, it will be attached to ligaments and connective tissue within the pelvis so that it remains well supported. The bladder will be repositioned appropriately and then routine abdominal closure will take place. You will either have staples or stitches that will be removed 7-10 days following the operation. The risks involved in this surgery include anaesthetic risks, bleeding (including the possibility that you may have to have a blood transfusion), infection, damage to internal organs such as bowel, bladder, the tubes that connect the kidneys to the bladder (ureters) and blood vessels, venous thromboembolism (blood clot) and immediate graft failure with subsequent need to remove the uterus. Further major surgery will be required to remove the implanted uterus, as described in section 12.

7. Post-operative monitoring

Following the operation you will be transferred to a recovery clinic where you will wake up from the anaesthetic. You will then be taken to the intensive care unit or the ward where you will be closely monitored. A catheter, which is a thin plastic tube, will be placed in your bladder until you are can mobilise sufficiently following the operation. A drain, another thin plastic tube, may also be left inside your pelvis that comes out through a small incision on your abdomen and will likely stay in for the first few days following the procedure. You will be monitored closely flowing the operation with frequent observations of your vital signs (Blood pressure, heart rate, temperature, respiratory rate, oxygen saturations). You will receive painkillers to keep you comfortable and undergo daily blood tests. You will also wear compression stockings and receive heparin injections whilst you are in hospital to reduce the chances of a blood clot forming in the deep veins of your leg or lung. You will remain in hospital until you are fit enough to return home which will be after 5-7 days. Following discharge you will be followed up in clinic by the surgical and transplant doctors. At these appointments you will have the option to discuss any problems you may be experiencing or any questions that
you may have. They will monitor your weight and blood pressure, examine your abdomen and perform a speculum examination to directly visualise the cervix and take bacterial swabs and/or biopsies if necessary. Biopsies of the cervix will be taken after weeks 1, 2 and 4 following the operation and then monthly thereafter. The biopsies are taken to monitor for episodes of rejection. In the event of abnormal signs (abnormal vaginal discharge, fever, discoloured cervix, or abdominal pain) then extra biopsies may be required. Frequent ultrasound assessments will also be undertaken to monitor the blood flow to the uterus. Blood tests to monitor your haemoglobin, platelets, white blood cells, inflammatory markers, glucose, liver function, kidney function and drug levels will also be taken. It is likely that you will be seen initially twice weekly during the first postoperative month and then every 2 weeks in months 2–6. Each appointment is likely to take between 2–3 hours but it may be best to leave your whole day free for these appointments. You will be able to contact Mr Benjamin Jones at any time in between these clinic appointments with any concerns or questions.

8. Immunosuppressive therapy

Immunosuppressive treatment will be vital to optimise the chances of a successful uterine transplant, as it will reduce the chances of your body rejecting the transplanted uterus. You will be closely monitored by the transplant team who will use a number of medications to reduce your immune response so it does not damage the transplanted uterus. The aim of this treatment is to suppress the immune system enough to successfully prevent organ rejection, whilst preserving your immune response to respond to infections. This treatment will be started immediately before the transplant and will be continued until the uterus is removed. You will initially take a combination of immunosuppressive medications to reduce the chance of acute rejection. The medications used will subsequently be reduced to the lowest number of medications and the lowest dose possible. The long term aim is to use a single immunosuppressive medication called tacrolimus. If any rejection episodes are identified on the cervical biopsies or on the blood tests then a course of steroids will be administered. In such cases additional immunosuppressive medications such as azathioprine and prednisolone may need to be added to prevent further rejection episodes. Too high doses of immunosuppressive medications can become toxic and damage various other organs including kidneys, liver and the heart. As a result you will need close monitoring with clinic appointments and blood tests to ensure the treatment is optimal. You will initially be seen twice weekly following the operation but once the treatment is stable and effective then you will be able to be seen less frequently. The main complications include infection, drug toxicity, kidney dysfunction, heart and blood vessel disease, high blood pressure, high cholesterol and an increased risk of both cancer and diabetes. You will be closely monitored for signs of these complications throughout the course of your treatment. During pregnancy, immunosuppressive therapy will need to be continued, just like in women who have had other organs transplanted. Such treatment has been shown to be safe in pregnancy and has not been shown to cause any major abnormalities in the structural development of the fetus. However it may cause the baby to have a lower birth weight and has been linked to pre-term labour. This regime has been safely and effectively used by the Swedish womb transplant team. Following the completion of your family, and/or once the transplanted uterus is removed, the immunosuppressive therapy can be stopped.

9. Embryo thawing and transfer

Approximately 12 months following the operation, assisted conception will be attempted. This initially involves thawing the eggs that were previously frozen prior to the uterine transplant. Those embryos that survive this procedure will then be inserted, under ultrasound guidance, into the transplanted uterus using a thin tube placed through the cervix. A single embryo will be transferred due to the risks of multiple pregnancy. The procedure is usually pain free although a little discomfort may be experienced from the speculum used which is very similar to that experienced during a cervical smear. Sedation could be used if you find these experiences particularly uncomfortable. Prior to this procedure you will receive medication by pessaries, gel or injections to help prepare the womb prior to embryo transfer. Sufficient numbers of embryos will have been taken initially to allow more than one cycle if necessary. The other main risk associated with this procedure is
ectopic pregnancy. This is when the pregnancy implants outside of the uterus, most commonly in a fallopian tube.

10. Antenatal monitoring

Following successful conception, you will be closely monitored by a specialist multi-disciplinary team of doctors, nurses and midwives to ensure your pregnancy runs as smoothly as possible. This team will work closely together to optimise the health of both yourself and your developing baby. You will continue to take immunosuppressive medication as guided by the transplant doctors who will tailor your medication accordingly throughout your pregnancy. You will be looked after by specialist obstetric medicine doctors at Queen Charlottes & Chelsea Hospital who will closely monitor you for signs of complications related to the womb transplant and immunosuppressive therapy. The normal risks associated with pregnancy also clearly still apply. It is likely that you will be seen every 2-3 weeks and each appointment will be approximately 30 minutes. Specialist fetal medicine doctors may also be involved, to monitor the growth of your baby by ultrasound every 2-4 weeks, and to investigate any complications should they arise. In the event of a miscarriage, or in the unlikely event that the pregnancy requires termination, then you may need specialist treatment. If this happened in early pregnancy (<14 weeks gestation), then it could be managed as normal with either medications or a simple suction and evacuation operation under general anaesthesia. If such an event happened later in pregnancy (>20 weeks gestation), it is likely you will require a more major operation called a hysterotomy which entails an incision across the lower part of your abdomen. If a miscarriage happened, or termination was necessary, between 14-20 weeks gestation, then a specialist multi-disciplinary team of healthcare professionals will discuss your case on an individual basis and offer you a choice of the above options, depending on the specific scenario.

11. Caesarean Section

Following an uncomplicated pregnancy you will deliver by Caesarean Section at 35-37 weeks gestation. This will be performed under regional anaesthesia so you will be awake during the procedure but will not feel any pain. Once the regional anaesthesia is effective you will have a catheter inserted in your bladder. The surgeons will clean your abdomen and put a screen up so you and your partner won’t see the operation, but it will be possible for this to be lowered for you to see your baby once it is born. A transverse incision will be made across the lower part of your abdomen, referred to as your ‘bikini line’. Your baby will be born after a few minutes, dried, wrapped in a blanket and then be brought over to you so you can do ‘skin to skin’ if desired. The operation will take approximately one hour. The risks of a Caesarean include anaesthetic risks, bleeding (including the possibility of you needing a blood transfusion), infection, damage to internal organs such as bowel, bladder, ureters and blood vessels, fetal injury and venous thromboembolism (blood clot). You will have a urinary catheter in place until the following morning. Following the operation you will remain an inpatient for a few days whilst recovering and establishing feeding. You should be able to breastfeed on immunosuppressive therapy. You will be required to have heparin injections for one week after the operation to reduce your risk of developing a blood clot in the deep veins of your leg or lungs.

12. Hysterectomy

If you have completed your family then approximately 6 months following the birth of your child you would undergo removal of the transplanted womb (hysterectomy). In a similar fashion to your first operation you will be put to sleep under general anaesthesia. This is another major operation, and the same midline incision will likely be used to excise all of the transplanted tissue including the uterus and blood vessels. You will wake up in recovery with a catheter in place and a drip in your arm. You will be transferred back to the ward where you will be monitored closely with frequent observations of your vital signs. You will be offered painkillers and kept comfortable whilst you recover. The catheter will be removed the following day. You will once again
receive heparin injections and wear the compression stockings to help prevent a blood clot. The risks of hysterectomy include anaesthetic risks, bleeding (including the possibility that you may have to have a blood transfusion), infection, venous thromboembolism (blood clot in veins or arteries) and damage to internal organs such as bowel, bladder, the tubes that connect the kidneys to the bladder (ureters) and blood vessels. Following hysterectomy you can safety stop the immunosuppressive medications and will not need any further treatment.

If you are keen to have another child then it may be possible to delay hysterectomy, undergo further IVF treatment, continue the immunosuppressive treatment, deliver by Caesarean Section as described above before undergoing hysterectomy 6 months later.

It is likely that it will take on average 2-3 years from entering the study to delivering a healthy pregnancy. You may then wish to proceed and have a second child. Therefore we predict a maximum of 5 years that you may be involved in the study. It is possible that after the womb transplant, you don’t become pregnant or do not end up with a living child. Given that this is still an experimental procedure it is difficult to predict the likely success rates, although the closest comparison would be the Swedish womb transplant team. They undertook nine womb transplants, with seven being successful (78% success rate). They officially reported the first live born child following uterine transplantation in September 2014. It has since been unofficially reported that a further three have delivered healthy babies whilst another has become pregnant resulting in a pregnancy rate of at least 71%, although official publication of these results is still awaited from the team. Although we expect similar excellent outcomes, it cannot be guaranteed and because of unforeseen problems, a much lower figure may instead be the case.

What do I need to do?

Following the transplant you will largely be able to live life as you normally do and you can drive as normal after the initial recovery following the operation. You will be expected to maintain a healthy lifestyle with a balanced diet and support can be available from dieticians if requested. You should ensure all food is well cooked, particularly meats, seafood and eggs. Furthermore you should avoid eating foods that cause infections like listeria such as unpasteurised cheese, milk & yoghurt, mayonnaise and pâté.

After the first 6-8 weeks following the operation you can remain active and moderate intensity exercise such as fast walking, swimming, or tennis is encouraged. You can drink alcohol in moderation before you become pregnant but you cannot drink alcohol to excess as it may alter how your body responds to some of the immunosuppressive medications and can also lead to increase weight gain and high blood pressure. It is expected that you refrain from smoking cigarettes and using illicit drugs throughout the course of the trial. If you take regular medications these will be reviewed at each clinic appointment and you will be advised accordingly. If you are prescribed medications by someone other than a member of the research team then you should let Dr Benjamin Jones know and they will confirm that it is suitable. Likewise you should check with the team before taking any over the counter medications or herbal remedies as well.

As explained previously, the immunosuppressive medications that you take to help prevent the transplant being rejected can lead to an increased risk of infection. As a result it is important that you avoid anyone with infections such as chickenpox or the flu. You should also practice good personal hygiene, including washing hands before meals and after going to the toilet. If you cut yourself then you should wash the wound with warm water, dry it then cover it with a dressing. You should avoid vaccines that contain live viruses such as the MMR vaccine. If you suffer with any symptoms such as a high temperature, severe headache, aching muscles or diarrhoea then contact one of the research team, who are available 24 hours a day, and who will advise you accordingly.

Your participation and cooperation in this trial is vital and it is expected that you attend the follow up appointments described above.
What is the intervention being tested?

This study, involving ten patients in total, will comprise the first UK cohort to undergo womb transplantation for the purpose of carrying a pregnancy. The study will most likely be conducted at Hammersmith Hospital, with fertility treatment taking place at The Lister Hospital, London. It is an experimental procedure that, as described above, requires at least three major operations (to transplant the womb, deliver the baby and remove the womb), all of which will require general anaesthesia. You will be required to take immunosuppressive medications to prevent your body from rejecting the womb, and you will need to commit to an intensive follow up regime, as described above, that ensures you are closely monitored for complications should they arise.

What are the alternatives?

The alternative options include not having children, adoption or surrogacy, all of which will be discussed in detail with you prior to undergoing this procedure.

What are the side effects and disadvantages of taking part?

As previously described, there are potential side effects and risks with every aspect of this trial. There are a variety of measures that will be taken to minimize these risks. Where possible, close follow up will allow early identification of such problems and subsequent action to be taken.

Physical risks of transplant

Risks associated with the uterine transplant include anaesthetic risks, bleeding (including possibility of blood transfusion), infection, damage to internal organs such as bowel, bladder, ureters and blood vessels, venous thromboembolism (blood clot) and immediate graft failure. There is also a future risk of graft rejection following surgery. These risks will be minimised by using an excellent surgical team and theatre staff, iron tablets supplementation before the operation if necessary, antibiotics to prevent infection, and leg stockings and medications to reduce the risk of a blood clot in the leg or lung.

Physical risks of Fertility treatment

These include risks with sedation / anaesthetic, pelvic infection and damage to bowel, bladder and blood vessels. There is also a risk of ovarian hyperstimulation syndrome (OHSS) as described previously.

Physical risks associated with immunosuppressive therapy

Risks include increased risk of infection, drug toxicity, kidney dysfunction, heart and blood vessel disease, high blood pressure, high cholesterol, diabetes reduced bone density and cancer. There are also fetal risks during pregnancy including congenital malformation, low birth weight and pre-term labour. These risks will be minimised by close monitoring and utilising the expertise of the transplant team and obstetric medicine teams at Hammersmith Hospital and Queen Charlottes & Chelsea Hospital respectively.

Psychological stress of failure

There are many points in this trial where things do not go as planned in the form of operative failure, rejection of the uterus, difficulty becoming pregnant, miscarriage or still birth. In the event of any negative outcome the research team will always be around to help, reassure and treat any adverse consequence that may have arisen.

Social factors including changes to lifestyle

Given the significance of the surgery and treatment plan, close follow up will be necessary to ensure optimal
management and early recognition of any problems. As such multiple clinic appointments and investigations may necessitate changes to lifestyle. The follow-up will similar to a follow-up of a general transplant recipient. During pregnancy, follow-up will be weekly initially and then change to a two weekly schedule. Performing all the tests and investigations on the same day as the appointment will hopefully reduce the inconvenience caused.

If you develop any of these symptoms then you can contact Mr Benjamin Jones at any time.

What are the possible benefits of taking part?

Whilst it cannot be guaranteed, the intended benefit of this trial is to allow you, by assisted fertilisation, become pregnant and give birth to a living, healthy baby. As this is still an experimental procedure, your participation in this research will also give us more knowledge and insight into uterine transplantation in the human setting. Through the dissemination of our research findings we might be able help make this treatment a viable option for other women absolute uterine factor infertility that want their own children.

Sometimes during the course of a research project, new information becomes available about the treatment that is being studied. If this happens, one of the research team will tell you about it and discuss with you whether you want to continue in the study. If you decide to withdraw your research doctor will make arrangements for your care to continue. If you decide to continue in the study you will be asked to sign an updated consent form.

What happens when the research study stops?

Your involvement in the trial will stop following your recovery from hysterectomy and after you have stopped all immunosuppressive therapy. Once you and the research team are happy with your recovery then you will not require any further treatment.

What if something goes wrong?

Imperial College holds Public Liability (“negligent harm”) and Clinical Trial (“non-negligent harm”) insurance policies which apply to this trial. If you can demonstrate that you experienced serious and enduring harm as a result of your participation in this trial, you may be eligible to claim compensation without having to prove that Imperial College is at fault. If the injury resulted from any procedure which is not part of the trial, Imperial College will not be required to compensate you in this way. Your legal rights to claim compensation for injury where you can prove negligence are not affected. Please contact the Principal Investigator if you would like further information about the insurance arrangements which apply to the trial.

Will my taking part be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital will have your name and address removed so that you cannot be recognised from it. Given the need to work effectively as part of a multi-disciplinary team in this trial, we will request your permission to inform your GP of your participation within the trial.

What will happen to the results of the research study?
The results will be disseminated through peer review scientific journals and conference presentations in the form of oral and poster presentations. Various results will be reported throughout the trial, all of which will be made aware to you as soon as they are available.

Who is organizing and funding the research?

Womb Transplant UK is a registered charity that is providing funding for the research. The full time clinical research fellow for the trial, Mr Benjamin Jones, is funded through an agreement with Imperial College and HCA Hospitals where he will work as a Registered Medical Officer throughout the course of the trial. The study will contribute to Mr Benjamin Jones’ PhD qualification at Imperial College London. The roles of Mr J Richard Smith and Mr Srdjan Saso are honorary and as such they will not receive any financial benefit as a result of you participating in this trial.

Who has reviewed the study?

This study was given a favorable ethical opinion for conduct in the NHS by the NHS/HSC R&D Office.

Contact for further information

We hope this information is of benefit to you. If you have any questions about any of the steps along this route then feel free to contact Mr Benjamin Jones via telephone or email on the contact details below and he will be happy to answer any questions you may have.

With best wishes,

Mr J. Richard Smith
Mr Srdjan Saso
Mr Benjamin Jones

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J. Richard Smith MD FRCOG
Consultant Gynaecological Surgeon
West London Gynaecological Cancer Centre
Queen Charlotte’s Hospital
Du Cane Road, London, W12 ONN
Email: info@wombtransplantuk.org
Tel: +44 (0)2077307077

Srdjan Saso MBBS BSc MRCS PhD
Senior Clinical Research Fellow
Division of Surgery and Cancer
Institute of Reproductive & Developmental Biology
Imperial College London
Hammersmith Hospital Campus
Du Cane Road, London, W12 0NN
Email: srdjan.saso@imperial.ac.uk
Tel: +44 (0)7890795182

Mr Benjamin Jones MBChB BSc
Clinical Research Fellow
Division of Surgery and Cancer
Institute of Reproductive & Developmental Biology
Imperial College London
Hammersmith Hospital Campus
Du Cane Road, London, W12 0NN
Email: benjamin.jones@nhs.net
Tel: +44 (0) 7740358900