

Infertility Journey

The Start of our Journey

Of all the journeys we set out to take in our lives, this particular one is both unplanned, and undesired. In addition, we never really know how or when it will end. Though many may feel that the infertility journey begins in the Gynecologist's office, the reality is that it starts in the privacy of a couple's home, with a sudden realization both in their minds, and in their hearts. While the start of this voyage is often filled with anxiety, fear, and uncertainty, the reward that is reached at the end of the trip is immeasurable, and the greatest that can ever be achieved through any of life's ventures. In addition, with the tremendous advancements in knowledge and expertise that are happening each day, the truth is that for the vast majority of hopeful people, this journey is joyfully and successfully completed.

For most couples planning a family, the statistics are that greater than 90% will do so after one year of unprotected intercourse. Therefore, if pregnancy is not achieved after 12 months of trying, the possibility of a fertility obstacle may be present, and this warrants further assessment. In situations where the female partner is over 35 years of age, it is prudent to initiate such an evaluation after only 6 months of trying since time is more of an essence. In most cases, the couple will present to their private physician, often the Gynecologist (GYN), and many GYNs will order a series of tests to help determine the underlying causes. These tests should include assessment of both the female and male partners. Often times, patients will be referred directly to a fertility specialist, especially if there is a known issue of significance present (e.g. blocked fallopian tubes), or if the female partner is of more advanced age (e.g. over 38 years). This in fact is a more efficient way to proceed in such cases, since fertility specialists have the necessary resources and training to effectively treat such patients. Irrespectively, if any female has been attempting to achieve pregnancy for 6 months to a year without success, she should bring this to her doctor's attention. Her doctor should then start an evaluation, and perhaps offer some general treatment alternatives to help the patient conceive. If after a few months, generally 3 to 4, she has still not achieved pregnancy, she should then be referred to a fertility specialist, or Reproductive Endocrinologist, for further evaluation and treatment. Alternatively, any patient can certainly make an appointment directly with such a specialist at any time in this process.

Choosing our Path

When seeking care with a fertility specialist, there are a few things that should be kept in mind. First off, it is critical that such physicians have completed a fellowship training program specifically in Reproductive Endocrinology and Infertility. Second, one should make certain that these doctors are Board Certified in both Obstetrics and Gynecology, and Reproductive Endocrinology and Infertility. Such Board Certification indicates that the individual has successfully passed a series of comprehensive assessments which confirm his or her appropriate knowledge and competence in this area of medicine. In addition, the reputation of both the physician and his or her Fertility Center must be strong and positive. Individuals should not be shy to check with friends, colleagues, or physicians who refer patients to these specialists regarding their feedback and experiences in dealing with them. Many centers will publish (most commonly on their websites) their individual "success rates", or pregnancy rates, in some of the more advanced reproductive therapies they offer. This is important for patients to know since they need to start their journeys with confidence in their chances for success should they require such therapies. Finally, the accessibility of the

center in terms of e.g. location and available appointment times is a key element in terms of patient convenience. Patients should give greater consideration to seeking out an office that is geographically close and/or easily accessible to them, as well as one that offers amenable scheduling options, such as evening hours, that more readily fit their needs.

Testing along the Way

Once a patient or couple has embarked upon their fertility journey, there are certain basic tests that must be performed to comprehensively uncover any underlying issues they may have. These tests follow the general pathway towards achieving conception, i.e. the sperm traveling through the reproductive tract to reach and fertilize the ovulating egg, and the resultant embryo traveling back down the fallopian tube to implant in the uterine cavity and yield a pregnancy. Therefore, the male partner should undergo a semen analysis which assesses several sperm parameters including the count, the motility (movement), and the morphology (structure, shape) of the sperm. In terms of the female partner, she needs to have an assessment of her fallopian tubes via a hysterosalpingogram (HSG or x-ray dye test) or, less commonly, a laparoscopy (same-day outpatient surgical procedure), as well as her uterine cavity via an HSG, hysteroscopy, or sonohysterogram (the latter 2 can generally be done in the specialist's office). General hormonal testing including thyroid and prolactin testing should be performed, as should an assessment of her egg quality and quantity (often referred to as "ovarian reserve"). Egg quality testing is done via baseline (menstrual cycle day 2, 3, or 4) hormone (FSH, LH, Estradiol) testing combined with vaginal ultrasound assessment of the ovaries to look for the presence of basal ("antral") follicles. The ultrasound also can uncover other pertinent findings such as uterine fibroids, ovarian cysts, etc. At times, patients may undergo an additional screening test for ovarian reserve, most commonly a "Clomid Challenge Test", however this is determined on an individual case by case basis. Nevertheless, the above outlined tests are the "bare minimum" required in order to be able to accurately counsel patients regarding their fertility options. Certainly if a patient or couple present with other significant factors in their history, then further testing and/or therapy to evaluate and treat such conditions would also be recommended. For example, if a woman has large uterine fibroids, a scar band (septum) in her uterus, or a blocked, swollen fallopian tube or tubes ("Hydrosalpinx"), she may need to first undergo surgical intervention before attempting pregnancy since these findings could both negatively impact her prognosis, and increase her risk of a miscarriage. In many cases, these surgeries are performed as outpatient procedures (e.g. a Laparoscopy to treat blocked tubes or pelvic scarring, or a Hysteroscopy to treat a uterine septum) and the patient will go home that same day. Less commonly, a laparotomy procedure with an incision on the belly and 2-3 days of inpatient hospital recovery may be needed, as in the case of large uterine fibroids.

The Roads to Treatment

Once a diagnosis has been made concerning the possible cause of a patient's infertility condition, appropriate treatment can be initiated. In some instances, an obvious etiology may not be uncovered, and such couples are diagnosed as having "Unexplained" infertility. Irrespectively, the most common therapeutic options undertaken include ovulation induction, or superovulation, whereby the female is prescribed a sequence of medications to enhance the production, or recruitment, and ongoing maturation, of her eggs. In general, more than one egg will end up ovulating thus there is a chance of achieving a multiple pregnancy. Therefore, it is critical that the fertility center closely monitor the patient with

blood and ultrasound testing while she is undergoing such treatments to minimize this risk. The medications used are injectable (Follistim, Bravelle, Gonal-F, Ovidrel, Ganirelix, etc.), and often referred to as “fertility shots”. Since these shots are given subcutaneously (right under the skin, like insulin), patients are generally taught to self administer them at home, or in some cases, their partners may give the shots to them. At times, especially in younger women (e.g. < 35 years old), or in those whose sole obstacle is an ovulatory dysfunction (e.g. irregular menstrual cycles), a milder form of stimulation involving clomiphene citrate (Clomid) with or without the fertility injections may also be used. Very often, the treatment cycle is coupled with a well timed intrauterine insemination (IUI), in which the husband’s (or partner’s or donor’s) sperm is processed and deposited directly into the female’s uterus through a narrow, sterile catheter at the time of her ovulation. Since this procedure offers the advantages of bypassing any possible obstacles within the vagina or cervix, concentrating and recovering the healthiest, most motile sperm available, and simultaneously improving the timing of when the sperm is present to fertilize the egg(s), it has been shown to nearly double the success rate of such treatment cycles! Patients are then usually started on progesterone therapy to help support the lining of the womb in anticipation of an implanting pregnancy, often in the form of a vaginal supplement (Crinone, Prometrium, Endometrin, etc.).

In general, if any given treatment protocol is destined to succeed in achieving pregnancy for a couple, statistically it should do so ~ 90 – 95% of the time within three to four attempts. Therefore, to continue with a treatment that has not succeeded within these 3 – 4 cycles is not in a patients’ best interest, and often leads to further frustration, disappointment, and potentially, unnecessary depletion of that patient’s infertility insurance benefits. As a result, since many such patients still have an excellent chance to conceive with more aggressive means, the option of In Vitro Fertilization, or IVF, becomes their most logical alternative. IVF is considered to be the “gold standard” of all fertility therapies. It involves the stimulation of a woman’s ovaries to produce multiple eggs, the aspiration of these eggs via an in-office egg retrieval procedure (with anesthesia), the fertilization of the eggs with the husband’s (partner’s, donor’s) sperm in the laboratory, and the transfer of the resultant embryos into the patient’s uterus in hopes of achieving pregnancy. Notwithstanding patients who may not have succeeded with less aggressive therapies, IVF is rapidly becoming the most popular treatment choice for couples with various types of infertility since it is the most successful and fastest method available to achieve pregnancy. In some instances, such as patients with blocked fallopian tubes, significant sperm and/or egg quality issues, or advanced endometriosis, IVF should actually be the first-line choice since other treatment options are extremely unlikely to yield a successful outcome. Additionally, many insurance companies now fortunately cover the costs involved in IVF therapy, thus eliminating the financial burden for a vast number of eligible couples. As a result, many are actually choosing to undergo this comprehensive treatment alternative right away in their path towards achieving their dreams of parenthood.

Other Treatment Pathways – Continuing our Journey

Even with the tremendous constant improvement in our reproductive technologies, there are instances that arise when a couple’s goal is unfortunately not reached with the options previously outlined. Such couples stressfully find themselves at a major obstacle in the road of their ongoing journey; however, their voyage is not over; rather, an alternative route or “detour” now comes into focus for them. For example, in patients who may have undergone multiple unsuccessful IVF cycles, or those with a very poor prognosis for IVF success using their own eggs, (e.g. women with premature menopause, advanced reproductive age (e.g. over 42), elevated FSH levels (e.g. > 12 U/L), etc.), Egg Donation is an extremely successful treatment option. Egg donation can be performed with a known egg

donor (e.g. a relative or friend), or an anonymous donor who would be matched with the patient as per her desires, and following an intense and comprehensive screening process. The egg donor undergoes the IVF process, and the eggs would then belong to the patient (recipient) who would undergo an embryo transfer procedure into her own uterus following fertilization of these eggs with her husband's, or donor, sperm. The clear benefit of Egg Donation is that with a tremendously high prognosis for success, it allows for a woman to experience the joys of pregnancy and childbearing as the biological mother of her child when she otherwise may not have been able to do so. Alternatively, a patient may be faced with other factors such as considerable damage to her uterus from previous surgeries, advanced medical problems that would make pregnancy medically risky to her, or having undergone a hysterectomy with preservation of her ovaries. In these cases, the use of a Gestational Carrier; i.e. an individual who carries a pregnancy for a couple when the female partner is not able to do so, would be indicated. The patient would undergo an IVF procedure with her own eggs being retrieved, fertilized with her husband's or donor sperm, and the resultant embryo(s) transferred into the uterus of the gestational carrier who would carry the pregnancy to term for the patient/couple. Certain steps are then undertaken as the couple receives their child(ren) following delivery, and an attorney who is specialized in this field of reproductive law is often involved in the process. Finally, when patients or couples have exhausted all of the reproductive therapies available to them, the choice of Adoption is certainly one that they may elect to pursue. In fact, this option can be considered at any time during their journey, and is entirely based upon how far they may wish to travel down the road of fertility treatment before deciding upon this alternate pathway, one that still provides joy to countless loving individuals and/or couples worldwide.

Support Systems throughout our Journey

Very often when journeys are undertaken in our lives, unforeseen barriers arise that we may not be prepared for at the start of the voyage. The infertility journey is certainly not an exception to this rule, with the most common obstacle encountered being the overall emotional and psychological stress that accompanies the entire process. However as this occurs, the reality is that patients are in fact experiencing normal reactions to abnormal situations, not the other way around. It is not unusual that such degrees of stress begin to hinder patients' relationships with their families, friends, and even each other. In addition, they may rise to such a level that their mission is abandoned before the final goal is ever actually reached, which is both sad and very often avoidable. Individuals who experience these degrees of stress at any time along their path should never hesitate to seek out professional help from a fertility counselor, which any qualified fertility center has access to. Ironically, a major advantage of this journey is that while patients may feel alone in their endeavors and isolated from all those around them, in fact, a multitude of professional resources are available to help them along their way. These include organizations such as RESOLVE, support groups, infertility counselors, and needless to say, the entire team of caring physicians, nursing staff, and all others at their fertility center.

The Completion of our Journey – Mission Accomplished

As was highlighted at the very beginning, the entire process starts with an acceptance that something is in the way of a patient's quest to grow her family. The fertility journey then begins, and while initially wrought with doubt and insecurity, the trip becomes smoother and easier while the excitement and anticipation of its completion draws near. As the

appropriately indicated pathways are confidently navigated, success then becomes imminent for endless numbers of well-deserving couples. Finally, once that day of joy arrives....



Indescribable in words alone!