

Determining What's Next



**Southern Ontario
Fertility Technologies**

Introduction

The purpose of this information sheet is to outline the factors which are considered when deciding what **investigations or treatment should be done next** if a pregnancy has not yet occurred. It is an advanced information sheet because it assumes you have knowledge of many of the investigations and treatments. Information is available on separate information sheets outlining most of the individual investigations and treatments. You may need to refer to them while using this information sheet.

At S.O.F.T. we think it is very important that you have a great deal of input into and understanding of your progression through infertility investigation and treatment. Infertility treatment can be very frustrating as many times treatments must be redone over again when they have not worked the first time. Changes in treatment have to be made from time to time. New treatments or further investigation may have to be considered if a pregnancy has not occurred.

Frustration with this process can be kept to a minimum if you understand the logic behind the progression of your treatment and you can get on with it without needless delays.

To help you understand and participate in the decision on what to do next, this information sheet was produced. It cannot, of course, cover every individual circumstance but will attempt to outline what factors are taken into consideration in the decision of “what to do next”.

Our Review of Your Treatment

To facilitate the progression of treatment, **each cycle of treatment is reviewed**, as it is completed or just after it is completed and a suggestion is written in your chart on the next step. **This process becomes more involved, the more complicated your treatment has been.** For example, if you are doing ovulation induction with clomiphene citrate, abnormal luteal progesterones are reviewed and you will be contacted with a suggestion for your next cycle. If you are doing intrauterine insemination or donor insemination, the monitoring sheet and sperm recovery sheet are reviewed with you at the time of insemination or just after (before your chart is refilled). In IVF or IVF with ICSI cycles, usually we suggest a formal office appointment to discuss next steps.

When a suggestion is made as a result of one of these reviews, it is only a suggestion and we welcome your input. At any time during your treatment you can request a review appointment. If we feel our review of your treatment warrants a visit, we will ask you to arrange one.

Your treatment is reviewed by Dr. Martin or Dr. McNaught. However, at S.O.F.T., we pride ourselves on our team approach and any comments or suggestions can be brought forward to any member of the team.

How We Start

The first visit to S.O.F.T. is a consultation. Your **consultation** will involve a detailed medical history, a review of past investigations and treatment when these have been sent by your

doctor. A directed physical examination is sometimes done if necessary. Usually, any investigations which have not already been done are arranged for you. Fortunately, these can usually be **completed in the next cycle after the consultation and treatment can be started promptly.**

A **“basic infertility investigation”** will be completed. A basic infertility investigation involves testing of three things: the woman’s hormone status (day 3 blood work), a test of the Fallopian tubes, and a sperm count. **Almost without exception, the whole basic infertility investigation is completed in one cycle.** Sometimes the cause of the infertility is obvious. For example, if the man has no sperm or the woman has no cycle. However, we will still recommend all three aspects of the investigation.

If the treatment options are fairly obvious the treatment is **sometimes started in the same cycle as the investigations are done.** You will be given information sheets about everything that is recommended (except for blood tests and semen analysis for which you will be given requisitions).

Except in circumstances where there has been a recent (within a year) test of the Fallopian tubes, a second visit will be arranged on the same day as the hysterosalpingogram (HSG). At this visit, the initial plan for treatment is formulated or confirmed if it was actually started in your first visit.

The Limited Nature of Infertility Investigations

Once the basic infertility investigation is completed, there are not a lot of other effective investigations.

Further investigations can include a laparoscopy or tests of sperm function.

Laparoscopy is indicated by history, physical examination, hysterosalpingogram or ultrasound findings that indicate it could possibly be helpful. (A complete information sheet is available on laparoscopy.)

Tests of sperm function are offered in some infertility clinics but are usually performed as part of the sperm washing procedure for intrauterine insemination at S.O.F.T.

Investigations are very limited in infertility. We can determine that the tubes are open, sperm are present and that ovulation is occurring. However, **there are many steps to a successful pregnancy for which we have no diagnostic test.** Our approach is to offer treatment in a progressive fashion so that more and more of these steps, which cannot be tested, are instead bypassed by the treatment.

Unfortunately, many couples will fall into the **“idiopathic”** infertility group. Idiopathic means “no obvious cause”. That doesn’t mean there isn’t a cause but that the cause doesn’t make itself clear during our limited investigations.

The Concept of Multiple Causes

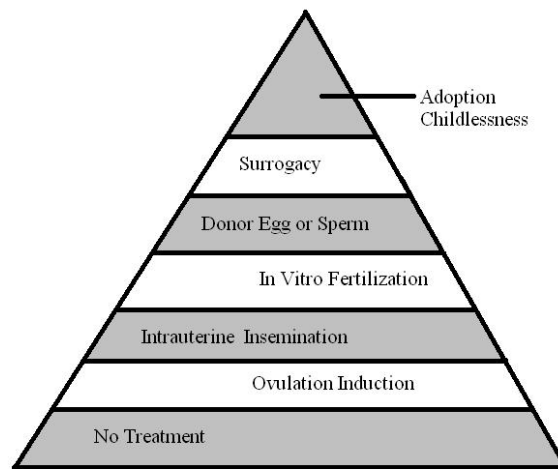
Generally in medicine an illness has one cause. This is usually not the case with infertility.

The majority of couples will have no definitive diagnostic cause but some tests are suspicious. For example, there may be a normal sperm count but one which is consistently in the lower end of the range. Or there may be regular cycles but they may be shorter than usual (24 days) or vary a little with each cycle (27 to 31 days). Or the hysterosalpingogram may demonstrate one tube open but not both.

We believe about **7% of females and 5% of males have some sub fertility factor**. This does not mean that they are infertile but that they may have something that causes them to need more tries to become pregnant. These sub fertility factors are not usually apparent on our investigations. If these sub fertile individuals got together randomly, you would expect to find only one in three hundred couples ($7\% \times 5\% = 0.35\%$) with a sub fertility factor in both the male and the female. In fact, we find over 30% with a sub fertility factor in both members of the couple. The reason for this is that an extremely fertile female will overcome a mild sub fertility factor in her male partner. Similarly, an extremely fertile male will overcome a mild sub fertility factor in his female partner. These couples never present to a fertility clinic such as S.O.F.T... However, if a mild sub fertility factor exists in both the male and female, these multiply rather than just add up and this couple will require help because of a delay in getting pregnant. **It really is a couple's problem and not one or the others fault!!!**

The General Pattern of Fertility Treatment

Unless a specific problem is discovered in the initial basic infertility investigation, most couples will progress through a similar progression of infertility treatment. **At S.O.F.T., we refer to this as the fertility treatment pyramid.** This begins with the first option of **no treatment**. It then progresses to **ovulation induction** or mild fertility pills to promote ovulation or even the release of more than one egg per cycle. The next step is usually some form of **intrauterine insemination (IUI)**. IUI can be very simple such as done in a spontaneous cycle with no medication. It can also be very complex using medications similar to an **in vitro fertilization cycle (IVF)**. The next step is usually IVF or IVF with intracytoplasmic sperm injection (ICSI). IVF is the procedure where multiple eggs are produced in the female. These eggs are matured and retrieved from her body. Once retrieved, they are combined with the male's sperm outside of the body. When they are combined, they fertilize and become embryos. The embryos are then grown outside of the body and then transferred back into the woman's uterus in a few days.



The next step is **donor sperm or donor eggs**. Donor sperm is a reasonably simple technology. However, it is placed this far up “the pyramid” because it usually involves some complex psychological issues. Donor eggs is a more complex process involving more intensive treatment but is similar to donor sperm in its psychological issues. Donor eggs involves an IVF cycle in which two women are synchronized and trade places.

The next step is **surrogacy**. Very few people require surrogacy. It involves similar technology to donor eggs but probably involves some of the most difficult psychological issues. The last two steps of the pyramid are **adoption or remaining childless**.

Side trips off this can occur at any time. For instance, fertility enhancing surgery could be recommended at any time. Not everybody starts at the bottom and works up. For example, a

woman with blocked tubes starts at IVF, a lesbian couple starts at donor insemination or a woman without a uterus starts at surrogacy. Also, some of the steps never become appropriate for some patients.

The Prognosis (With No Treatment)

Prognosis is the term used to refer to the overall chance of a good result. It can refer to the chance of a pregnancy in a single attempt or it can refer to the chance of a pregnancy long term, given use of all available fertility treatments. **Prognosis calculation** or estimation is the tool we use constantly in designing treatment for our patients at S.O.F.T.

You will be given the prognosis or the chance of any treatment working before you start it. This is **balanced against the chance of a spontaneous pregnancy occurring.**

The chance of a spontaneous pregnancy occurring **should not be considered in a couple having trouble getting pregnant until the appropriate infertility investigations are completed.** At the initial consultation at S.O.F.T., this involves completion of the basic infertility investigation. During your ongoing treatment it may involve repeating any of these investigations or adding new investigations such as a laparoscopy.

Female age affects the chance of a spontaneous pregnancy. In general, the chance of a pregnancy occurring in one year in a 25 year old couple with no sub fertility factors is 25% per cycle or 85% in one year. If the female partner is 35 years old, the monthly pregnancy rate drops to about 20% and at 38 to about 15%.

The **length of infertility** affects the prognosis. The 25 year old couple with a 85% chance of a pregnancy in their first year and a 40% chance in their second year goes on to a 24% chance after two years of infertility and a 12% chance after three years.

The **length of infertility interacts with female age** to affect the chance of a spontaneous pregnancy. If a year of infertility has occurred but the basic infertility investigation is normal, the 25 year olds have a 40% chance of a pregnancy occurring spontaneously in the next year. However, at a female age of 38 years old, this is probably more like 20% and at 40 years old, about 10%. This is the backdrop on which we consider infertility treatment in the first place.

| Female Age | 25 Years Old | 34 Years Old | 38 Years Old | 40 Years Old |
|------------------------------|---------------------|---------------------|---------------------|---------------------|
| Length Of Infertility | | | | |
| None | 85% | 70% | 50% | 25% |
| 1 Year | 40% | 35% | 20% | 10% |
| 2 Years | 24% | 12% | 6% | <6% |
| 3 Years | 12% | 6% | <6% | <6% |
| 5 Years | 6% | <6% | <6% | <6% |
| 10 Years | <6% | <6% | <6% | <6% |

Table Indicating the Chance of a Spontaneous Pregnancy Occurring In Each Year with Different Lengths of Infertility and Different Female Ages

Prognosis with Treatment

Ovulation induction tends to double to triple the expected rate of pregnancy and in most major studies demonstrates a pregnancy rate of about 5% per cycle. However, in a 25 year old with one year of infertility, we might expect a $(40/12 \times 2.5 \% =)$ 8.3% pregnancy rate. That means this treatment is worth a really good trial; perhaps 12 cycles. In a 38 year old with two years of infertility, we might expect a $(6/12 \times 2.5 \% =)$ 1.25% pregnancy rate. This means this treatment may be worth a trial but is not good enough to persist with for too long.

Intrauterine insemination (including donor insemination) tends to have a pregnancy rate of between 10-15% (13.8% per cycle at S.O.F.T.) per cycle. We think this gives 6 times the baseline pregnancy rate. This is lowered by female age (as indicated by the table) but not as drastically as ovulation induction. In fact, a study I did earlier in my career indicated we could achieve a pregnancy rate of 7% per cycle in women 40 to 42 with “medium stimulation” intrauterine insemination. Therefore a 25 year old with 1 year of infertility could expect a pregnancy rate of $(40/12 \times 6\% =) 20\%$ per cycle pregnancy rate. However, a 38 year old with 2 years of infertility could only expect a $(6/12 \times 6\% =) 3\%$ per cycle pregnancy rate. In fact, our true observation is that it might be slightly resistant to the age and length of infertility factors and give a better than expected pregnancy rate in the lower prognosis group, perhaps up to 10% per cycle.

IVF or IVF with ICSI has pregnancy rates of about 40% in good candidates. This is reduced by female age so that a 38 to 40 year old has about a 20% chance in an IVF cycle. IVF seems to be more sensitive to female age but is probably not as affected by length of infertility.

Prognosis Point of View

Prognostic perception is the term we use to describe your own idea about the prognosis. It is not always the same as the actual prognosis or the prognosis that we as your care-givers calculate for you. In fact, it is consistently poorer than the actual prognosis. A couple who have been trying for 2 years, were the female partner is 34 and who have completed six cycles of ovulation induction with clomiphene citrate and then has gone on to do two cycles intrauterine insemination may consider their situation hopeless. However, we at S.O.F.T. would consider their chance of pregnancy very good. In fact in 4 remaining IUI cycles they would have up to a 10% chance each cycle and if they had to go on to IVF, would have a 30% chance in each cycle up to about 3 cycles.

**Your Perception of the
Chance of a Pregnancy
is always less than it
really is!**

Per Cycle Pregnancy Rates and Long Term Success Rates

Per cycle pregnancy rates at S.O.F.T. are indicated in the table. Our philosophy at S.O.F.T. is that patients are more important than statistics and so we will give anyone a chance at a pregnancy despite the fact that their poor chance may adversely affect our overall statistics. Despite this philosophy, our pregnancy rates per cycle of treatment compare very well with any fertility treatment centre.

| Treatment | % Per Cycle |
|---------------------|-------------|
| Ovulation Induction | 4.4% |
| IUI | 13.8% |
| IVF | 34.6% |

**Pregnancy Rates per Cycle
Depending On Treatment Type**

Looking at the pregnancy rates for the different treatments, it would be tempting as a patient to do IVF first. However, the treatments become progressively more expensive, time intensive and complicated. Therefore, we almost always start with the simplest treatment and work up to more complex treatment if they are not successful. The rate at which an individual patient “progresses” through the treatment types is modified by female age, length of infertility and patient preference.

Long term success rates are something that is not as often discussed. We often discuss our per cycle pregnancy rates. These are important because for us at S.O.F.T. they evaluate how

well we are doing on individual treatment cycles and are important for us in our quality assurance. It is also important for you as a patient as you are investing your money, time and emotional energy in each treatment cycle you do with us. However, at S.O.F.T. we pride ourselves on the very difficult pregnancies we achieve. We will not give up, unless you want to, until every avenue is explored.

Recently, a very good Canadian infertility clinic presented its success rates in all patients attending their clinic after one and two years of treatment. After the first year (one year from their first consultation), they were able to obtain viable pregnancies in 22% of the couples and after two years it rose to 38% of couples. At S.O.F.T., we have 33% of our consultations pregnant one year after their initial consultation, 44% pregnant after two years and 59% pregnant after three years. Our record is a successful pregnancy after 15 years of infertility!

| Years | % Pregnant |
|--------------|----------------------|
| One | 44% |
| Two | 66% |
| Three | Not Available |

% Pregnant Each Year of Treatment

The “Rule of Six”

In general, most infertility treatments are worth trying for six times. For example, ovulation induction with clomiphene citrate or intrauterine insemination with clomiphene and injectable infertility medication or IVF can be used for up to six times per pregnancy. Lots of exceptions, however, occur to this rule! Factors taken into consideration are discussed below.

Smart, but not That Smart

A logical treatment plan is developed for each patient. However, the exact treatment which will result in a pregnancy is not always possible to predict. Surprising pregnancies occur sometimes with what appear to be very minor adjustments in treatment. However, we have come to realize that these apparently trivial changes may be critical for the individual.

It seems almost as though there is a “**key**” to obtaining a pregnancy in each individual and although treatment plans are developed logically, the “key” is not always predictable. One way we use the “key” is in obtaining second or even third pregnancies. Our standard approach to obtaining another pregnancy for someone is to repeat whatever worked two or three times before re-doing all the basic infertility investigations. With the approach, almost 50% (48%) obtain their second (or even third) pregnancies without getting to the point were they repeat their investigations.

Treatment Options

No Treatment

No treatment has limited use. By the time most couples arrive at S.O.F.T., they are ready to consider more active treatment. However, when the length of infertility is short, female age is young and the basic infertility investigation has ruled out and major areas of concern, it can be considered for a short time.

Sometimes, at S.O.F.T., we will advise alternate months of using ovulation induction in these circumstances. There is reasonable evidence that the pregnancy rate in the “in between” cycles is improved and that “the first” cycle of ovulation induction may have a higher pregnancy rate. By doing alternate months, it may be like starting the first cycle over and over again.

Ovulation Induction

The first treatment often offered is ovulation induction. Ovulation induction refers to the use of oral pills to stimulate the cycle and timing of intercourse. The pills that can be used to do this are **clomiphene citrate, femara or tamoxifene**. As long as one Fallopian tube is open and there are sufficient sperm present this will probably be the first treatment attempted. Ovulation induction may be attempted for one to six cycles. Usually we expect about a 5% (2.5-12%) pregnancy rate per cycle.

Intrauterine Insemination (IUI)

IUI is the backbone of clinic based infertility treatment. At any given time, it is what most of the patients at S.O.F.T. are doing. Over half of S.O.F.T.'s successful pregnancies have occurred in IUI cycles.

In Vitro Fertilization (IVF)

IVF is the glamour and glitter of infertility treatment. It involves the stimulation of multiple eggs in the female partner. These eggs are then removed from the body and fertilized outside of the body. Fertilizing the eggs outside of the body is what gives IVF its name.

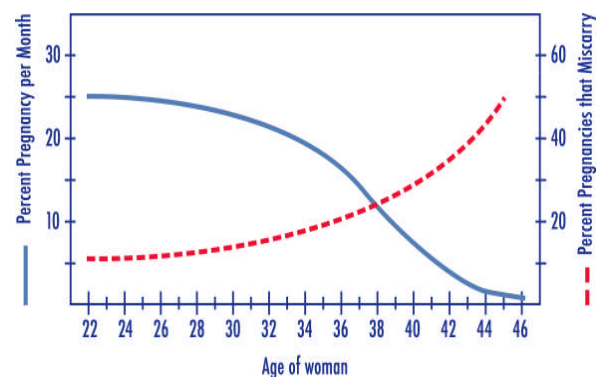
Conventional IVF occurs when the eggs and sperm are combined and allowed to fertilize on their own. Intracytoplasmic sperm injection (ICSI) is when a single sperm is injected into each egg, thus bypassing fertilization.

Factors Considered When Modifying the "Rule of Six"

The factors determining how many cycles will be attempted are female age, previous pregnancies, ovarian reserve, length of infertility, response to the treatment, cost considerations, work commitments, presence of infertility factors like endometriosis, tubal factor, and male factor. Patient preference and driving distance from London are also considered.

Fertility potential decreases with age (see graph). More cycles of ovulation induction are likely to be tried with younger women. For example, in a 25 year old at least 6 cycles of clomiphene might be considered. If other factors dictated it (distance from London, cost considerations), we might even try some ovulation induction with an alternate medicine before moving on to intrauterine induction. With a 35 year old woman we would probably consider only three cycles of clomiphene citrate before moving on to intrauterine insemination. At 40 years old we might go directly to intrauterine insemination because of the increased cycle information and increased pregnancy rate.

A previous pregnancy improves the chance of another pregnancy and may make us consider sticking with ovulation induction longer. This is more important if the previous pregnancy has been recent. It is more important if the pregnancy has occurred with the same partner and especially important if it occurred using ovulation induction. Even if a miscarriage has occurred with ovulation induction, this improves the chance of a normal pregnancy occurring with the same technology.



Ovarian reserve refers to the number of eggs left in the ovaries. Ovarian reserve can be estimated by day 3 FSH level, clomiphene challenge test, ultrasound estimate of ovarian volume or response to the usual fertility medications. A better ovarian reserve indicates a better chance of a successful pregnancy and may cause us to offer more cycles of ovulation induction.

Length of infertility may indicate the severity of the infertility. This can, of course be misleading with someone with only a short duration of infertility as they may go on, given more time to a longer duration of infertility. Someone with only a year of infertility has a reasonable chance of a spontaneous pregnancy.

The chance of a pregnancy with any technology in fertility depends on **how the individual patient reacts to the treatment.** For example, ovulation induction with clomiphene citrate at the lowest dose (50 mg days 3 to 7 of the cycle) should cause the patient to have regular cycles that are 30 to 32 days long and elevated luteal phase progesterone. If all of these factors are optimum, we will usually advise more cycles than if they are not.

Ovulation induction is a very inexpensive treatment. Sometimes, **even minimal costs can be a roadblock to treatment.** Although the next step, intrauterine insemination is not a great cost, it can be difficult for some couples. Under this circumstance we may advise a few more cycles of ovulation induction, perhaps changing the medication. Similarly, if a work or school **time commitment** makes monitoring the cycle impossible from a time commitment point of view, we may continue ovulation induction a little longer.

Diagnostic considerations are an important factor in deciding treatment options and progression through treatment. As discussed earlier in this information sheet, often couples are found to have “suspicious” elements to their treatment. The examples used were: there may be a normal sperm count but one which is consistently in the lower end of the range. Or there may be regular cycles but they may be shorter than usual (24 days) or vary a little with each cycle (27 to 31 days). Or the hysterosalpingogram may demonstrate one tube open but not both.

The couple with the normal but lower sperm count may be offered intrauterine insemination first or earlier as this addresses this cause of infertility. The couple with regular cycles but shorter or slightly variable, we may be more persistent with ovulation induction as this may directly address the infertility cause. The couple with an abnormal hysterosalpingogram may be offered a laparoscopy earlier.

Patient preference is always taken into consideration. In fact we like you to make the treatment decisions with the benefit of our advice.

Some Examples to Illustrate how “What Next” Decisions are Made.

The following examples will attempt to illustrate elements of the “What Next” decision process.

Mr. and Mrs. L. K. were 25 years old. They had 2 years of infertility and had already taken six cycles of clomiphene citrate before their consultation without success. Basic infertility investigation was normal except Mrs. L. K. had irregular cycles (17 to 43 days). They lived over three hours travel time from London. They were therefore prescribed three cycles of Femara for additional ovulation induction before a plan to proceed to IUI. They became pregnant on their third cycle of Femara.

Mr. and Mrs. J. F. were 33. They had 3 years of infertility. Infertility investigation was normal except Mrs. J. F. has an extremely tipped uterus and experienced severe pain with intercourse. Because intercourse was painful, a laparoscopy was done. Severe endometriosis was

found. This was treated at laparoscopy but could not be fully treated because of the extent and position of the lesions. A course of Depolupron was given for 3 months. The combination of the laparoscopy and Depolupron made intercourse painless and a spontaneous pregnancy occurred 4 months after the end of the Depolupron.

Mr. and Mrs. C. S. were 35. They have 2.5 years of infertility. Basic infertility investigation was normal except one of two semen analysis were slightly low. Mrs. C. S. had a pregnancy without much delay in her first relationship. They were offered IUI in spontaneous cycles (no medication) and became pregnant on their second cycle.

Mr. and Mrs. D. A. were 41 years old with 9 months of infertility. Because of her age, the basic infertility investigation was extended to include a clomiphene challenge test. (Information about a clomiphene challenge test is available on the information sheet on decreased ovarian function) During the basic infertility investigation it was found that Mr. D. A. has a normal but low sperm count. The clomiphene challenge test was favorable and Mrs. D.A. was found to have two larger follicles on day ten of her cycle. The cycle was completed with IUI and the couple became pregnant.

Mr. and Mrs. M. W. were 22 with 1.5 years of infertility. A basic infertility investigation was normal except for a very low sperm count. Mr. M. W. was found to have a varicocele and varicocele embolization was done. The varicocele resolved and Mr. M.W. had an improvement in the sperm count but it still remained very low. Ideally the couple would benefit from IVF with ICSI but they could not afford it. Mr. M. W. was placed on some supplements we refer to as “the S.O.F.T. Potion” (information on the Male Factor information sheet). They started to do IUI. Sperm recoveries were less than ideal but it was the only form of advanced treatment they could afford. They completed 8 cycles of IUI with various changes in accompanying medications and then became pregnant on their 9th cycle.

Mr. and Mrs. V. O. were 27. Mrs. V. O. had been born without a uterus. Their basic infertility investigation was normal otherwise. Mrs. V. O.’s lifelong friend Mrs. F. G. agreed to be the couple’s surrogate. She was 27 as well and had two children of her own and had a tubal ligation. Her basic infertility investigation was otherwise normal. Mrs. And Mr. F. G. were informed about the procedure, offered extra counseling and completed an agreement document with Mr. and Mrs. V. O. Mrs. V. O. then underwent ovarian stimulation and retrieval of her eggs. Mr. V. O. gave a sperm sample to fertilize the eggs. Mrs. F. G. had her uterus synchronized with the cycle and two of the embryos were transferred into her (with three additional embryos frozen) and she became pregnant with twins.

Miss. C. R. was 38 years old. She was single and a very successful business woman. She had always wanted children and had good support from her family and friends. She underwent a basic infertility investigation which was normal. She then did donor insemination and achieved a successful pregnancy with her 5th cycle.

Mr. and Mrs. A. Z. were 26 years old and had 4 years of infertility. Their basic infertility investigation was normal. They lives 2.5 hours from London and both had heavy work commitments. Ovulation induction was tried for 6 cycles because of its ease of use in this situation but was not successful. Intrauterine insemination was then attempted for two cycles but was not successful. Intrauterine insemination was stressful for the couple because of the distance and time. Therefore, IVF was done next and was successful on the first attempt.

Mr. and Mrs. G.W. were 44. They had never been married before but found each other last year and after a world-wind romance got married and decided they would like to have

children. Basic infertility investigation was very abnormal. Mrs. G. W. had a day three FSH level of 62, indicating a severely depleted ovarian reserve. Not only that, but Mr. G. W. had only a few moving sperm in his ejaculate. The couple was counseled on Donor eggs, adoption or childlessness. They chose to do donor eggs. They advertised in their local newspaper and found Miss. J. P. who was 22 years old and a single mother of a 3 year old. Miss. J. P. underwent a basic infertility investigation, informed consent and counseling. A donor egg cycle was performed and was combined with ICSI because of Mr. G. W.'s low sperm count and was successful.

Mr. and Mrs. R. C. were 29 years old with 1 year of infertility. A basic infertility investigation was normal. No treatment was chosen for 6 months knowing their chance in the next year was approximately 40%. The couple were using an ovulation detector and timing their intercourse. They were advised to increase the frequency of their intercourse and not go entirely on the ovulation predictor and had a pregnancy on their 5th cycle.

Mr. and Mrs. T. A. were 31 and had infertility for 6 years. A basic infertility investigation was normal except for a low sperm count. Intrauterine insemination was attempted for 8 cycles. This included 3 spontaneous cycles, 3 clomiphene citrate cycles and two "medium stimulation cycles". They then went on to do one cycle of IVF with ICSI. Unfortunately, this two was not successful. Mrs. T. A. stimulated well and 14 eggs were retrieved, 10 eggs fertilized and two embryos were transferred and 3 frozen. The frozen embryos were transferred 4 cycles later. The couple then decided to do donor insemination because of the lower cost and became pregnant on their second cycle.

Mr. and Mrs. D. D. were 30 years old and had 5 years of infertility. She was known to have endometriosis and has had laparoscopic removal of it twice. Basic infertility investigation was otherwise normal but intercourse was impossible because of a recurrence of the endometriosis. Repeat laparoscopy or medical treatment of the endometriosis was offered and treatment with Depolupron with estrogen add-back was chosen. The treatment resulted in significant improvement of symptoms. After the treatment the couple chose to go to IUI with clomiphene. Despite regular cycles, ovulation with clomiphene could not be documented during monitoring so the cycle was cancelled. A second IUI cycle was done with no medication and resulted in ovulation, insemination but not a pregnancy. The cycle was then repeated and was successful.

Mr. and Mrs. L.T. were 21 with 3 years of infertility. Their basic infertility investigation was normal except for irregular cycles (28 to 90 days). They had already had 8 cycles of clomiphene. IUI with clomiphene was attempted and resulted in ovulation but the endometrium was very thin (3 mm) despite attempts to thicken it with estrogen and then progesterone. The next IUI was done with Femara and resulted in ovulation, a thicker endometrium (9 mm) and a pregnancy!

Jim Martin ©
Southern Ontario Fertility Technologies (S.O.F.T.),
555 Southdale Rd E, Suite 107,
London, Ontario, N6E 1A2
Tel: 519 685-5559 Fax: 519 685-5510
Visit Our Web Page at: www.soft-infertility.com