

# WHAT TO EXPECT FROM A FERTILITY EXPERT

Conversations with Three  
Prominent Fertility Specialists

Sami David, MD  
Jamie A. Grifo, MD, PhD  
Jonathan Scher, MD

Julia Indichova, Series Facilitator



 fertileheart<sup>TM</sup>

Adapted from transcripts of the  
Fertile Heart Guest Teacher Series

FERTILE HEART™

Published by Fertile Heart™

Copyright © 2013 by Julia Indichova and Fertile Heart

Without limiting the rights under copyright reserved above, no part of this publication may be reproduced, stored in or introduced into a retrieval system, or transmitted, in any form, or by any means (electronic, mechanical, photocopying, recording or otherwise), without the prior written permission of both the copyright owner and the publisher of this book.

The scanning, uploading, and distribution of this book via the Internet or via any other means without the permission of the publisher is illegal and punishable by law.

Please purchase only authorized electronic or print editions, and do not participate in or encourage electronic or other piracy of copyrighted materials.

Your support of the author's rights is appreciated.

**Disclaimer:** The information offered in this eBook is not meant to replace the advice of an appropriate health professional; it is shared with the understanding that each reader accepts full responsibility for her/his well being.

## Table of Contents

<b>Sami David MD</b>	<b>7</b>
<b>Jamie Grifo, MD, Ph.D</b>	<b>27</b>
<b>Jonathan Scher, MD</b>	<b>53</b>
<b>FertileHeart Article Links</b>	<b>78</b>

Dear Unquestionably Fertile Friends,

All of the guest teachers who honored us by participating in the Fertile Heart™ Guest Teacher Teleconference Series are seasoned, caring professionals, highly respected in their field of expertise. I have known most of them for many years through the women and men I have worked with, some of whom were also treated by the doctors in this series.

As a facilitator of the guest teacher talks, my intention was to hear what each of our guests had to offer, without necessarily voicing my views during the call, although intermittently I did offer an alternate answer. Clearly, you don't have to agree with our guests, with me, or with any other teacher you meet on the baby- making trek.

The Fertile Heart™ Ovum tools are about tuning into the fertility specialist within you, so that you can discern which suggestions, or treatment protocols of the caregivers you encounter might be helpful, and which may not match your beliefs or your current needs.

You don't necessarily need to choose between the Fertile Heart™ practices or other holistic healing modalities, and the many forms of assisted reproductive technologies. It's not an either/or proposition. I have seen many women and men conceive naturally through the use of Fertile Heart™ tools alone, and I've also seen many good results from combining the techniques with IVF and other forms of ART, or with other complementary healing modalities.

It's a given that every caregiver you meet on your pilgrimage toward your child, be it a practitioner of traditional Chinese medicine, homeopathy or reproductive endocrinology, will offer his or her opinion of the best approach to your difficulty, shaped by their training and their professional and personal experiences.

My own explorations in this field, since the day I was diagnosed with elevated FSH in April of 1992 and the consequent years of research, teaching and learning, have shaped the way I view the case histories of people who approach me for guidance.

When a woman tells me that she is planning to start an IVF cycle tomorrow, and

that she's had hormonal problems since her late teens, I instantly recall the story of Maria, who conceived naturally soon after resolving haunting issues from her teenage years.

When a woman tells me that she has just turned forty, I think, "Young." Forty is young in my reality, because I myself gave birth a few months before my forty-fifth birthday, and I have seen many women go through uneventful full-term pregnancies well into their forties.

When someone says, "I have Polycystic Ovary Syndrome," the image of Krystina and Kristine, who were both diagnosed with PCOS before going on to conceive naturally, almost instantly enters my field of inner vision.

With endometriosis, I think of Myrna and her little girl. Myrna came to the Fertile Heart™ practice after several failed IVF cycles and a diagnosis of endometriosis. Following some lifestyle changes and a consistent commitment to her practice, she was able to conceive naturally.

When I hear: "I've had three miscarriages," I think of Louise and Nadine envisioning a road of healing that might not only stop the loop of interrupted pregnancies, but can also heal countless other losses – losses that might have been causing a lifetime's worth of undetected internal grieving -- and may have one day manifested as a life-threatening disease.

Unexplained infertility? Mandy, cradling her newborn daughter Annabelle, and Jana holding up her baby boy lead the long line of moms whose stories continue to validate an undeniable truth: there is something about conceiving a life that remains a mystery in spite of decades and billions of dollars spent on research.

I remember each of these women as enthusiastic practitioners of the Fertile Heart™ Ovum tools, who conceived their children the old-fashioned way, beating seemingly unbeatable odds.

My hope is that reading the—at times very different—views expressed in these sessions might evoke an inner dialogue with the fertility expert within you. In the

language of the Fertile Heart™ Ovum Practice, your own inner expert is the voice of the Visionary and the Ultimate Mother aspect of your nature. May those two voices of knowing help you receive from these transcripts the many useful insights shared by our guests.

Keep walking, you only need to meet your child halfway!

Julia Indichova

January 3, 2013, Woodstock, New York



# Sami David, MD



Julia Indichova: Welcome, Sami! I'm so glad that you accepted our invitation.

Dr. Sami David: It's an honor; I hope I can share some information with people that might put things into perspective.

Jl: That's what this series hopes to do. Let's dive in and start at the beginning!

The one thing I learned from working with people in the last decade and a half is how important the diagnostic process is. In my own work, the diagnostic consultation can take as long as three hours, and sometimes even that is not sufficient.

Could you give us an overview of what your diagnostic process looks like?

SD: I'd be happy to. Within the first few minutes of the interview, I'm trying to decide whether the patient really has infertility as non-conception or whether I'm dealing with implantation failure. There are many women who don't realize that they could be getting pregnant repeatedly and miscarrying precisely on the day of their expected menstrual cycle. And there are a number of women that will be able to tell you, if you let them know what to look for, whether or not their problem is implantation or miscarriage.

Jl: Could you name some of those early pregnancy symptoms?

SD: It's not just the issue of breast soreness, but also nipple tenderness, changes in smell or taste, urinary frequency, fatigue levels. It's not uncommon for me to discover just in the first few minutes of trying to understand this person's cycle, that they've been miscarrying. Even if the person has a 28-day cycle like clockwork. Many years ago when a woman came in from Paris who had four years of what appeared to be infertility, but questioning her further, it turned out that she was miscarrying about four times a year. That's about sixteen miscarriages in four years without ever knowing that she was conceiving.

Then the next issue is the history of the husband. And if any of you listening have been through IVF or have seen IVF doctors, what drives me crazy is when I see my colleagues writing in the charts that the husband's sperm analysis is "adequate



for IVF.” Basically what they are telling you is, Yeah, your husband’s sperm is not good, but we can pump you up with drugs, and make more eggs and maybe get you pregnant. And if that doesn’t work, we’ll go on to higher doses of fertility drugs. I think one of the most underused specialists in the fertility team, is the urologist. If you note what the statistics are, about 30% of infertility may be male related, I think as consumers of medical care, you should insist that your husband should be evaluated. It’s unfair for women to carry the burden of infertility on their shoulders, when the husband could have a problem as well.

In medical school you are taught to make a diagnosis first, and treat the diagnosis. So for example, that woman in Paris only needed progesterone, and she had babies. I had seen a patient who has been through several cycles of drugs, and I simply said to the couple when I first met them, Your husband needs to be seen, and about five months later I get a letter saying, “Thank you, Dr. David. I’m pregnant. My husband saw a specialist.” It was his problem, not the wife’s.

In medical school you’re taught to evaluate a medical problem in terms of categories: genetic categories, metabolic/hormonal categories, autoimmune categories, environmental categories. And to be a good diagnostician, you have to touch base on every one of these categories. You’re not doing the patient a service as a good medical detective unless you have at least an hour consultation with the husband and the wife together. It should not be just the wife bearing the responsibility.

The most criticism I have toward my colleagues who do IVF—and I don’t do IVF, by the way—is that they don’t pay enough attention to the man. So when it comes to secondary infertility, in five years, or six years, they’ll rather say, Your eggs are not fertilizing, we are getting no response, rather than saying, Well, maybe your husband’s sperm was just barely enough to get you pregnant back then. And now it’s gotten worse. So what’s important is that your doctor should focus critically—and I stress critically—and evaluate the shape of the sperm.

I’ve literally seen dozens and dozens of patients, where the one thing that has always been missed, and terribly missed by the best doctors, by the way, is looking at bacteria in the husband’s semen.

So if you think that infection can cause disease, and I think most people would agree that that’s true, why do reproductive endocrinologists not require a thorough testing for bacteria? Most often they’ll test you for what? Chlamydia, gonorrhea,

maybe for mycoplasma or ureaplasma. After that the sperm is declared to be adequate and your husband goes free.

To share another story, a couple from Los Angeles spent \$100,000 or so before they came to New York to see me. What happened was no one did cultures. They did every test that should have been done, but no cultures on the man's sperm. The sperm contained bacteria called E. coli. And this couple, after spending all the time and money and drugs on the wife, became pregnant about three months after a simple course of antibiotics. In their own bedroom, with no drugs.

Jl: This is a very important piece in my work as well. I see it changing a bit now, but for years it was the wife that would attend the workshop and learn about food and supplements, and emotional obstacles, even when it was the husband who was diagnosed.

What I have also seen that's worth noting, is that even if after evaluating the husband, no sperm issues are found, when both partners increase their overall level of health, pregnancy rates go up. So I think it's always essential for both people to engage in the healing process.

There is actually research showing that when sperm quality goes up, miscarriage rates go down. Most recently a client reported to me that proper supplementation doubled her husband's sperm count, and was also a factor in her becoming pregnant.

Okay, we're going to take some calls.

Caller 1: I am 42 and I've been dealing with infertility for five years. I have an eight-year-old daughter. I had a miscarriage prior to having her. I have not gotten pregnant since and I am embarking on an IVF cycle as we speak. And I was wondering, because I've had a lot of concerns about the medications, what the long-term effects might be on the woman. And also what kind of effects they may have on the child, if any.

SD: Well, with IVF they are very, very subtle effects generally on the pregnancy and on the children. There may be a very small percentage of IVF conceived children

that might have learning disability. But if I was in your situation, the idea of having a baby is so important compared to the small risk of having a baby that might have minor, again I stress minor, disability, I'd certainly do in-vitro, especially if it was necessary.

Can I ask you how quickly did you conceive your daughter, and what was the relationship of the miscarriage to your daughter?

C1: The miscarriage was in the beginning of the year in January and then my daughter was born in August of the following year. And we didn't try right away because I had a lot of emotional issues after the miscarriage. But we did get pregnant without any issue. And then, since that time, not again. You know, I heard what you said regarding the possibility of implantation problems. Sometimes I'd get a very heavy period and I'd wonder. But there was never any follow-up on that from any of the doctors.

SD: The point is, when I see a couple, I say okay, you've been trying to get pregnant for twelve months. So what does that represent? That's twelve ovulations in the past year. So why would I believe, if I give you fertility drugs and make three eggs a month instead of one egg a month, that you should get pregnant? They're not making a diagnosis. That bothers me immensely, and Julia will know that, you really have to take a complete history. The men are getting away with only a cursory evaluation. The fact that you had a miscarriage and then your daughter, I would really look at your husband's analysis, and it all depends on what you've been through prior to IVF, and why you have been told that you must go through IVF.

C1: Initially I was told it was unexplained secondary infertility. When they did all the tests, including the post-coital test, the doctor told me, while looking through a microscope at the sperm that I should be getting pregnant. Those were his words. But of course I have not gotten pregnant.

SD: It doesn't matter; the numbers of sperm are not what the key is. We have to look at the shapes of sperm and if there's bacteria on the sperm.

Jl: Sami, are you saying that when semen analysis is done, most urologists will not routinely test for bacteria?

SD: Correct, absolutely yes! You go to any laboratory and you can see, they just do sperm analysis and no testing for bacteria. I've had the hardest time, in fact, I once had a couple from Bangladesh—I had to have the sperm shipped over from Bangladesh for cultures. And that couple had miscarriages. And yes, the man had the bacteria.

Jl: So Sami, and this actually was a question that came up from another caller, and I think we might as well pose it, here. Do you routinely prescribe testing for bacteria when someone comes to you?

SD: Absolutely routinely. Without a doubt.

Jl: Could you tell us what specific tests you require apart from the sperm analysis?

SD: Sperm analysis will tell you the count and motility, which is just very superficial. The critical issue in sperm analysis is the shape of the sperm and if there are bacteria. So consequently, what I'm looking for in sperm analysis, I'll tell the husband I don't care if the semen sample is one hour old, or two hours old, or maybe it's even three hours old. What happens with aging of the sperm is simply the motility goes down. I want a laboratory, not Quest, not Labcorp, not a commercial lab, to evaluate the sperm. I want a lab where technicians are carefully taught how to read sperm shape, to tell me the shapes of the sperm. And I want a laboratory that's equally good in culturing out the sperm. And not just for ureaplasma or chlamydia or gonorrhea, but also for routine bacteria.

Mark Goldstein, who was one of the guest teachers I believe you mentioned, Julia, is a close friend of mine and we've worked together for twenty-five years. He's at Cornell, and a world expert on male infertility. He and I were looking at this issue of bacteria literally twenty-five years ago, and all these years later doctors still don't look for bacteria. In medical school, again, you're thinking what causes disease, right? Anatomy, tumors, genetic issues, hormonal/metabolic issues, etc, but

somehow the doctors, IVF doctors, seem not to pursue this.

Jl: Why do you think that is, Sami?

SD: I don't know why it should escape them. We're taught basic evaluations in medical school.

Jl: So for the people who are listening, if you could just review? For the women, I think the caller was asking specifically, what would you be testing for?

SD: The same thing—routine bacteria, mycoplasma, ureaplasma and chlamydia. To give you an example, there was an article written by an IVF team and published in one of the journals, an article which probably a lot of IVF doctors dismissed. This IVF team, they found that if E. coli was in the cervical mucus, as the catheter passing embryos through the cervical mucus was placed into the uterus, if the catheter was infected by E. coli, IVF success rates were half of what they should have been. Which shows us that even simple bacteria like E. coli or enterococcus or any bacteria in the cervical mucus should be addressed.

C2: I have a question regarding the E. coli. Is that not a standard test that physicians would test for before they even do a transfer, just so that they know that the uterus is a safe environment that does not have E. coli? One would think that that would just be a standard procedure.

SD: One would think that, but they don't. Can I ask the people listening, when you do IVF, they do give you and your husband doxycycline correct?

C2: Yes.

SD: All right, what does doxycycline do? It only kills off ureaplasma and mycoplasma. It has nothing to do with E coli, enterococcus, any of these other bacteria. And also I know that in a lot of these IVF programs, the husband and the wife are not treated

simultaneously. Rather they're sort of treated in tandem, and treated superficially, with five or six or seven days of antibiotics, rather than ten days or two weeks. I'm not just trying to stress the importance of that germ, I'm just trying to stress that you have to look for it. I don't give everybody antibiotics, but amazing numbers of couples who are not getting pregnant, or getting pregnant and miscarrying, have bacteria.

C2: And what is the technique that's typically used to test for E coli in the uterus?

SD: It's very, very simple. You just take a sterilized Q-tip and place the Q-tip high inside the cervical canal, collect the mucus, and send it to a good laboratory. It's so simple.

Jl: Simple enough and it might save you \$200,000 not to mention a lot of heartache.

SD: Yes! You can be an IVF doctor, but don't put people through IVF; don't pump them up with drugs, until you've done everything you possibly can.

Jl: And if I may add, the same advice would be useful for the patient. Don't go through the expense, emotional pressures and expose yourself to possible side effects of IVF until you have done what it takes to prepare yourself physically and emotionally. I find it sad to hear that people have gone through several failed cycles of IVF without having any real understanding of the many possible reasons for their fertility challenges.

Time for more questions:

C3: I have a question about ICSI. Isn't that on the increase?

SD: What do you mean "is on the increase"?

C3: It seems like more doctors are kind of like just doing it for the sake of doing it, in

the sense they don't have a really good reason to do it.

SD: Or they're doing it for the extra money? I can't say, because I don't do IVF. I performed the first successful IVF in New York, 25 years ago, and I quit after that.

Jl: From my experience, increasing your overall level of health is not taken very seriously when it comes to sperm quality or egg quality for that matter. I continue to see a large number of couples where ICSI is suppose to be an easy way out.

SD: I'll say to you, if the sperm is not good and therefore they have to do ICSI, why don't they send the husband off to a specialist? They're bypassing the problem.

Jl: And, sadly, bypassing our problems will eventually catch up with us. In an interesting book, *Everything Conceivable* by Liza Mundy, urologist Paul Turek is quoted saying that ICSI could in fact be setting up the next generation of infertility patients. He says that the procedure is permitting certain genetic diseases to be transmitted.

SD: Nature chooses usually the best sperm.

Jl: And I guess if it doesn't choose a sperm or an egg, it has a reason not to.

SD: Empower yourself and say, "Listen, fine I'll do IVF, fine I'll do ICSI, but I want my husband's semen to be tested as well, because I don't want to come back to you two years from now for a second child."

Jl: There are also studies that show that when it comes to health issues of IVF- conceived children, some of those problems are linked to the underlying health problems of the parents that remained undetected or unresolved before the couple moved on to IVF.

So again, it makes total sense to do all we can to assess the overall level of health and address those issues.

Now I will go to one of the questions that came through email.

It is from a caller who is 44 and 4 months old, and she writes: "I feel like my periods are getting shorter in the past couple of months. My last FSH reading in August was 8.7, and my estrogen was 45. Two months prior to that, in June, my FSH was 5.9 and estrogen was 19 or 24. What do you think the variation in these numbers means over the course of two months?" What about the shorter periods?

SD: If she's showing up with normal FSH, that is, under 11 and estradiol levels say under 60 or 70, that would imply a good ovarian reserve. The fact is, unfortunately, she's still age 44. So age is more important than FSH and estradiol. Why she's having shorter cycles, 25 or 24 days I'm not sure. The bleeding is shorter? It lasts two days?

Jl: Yes, actually, the first two days she says, it is full of clotty substance. The next two or three days is brown spotting where she can get away without using a pad.

SD: So if there's been a change in the quality of menstrual cycle, then you want to be able to do an endometrial biopsy ten days after she ovulates. Just look and see how the endometrium is developing. I'd probably put her through full testing. Not looking for cancer, but looking for polyps or abnormally developed endometrium.

If the endometrium is not developed correctly, she may be producing healthy eggs, and maybe hopefully healthy embryos, but they won't implant because something in her menstrual cycle is changing, it's not like it used to be, and there might be an underlying reason why she's not implanting.

Jl: Clots in the menstrual blood are also symptomatic of low progesterone, aren't they?

SD: Yes, correct.

Jl: Since we are on the subject of endometrial linings and the endometrium, we have a question here from someone who was diagnosed with stage 3 endometriosis,



and she's asking what your experience is with women who have fairly advanced endometriosis, and what would be your approach to treating them?

SD: Some of the doctors I noticed over-rate their staging of endometriosis. And if I were to review either photographs or their descriptions of an operative report, it may be only a stage one or a stage two. Stage three means scar tissue and involves cysts. If she has stage three, then I would probably do a procedure, laparoscopy, to get rid of as much endometriosis as possible. If within three months she doesn't get pregnant, I'd probably recommend IVF, whether it's a male factor or not. But I'd also still be looking at the male factor.

And I'm not anti-IVF. I'm against IVF as being used too quickly, or as a scare tactic, like one of the individuals said, "I'm 41, the doctor says I have to do IVF now." You don't need to do IVF until you've had a full evaluation. And that full evaluation can be done within two to three months, so you know what you're dealing with.

Caller 4: Can you address the issue of egg quality and high FSH, and do you think anything can be done to improve egg quality, since my doctor is saying there's nothing that can be done because my FSH is too high.

Jl: I would love to hear what Sami has to say about this question because it's one of those subjects that I've done a lot of research on in my personal journey and I've also seen many, many women with elevated FSH and low AMH give birth to healthy babies after using the Fertile Heart™ tools to increase their health and consequently improve egg quality.

SD: Age is more important than the FSH. One patient I told you about, where I did surgery to remove abnormal endometrial tissue, was only, maybe 36 years old, two years ago had failed IVF a few times, and her FSH levels had been running in the 14, 15 or 16 range. Another patient, a 39-year-old, who had FSH levels that were ranging anywhere from as low as 15 to as high as 90, because she'd had chemotherapy for Hodgkin's. She lives in Albany. Everyone wrote her off as, You'll never have your own baby. So, guess what? The husband had bacteria, I gave the couple antibiotics, and she has a 9-year-old son. What was in her favor, she was relatively young, 39. I'd rather have a 36-year-old with an FSH of 18-24 than a 42,

or a 44-year-old with an FSH of 9.

Jl: Okay now I have to stop for a moment, Sami. Because you and I also know, and I can cite lots of names of women who were in their forties and after doing what they needed to do to eliminate inner conflicts, increase their overall health and whatever else their “inner authority” guided them to do, conceived healthy babies. As you well know I’m one of those women, and some of the names I’d cite you might even recognize. This is, as you also well know, a very age-conscious field, and we have some lovely eminently fertile women in their forties on the line. I don’t want them to walk away tonight with the same message they hear everywhere they go, “It’s your age.”

SD: You know that I never give up on anybody.

Jl: Of course, I know that and it’s not a question of giving up, it’s that there are many, many women out there who have babies in their forties but most of them never see a fertility specialist. So the belief that is being perpetuated is that once you hit forty you’re going to have a problem and will definitely need medical help, is helping the infertility industry but not serving the interest of the women.

SD: A 47-year-old who was told, she’d never get pregnant, had her baby at age 48.

Jl: There you go, those are the stories we love to hear.

You know, Sami, you’re talking about the things that get to you about the IVF practices. And what gets to me, is that every IVF clinic has now a mind/body program. But ironically, with the whole mind/body connection that they claim plays such an important role, the first thing that happens when the woman steps foot in one of those clinics, is that she is handed a pamphlet with devastating statistics. Or someone tells her about her “advanced maternal age” or as one client who worried about a multiple pregnancy was told: “The days when you’d have to worry about getting pregnant with twins are over.” So before they even begin testing these women are already battling statistics. That’s the kind of mind-body treatment that does a great disservice to the patient and sets them up for failure. Yes, age is a factor, we don’t

want women to live in denial of that reality. But fear is a great marketing tool and turning the biological clock into a time bomb sets women up for failure before they even begin to start trying to conceive.

So, Sami, we want to hear some great stories of women in their forties. We have plenty of them on the website under Testimonials.

Obviously there are limits, but Sami, what is the oldest first-time pregnancy that you helped bring about?

SD: That carried to term was 47 years old, delivering at age 48. I've had patients getting pregnant at age 48 and 49 and even at 50, but they've miscarried.

Jl: I mean a full term pregnancy and before we move on, perhaps we can take a breath. Let's take a breath, stop for a few seconds and re-group. And I just want to say a couple of things. I've had the privilege of seeing a number—and I don't count them, because I'm not out to prove anything—a number of 45-year-olds become pregnant naturally. And you know, consciousness, or a certain mindset is something that we don't look at. We pay lip service to it. And it's not just the fertility world. We are, as a culture, and I hope you will comment on this, Sami, but I think as a culture we don't take into account the fact that we are creating this consciousness: Oh, are you in your forties, It's all over for you. There was an ad in the New York Times several weeks ago, "Are you over 40? We have a great donor program for you."

When I was diagnosed in 1992, basically everyone said to me, Oh no you can't get pregnant. Even among alternative practitioners, no one I saw could name a case of someone conceiving with my numbers. Well, there's something that happened since then, and hopefully *Inconceivable* contributed to some of that shift in consciousness. Now no one, at least in the alternative world, is saying that an elevated FSH means no baby. You know, we need to start looking at our bodies, our over-forty bodies, through the lens of possibility and also talk to women in their forties who became pregnant. I have to say, most of the pregnancies that I have seen, I don't know, I would love to hear what you have to say about this, but most of the pregnancies that I have seen in the women over forty-four, over forty-three, were natural pregnancies. I don't know if that's your experience.

SD: I totally agree. But, you know, with some caveat, which is, has the husband been fully evaluated, is her cervical mucus very thick or is it thin, is the pH good, is there bacteria present?

Jl: Actually, I have a question about cervical fluid since you brought it up from a caller who sent in an email: How can a woman of my age, 44, do things holistically to increase the chances of getting pregnant naturally? How do I control the pH in my vagina effectively? I've tried using baking soda and felt as though I had pain and infections, and things were thrown off. When I used Mucinex, I feel as though my lungs get clogged and I have difficulty breathing.

SD: Two answers. It depends on how many Mucinex she's taking. One Mucinex is six teaspoons of Robitussin. She should also be drinking more liquid, and you should start four or five days before ovulation to work on thinning the mucus. That's one. Two, if I give a prescription for baking soda, I'm very specific on how to use it.

Jl: Eliminating dairy products can also help thin cervical fluid. But could you share with us those instructions for using baking soda, Sami?

SD: Of course. One tablespoon of simple Arm & Hammer baking soda in hot or very warm water, just let the powder dissolve. Let it go down to room temperature. You've got to do this lying down in the tub. If you do it sitting down in the shower or over the toilet, it won't reach the cervix. And I stress very, very gently, squeeze the bulb of the douche for only about a minute. There will still be fluid in the container, but you only need to gently and slowly squeeze the bulb for one minute. That's all you need for it to change the pH for about twenty-four hours. Then you should stand up in the tub and cough and place your finger in the vagina so that no water remains in the upper vagina. Water is hypotonic; it's going to kill off the sperm. And if you have intercourse too soon, you're going to be too alkaline. You wait about an hour or two after using the douche before intercourse. And I stress you only do this once or twice a month, only when you need to. But be precise about when you're ovulating and use the douche then. I'm not a proponent of douching in general, but it's nice for changing the pH for that period of time when you need it, to be alkaline.

Sometimes I tell the person to use a douche, sometimes I just tell the person for

a few days prior to ovulation, not all the time, but a few days prior to ovulation, try changing your diet. That deals with acidity and it also deals with thick cervical mucus. But I still do use Mucinex. But Mucinex alone doesn't work without you drinking lots of fluids.

Jl: In *The Fertile Female*, specifically in The Ally in the Cupboard chapter, I talk about alkaline foods and also offer some recipes in the practice section of the book. And we have a wonderful article on the website called "Alkalize for Conception, Pregnancy and Health." I would also wholeheartedly recommend a diet overhaul not only for the five days prior to ovulation but as soon as possible and to keep experimenting with food as a medicine for the rest of your life. Food can be a great fertility drug, it can not only alkalize but increase estrogen, and progesterone, nourish your adrenals, and balance your hormone levels.

Thank you for that reminder to alkalize, Sami! Let's go to the next caller.

Caller 5: Hi. This is a caller from Montreal. My husband's sperm was tested and they did find bacteria in his sperm. We were going to do fertility treatments, and we were waiting to see what was going to be done about his sperm, and then I got pregnant, naturally. So we thought okay, well then everything's fine. But I miscarried at exactly three months. Could the miscarriage have had to do with the bacteria in his sperm?

SD: Without a doubt, yes. I'm sorry to say yes. For example, ureaplasma and mycoplasma can cause miscarriages. I've seen it cause miscarriages as late as sixteen to eighteen weeks. Fetuses have died even at six months and if they had ureaplasma or mycoplasma, you'd actually find that organism in the baby's organs. So it passes through the placenta to the baby. And unfortunately I'll say yes, it's possible. Did they test the tissue genetically?

C5: No

SD: So your doctor is not going to be interested in finding out why this thing happened to you?. You can't say that Sorry, it was just not meant to be, try again. If for exam-

ple it was a normal male or female fetus, you want to pause a bit, even before the person tries for another pregnancy or else they could miscarry again, if it's due to some immunological factors, killer cells, or clotting factors.

C5: I was checked for all of those. I was checked for all the clotting stuff and everything, but not for bacteria.

SD: The bacteria in your husband's sperm could have been the cause of it. I would certainly have wanted to know.

C5: Well, I did want to know. And he read the thing to me, and of course it didn't make sense to me, and he said, "Well, it's just what happened." He didn't seem to think it showed anything majorly abnormal.

SD: You can't make a diagnosis of a genetically normal or abnormal fetus from just tissue analysis. The tissue has to go to a genetic laboratory.

C5: Can I interject something? I just feel in listening to everything that you've been saying, that we're being asked in a way to somehow maneuver a system that seems to be designed to avoid giving us the information we need in the first place. And I find that to be just mind-boggling. I mean when you go to a specialist, and you tell them your situation, you expect that they will be open with you.

Jl: You're right. But the question is what do you think is being asked of us?

C5: I don't know.

Jl: Perhaps what's being asked of us is to learn about this and to change the system, to become our own advocates, right?

SD: You're absolutely right, Julia. You have to be informed and say, "Hey, doc, I don't want to have three eggs this month right now, I want to know why I didn't get preg-

nant. Again, Doctor, I've had twelve months of infertility where I think I'm not getting pregnant. That's twelve eggs. "Give me an answer, don't give me more eggs."

Jl: I'm going to ask another specific question, because I think that's what's going to be most helpful for us. It's wonderful to have the opportunity to address some of these questions with you, Sami.

SD: My privilege, Julia.

Jl: Here's a question: is there a systematic approach, such as a blood test, for certain protein markers, to determine ahead of time the chances of implantation for embryo transfer?

SD: You're talking about IVF.

Jl: Yes.

SD: Well, there was a doctor at Yale who was looking for certain proteins, which he thought were important. Many years ago, when I did my fellowship at Penn, one of the researchers found a certain protein and he said, Oh, this is the answer for lack of implantation. Everyone's looking for some type of magic marker, and I don't think there is one. And Julia, as you know, everyone has to be individualized. You and I both have seen women who have been told you'll never get pregnant who beat the odds and they do get pregnant.

So the answer is I don't know of any marker that everyone agrees will tell you if implantation will succeed or not.

Jl: I guess what makes sense to me with regard to implantation is to keep building up our blood for a healthier endometrial lining, and reduce inflammation especially post transfer among other things.

Here is a question that I think you do know something about, and it's a question

that came up quite a bit in the emails that I receive, so “What is your experience with women taking DHEA, and have you used it in treating patients?” And the woman continues: “I have a friend who took it and swore by it, and then when her daughter was born with a severe tongue tie, she wondered if it was caused by the DHEA.”

SD: Probably not, but again, if you’re going to be scientific about it, I do use DHEA as a dietary supplement if the blood level of DHEA is low. So I’ve been routinely testing women for DHEA levels. DHEA, is an adrenal hormone, a metabolizing adrenal hormone. So if a woman needs it, then I give it. I don’t routinely give it.

And I think that the studies that were done with using very high doses of 25 milligrams three times a day, I think that is really, really very high. And what I know of these studies is that apparently they increased the number of eggs for patients who were not producing enough eggs, but I don’t know if it translated to higher pregnancy rates. I’m not sure what their next article will show.

Jl: I’m glad to hear you say that, Sami. I think DHEA is widely misused. The authors of the study you mentioned themselves admitted that they don’t really understand fully the effect of DHEA. For anyone who would like more information on DHEA and what to watch out for if you are choosing to use it as a dietary supplement, we have a great article on [www.fertileheart.com](http://www.fertileheart.com), titled Facts and Fiction on DHEA Benefits.

Okay, we have time for one more question.

Caller 6: I’m wondering if the doctor has any advice for women who have Premature Ovarian Failure (POF) and if you think that could be bacterially related as well.

SD: No, it really is a tough one. We don’t know what it is. Some people claim anti-ovarian antibodies, might be an issue. I’ve had some success with patients with FSH as high as a hundred. And using my knowledge of internal medicine, this is how I approach it. It’s similar to the case of someone who has heart disease, and she comes in with low blood pressure, you think you have to give them fluids, but they already have too much fluid in their system. So someone with a high FSH shouldn’t be given more FSH. But my attitude is that if the woman comes in with



high FSH of eighty I do give them low dose estrogen, synthetic estrogen actually, to lower the FSH. The cause of POF we absolutely do not know.

Jl: In the last decade and a half I've had the privilege to work with a large number of women diagnosed with POF. Some of those stories are in my books but I've seen many of those women conceive and to me the answers unfolded for each person differently. The Fertile Heart™ Ovum tools are wonderful remedies to use as people begin to unravel the mysteries of that diagnosis. Since high FSH was what got me into this field originally, it's a subject I have spent a great deal of time researching.

SD: There are people who think it's genetic. Sometimes it happens in families, where sometimes if the mother has gone through menopause at age 42, the daughter also goes through menopause at age 40/42. I'm so sorry, I wish I knew.

Jl: It's interesting to hear you say that, Sami. My mother went through early menopause, my sister had a fairly early and difficult menopause and that's the direction I was heading in when I was diagnosed. But the science of epigenetics is showing us that genes will behave differently in different environments, the choices we make and environmental factors have a great deal of influence on gene expression. And we can change both our outer and our inner environment in many, many ways and influence the expression of the genetic blueprint.

I actually renamed POF many years ago. POF doesn't mean Premature Ovarian Failure. POF means "Plan on Fighting."

SD: Wonderful, Julia.

Jl: Because the POF clients who I have worked with, with every single one of them, there was some sort of trauma that was lodged in the body. With one client, she was adopted at birth, and when she started to work with the Ovum tools, within three months she found her biological mother and her biological father, and she was pregnant within five months. This is someone who had severe POF symptoms, she had night sweats.

The trouble is, if the symptoms are not expressed in the physical body, then we are told that it is unexplained. But just because the imbalance or symptom is not yet expressed physically or biochemically and because current medical research can't identify a root cause it doesn't mean that there are no answers. You just might have to look for them with different instruments. For example the very specific imagery exercises in the Fertile Heart™ Ovum Program are designed to identify the kind of symptoms that don't show up during a laparoscopy.

SD: Exactly right. I think that patients should fight for answers, and not just take things told to them by their doctors for granted.

Jl: Yes, we have to begin to be our own advocates. And that's how the system will change. So thank you again Sami, I hope you come back to visit with us again. Thank you so much for sharing your experience and valuable insights with us. Thank you everyone, I look forward to connecting with many of you on Monday night at our Fertility Support Teleconference.

# Jamie Grifo, MD, Ph.D



Julia Indichova: Dr. Jamie Griffo is easily one of the best known reproductive endocrinologists in the world.

Your name pops up in just about every New York Times piece, and everywhere else, Jamie. And you have a reputation for being a very compassionate doctor. Thank you for accepting my invitation.

Dr. Jamie Griffo: Compassion is a big part of what we do. Most of what I do is really just helping get people through the treatment. The technical part of it, the scientific part of it, becomes formulaic, but the rest of the treatment does not. That's the hard part, I think. That's a very important part of what we do as practitioners.

J: That's an especially encouraging thing to hear from a reproductive healthcare practitioner. Because the aspect of the fertility journey that's not formulaic, the part that has to do with each person finding their own unique path to the baby is the essence of the Fertile Heart™ Ovum practice. So that's a great way to start this conversation.

Why don't we dive in, if you don't mind, with an overview of what you are looking at when a couple comes to you and before you would recommend IVF?

JG: Well, I think that most patients don't even require IVF. IVF is our last resort, not our first resort.

Although it is the most effective and efficient treatment that we have, we will often try simpler things first.

Before you talk about treatment, you have to talk about diagnosis. You know, 40% of infertility is male-factor related, so you need to evaluate the male, and you need to evaluate the correctable cause of infertility in the female, such as ovulatory dysfunction, tubal disease, endometriosis, uterine anomalies, fibroids, ovarian cysts, hormonal or endocrine abnormalities, like prolactinoma, and adrenal disease, thyroid disease. You know, these things are all correctable, and often, just correcting the problem results in achieving a pregnancy.

But what is remarkable is that about 40% of the patients or couples that we see

really have no explainable cause for infertility. We physicians, and patients, we like to have labels for things, so we use the term “idiopathic infertility,” which sounds very mysterious, and makes it sound like we know something that you don’t. Well, I’ll let you in on a little secret about idiopathic infertility—it means that I’m an idiot, and I can’t figure out your pathology. But if you like the “Wizard of Oz” analogy, then that’s a good label. I like to tell patients, “we don’t always know why you’re not getting pregnant, but we don’t need to know, as long as we rule out the correctable causes.”

What we want to do then is improve their chances, because, as you know, fertility is a very inefficient process. We all have friends who say, “Oh, we tried one month—we’re pregnant!” You know, we hear that all the time. But they are about five percent of the population, and they have really big mouths. It’s really hard to get pregnant. We spend our lives avoiding trying to get pregnant, often to realize that it’s not so easy, even at the young age when fertility is optimal for women. There is this decline with age in fertility for women, and a little bit with men, but it’s not as distinct at all in men.

Men retain a good level of fertility well into their late years, whereas women clearly have a defined time span. The problem with the time span is it’s not really predictable for the individual; it’s just that we use population statistics to guide us. You know, peak fertility is in the mid-twenties. Socially, most of us aren’t really ready to be thinking about being parents at that age.

Jl: I certainly wasn’t.

JG: I think that one of the reasons that I’m so busy is that most fertility we see is so “unexplained,” but really it is explained. It’s explained by normal, natural aging and the related decline in fertility that accompanies aging. Our goals for treatment are to just increase the chances. That’s how the treatments work. The initial treatments after a workup is done, usually involve fertility medicines which make a better environment. The initial drug we often use, a Clomid type of medication, oral medication, often only induces ovulation of one follicle. Many of the couples that we meet are already doing that on their own, and yet Clomid given to infertile women, doubles the pregnancy rate. It must do more than just make more eggs; it must make a better environment in some way. That’s a first line, simple treatment.

You couple that with monitoring and appropriately timed intercourse, and/or insemination, although we like to do both of those things, just to have the best chance of getting those cycles working. That doubles the pregnancy rate.

One level above that are the stronger fertility medicines, the injectables. Those drugs actually increase pregnancy rates over Clomid a little bit, but not dramatically. So, if you have a couple, and the woman's thirty-five, you're looking at a baseline natural pregnancy rate of probably less than 5%, in a group of patients who have tried to get pregnant for a year, and aren't. I think that's a number that surprises very many people.

You'd think it'd be much higher, but it's not. You start with Clomid with that group of patients, now you've increased their odds from 5% to 10%, which on a cycle, is not any miraculous treatment, but in reality, if you try that a few times, you've really substantially increased the chances for that couple to be successful.

Now if you do the injectables, that chance may be in the range of 12%.

And then, IVF, the final treatment. You know, the way I describe IVF is that it's really like a year's worth of trying compressed into one month. With IVF, you generally get around ten or twelve eggs on average. You try to fertilize those eggs, and 70% or 80% fertilize, so now ten eggs become seven embryos.

And then, you watch those embryos grow and develop in the lab, and pretty soon, those seven embryos become one or two good ones that you transfer, and maybe sometimes, in a third of the cycles, you have extra embryos to freeze. Most of the time you don't; you just get one or two good embryos.

But that then takes that patient's 5% chance, and for a patient thirty-five and under, and we're looking at a 15% delivery rate, so you've dramatically improved the odds for that individual couple. IVF is the most effective treatment, but as I said, it's something we usually resort to after trying simpler stuff first.

**JJ: Do patients come to you and insist on going directly to IVF because they're in a hurry?**

**JG: That's a really good question. You know, my job, as a practitioner, is not to say,**

“Look, I’m smarter than you, I know better; here’s what you should do.” My job, really, is to educate them, to give them information so that they can make good decisions. I do it in a collaborative way. “Here are the choices. What do you think? What sounds right to you? What feels good? What makes sense?” There are some patients with whom we skip right to IVF because that’s their desire. However, most patients, I think, when they’re given the best information, usually make the most logical decisions.

That’s usually what I end up recommending. At the end of the day, no matter what, I always give the patients a choice. I always also say, “Here’s what I think. You know, I’ve done this for twenty-two years, I know a little bit about this.” I’ve also been the patient, too. I’ve experienced my own treatment.

Jl: You have?

JG: It’s a pretty fat chart. I don’t want to go too much into it, but you know, I’ve had the experience of failing five IVF attempts. And then contemplating egg donation.

Unfortunately, at that point, my wife had a hysterectomy, so we never even got there. I have a baby from an egg donor and a gestational carrier with my current wife because we couldn’t have a baby any other way.

So, I think one aspect of my compassion is from also my experience. My education was seven years of going through that whole process. Knowing what it’s like to be a patient, not just being a practitioner and seeing patients, you know, actually experiencing a taste of my own medicine, so to speak, has really broadened my ability to be effective as a doctor. In many ways, it’s made me a better person. It’s made me a better father, a better husband, and a better person, simply by experiencing all of that. I must say that it probably was one of the hardest experiences I went through in life. You know, things happen for a reason.

Jl: I appreciate you sharing this with us. As you may know, that’s how my work really evolved, out of my personal experience. I was diagnosed with secondary infertility at the age of 42 and an FSH of 42. And I did end up naturally conceiving a second child but in addition to having a second child, those experiences really changed my life.

It is one of the central ideas of the Fertile Heart™ practice, that this difficult, emotionally-charged and painful challenge can be an immense opportunity. It can humanize us and open our eyes; help us look at our lives, the world, and each other, differently.

JG: It also teaches us how to think better. We have so many patterned ways of thinking. For example, I'm in New York City, and I think our pattern is the "control freak" pattern. We think we're in control of everything, and while there are some good things about that, there are a lot of bad things about it. If you think you're in control of everything, and all of a sudden, you're not getting pregnant, you'll almost take responsibility for it. You'll blame yourself, and then you feel guilty and bad, and as if you must be doing something wrong. When the reality is you're doing nothing wrong, and it has nothing to do with you. You're just unfortunate, and are experiencing an awful problem with fertility, and you need to somehow manage it.

I think that that attitude of blaming yourself, is an unhealthy way of thinking, because thinking that you're in control makes it even more difficult. It makes the anxiety greater, it makes the process more painful, and if unsuccessful, I think it makes a resolution even more difficult.

Jl: We actually have a motto at the workshop. "Never, ever, ever, ever, EVER blame yourself." The flip side of it is that yes, we humans do not have control over all of life's circumstances, yet at the same time, there is a great deal that we can do to strengthen ourselves. On every level. That doesn't mean that we blame ourselves, or that we think we are omnipotent. I'm sure that you encourage people to do whatever they can do on their own behalf.

JG: Well, there are stages of thinking that you must go through, as a patient. I think it's interesting. There's a book I read as a medical student that had a profound impact on me. It's called *On Death and Dying*, by Elisabeth Kubler Ross. What does that have to do with infertility?

Well, it has a lot to do with it, because when you're infertile, and things don't work out, a piece of you dies, and you have to mourn that loss just like you have to accept your own death. If you study that book and see the stages that a dying person



goes through, you see that you go through the denial phase, and the anger phase, and the bargaining phase, and then finally, at some point, as you manage to work through those things, you reach the acceptance phase. That's where you gain inner peace and accept what's happening.

Jl: I'm just going to lift the energy here a little bit and maybe turn that idea around. I agree that this challenge is certainly about loss.

About losing the child that we feel should be in our arms right now, about surrendering to the idea that this child will not show up on our time table. But the Fertile Heart™ Ovum program is really a birthing practice. We turn the pain of that loss into labor pain.

To me this challenge is not only about birthing a child but about birthing the not yet born aspects of ourselves. It certainly sounds like that's what you did. I'm sure we have both seen thousands of women turn the pain of the fertility challenge into labor pain, and give birth to children, in one of the many, many different ways one can create a family. You experienced one. As I see it we absolutely can turn this into a redeeming experience for us.

All right, why don't we take some questions from the wonderful women who have called in?

C1: Hi, it's C. here. I'm just wondering, how did your wife feel when she went through the egg donor process? I have to consider this in the future, possibly, too, and I'm struggling a little bit with the loss of genetic connection. I've been told that lots of people do this, and afterward, they're fine, but I'm just wondering how she did, in terms of her feelings, getting used to the idea of egg donation.

JG: You know, this is just my personal experience, but most people say that they will never use an egg donor. But then, when push comes to shove, it becomes the last resort, where you're choosing between no child, or adoption, or egg donation, somehow you get enough comfort to go there. When you talk to patients who've had an egg donation about the hesitations they had initially felt, and you're talking to them while they have their two-year-old sitting there, and you remember the consults you had in the past, and the objections they had expressed about why they

could never do it, you look at them and ask, “How did you get here from there?” I keep expecting them to remember the struggle, but often they have gotten over it, forgotten about it, put it behind them. When you really press them, many of my patients say, “I really didn’t know what I was saying ‘no’ to. What I thought this was going to be is so different than what it is.” You know, “this is my baby. I know it’s not my egg, but it’s my baby, and I don’t really think about eggs that much.

I know I myself didn’t ever fully recover from that disappointment. And I’m struggling to understand the proper format for sharing this information with friends and family, and the child.

How do you do that?” You don’t want to make it bigger than it is, because it really isn’t that big, at the end of the day. If you take it from the innocent way that a child looks at it, they don’t even know. They could care less.

They want one thing. They want their mom, they want their dad, they want their parents, they want to be loved, and they want to be accepted. They want to feel good about where they come from. I think the problem is that keeping a secret adds a level of shame to it, but making it a big deal adds a level of complexity that makes it bigger than it is, and somewhere in-between is the balance.

Everybody has to work out their own way to get comfortable with it, because if you’re not comfortable with it, then your child’s not going to be comfortable with it. And that’s going to have consequences. We all have issues.

We all have things that we grow up with, that aren’t ideal, but we manage to somehow resolve those things. The more you can get comfortable with it and transmit that comfort to your child, the less they’re going to have to handle that burden.

C1: I hope that wasn’t too personal. Sorry.

JG: Not at all.

Jl: There is so much shame connected with this particular health challenge. If it were kidney disease that we were talking about, it would be a different story.

Jamie, what do you think the shame is all about?

JG: I'm not sure, because I really don't think there is anything to be ashamed of. I think we all experience that with infertility patients. It's not the picture of our lives that we thought we would have. It's not the complication that you expected. When it hits you, in some ways, I think you feel responsible, you feel that if you had done things differently you would've had a different outcome. Sometimes, you might be right, but who knows? Maybe not at all. And at the end of the day, even if it were true, what difference does it make? You're here now, in the situation. What happened in the past is not relevant, really, now. It's "Where are you going?" and "What are your options to solve this problem?"

Jl: I wonder sometimes if there is an implication of some sort in people's minds that a fertility challenge is linked to sexual inadequacy. I remember at a presentation years ago, which was being filmed, a member of the audience actually became violent. He said, "If there is any part of me at all in your film, I'll break your camera." Do you think that people somehow associate fertility issues with impaired sexuality?

JG: I think that's part of it. And it's also just not feeling complete, feeling like a failure, those are all aspects of it. I think it's just the sheer, great disappointment of it, of having to experience the whole process. All of those things contribute to the shame that one might experience, but I think it takes a different way of looking at it to get through the shame, beyond the shame. I think it really points to something I said earlier, about the question of where your control begins and ends. You don't really have that much control over this, and if you accept that, then you accept your situation, and then you feel more comfortable with who you are and where you're at, and you focus more on where you're going and spend less time feeling inadequate, or angry.

Jl: And you hopefully focus on what you can do to help yourself and what you can do to turn this "curse" into a blessing in your life.

JG: I say this to a lot of patients. “I can see it in your face, and I know you feel bad. It’s normal and natural and in some ways a sign of mental health but the point is you’re not going to feel like this for the rest of your life. Your way out of this is just to go through it. You have to just face it and then make the leap to focusing on what your choices are, and then make your choices.” Then, all of a sudden, you’re starting to think about the positive things, about resolutions, and you start to not feel so bad or so ashamed, you don’t feel so inadequate.

Jl: Once you start taking action on your own behalf I think you begin to feel more energized. And I think you begin to discover opportunities that you were not able to see before.

I’m going to turn to a couple of questions that came in via email.

Could you describe the most accurate, as you see them, tests for assessing ovarian reserve. Is AMH a reliable marker of ovarian reserve?

JG: Yes, it definitely is, and it’s a good one. I wouldn’t say it’s more accurate than FSH. It doesn’t like FSH predict who is going to get pregnant. It just gives us more data. It’s useful for determining parameters for stimulation. With a woman who has a low AMH you could use more drugs, a person with a high AMH can be hyper-stimulated. With AMH it’s reassuring to have a number over one. We don’t use AMH levels as a cut off for IVF, we use it as a guide for guiding patients. For someone who has an FSH of 15 several times and has an AMH of less than 0.16, we would have a hard time getting that patient pregnant.\*\*\*

Jl: What are your thoughts and your cut off for FSH?

JG: Our cut off is 13.5 for FSH. But there are a number of patients who were told by other doctors, “Look, your FSH is ‘twenty,’ and you’re never going to have a baby. You need an egg donor or adoption. See ya!” Many of those patients do need an egg donor, but they also need to try first if they get cycles where they can try. It depends on the age. The younger the patients with a high FSH, the more likely it is that some of those patients are able to have a baby. The older you are with an FSH, the less likely. That’s the kind of thing you share with a patient, and then you

make decisions. You try things, you do Clomid, and you do injectables. Do you even try an IVF cycle, knowing your chances aren't as good? Or do you not? Do you skip that? There are a whole lot of factors that filter into that decision. And one big aspect of it is the finances, because you don't want to spend all your money on something that isn't going to work when there are other options that are much more likely to work.

Jl: I do have to interject that I myself was 43 with high FSH levels when I conceived and I've seen quite a number of women in their forties with elevated FSH levels give birth to healthy babies. I do agree with you that in those cases, fertility drugs are not the way to go.

Anything else we should know about your approach to testing?

JG: We generally check FSH on day two, or day three – they're really equivalent, but we generally prefer to do them on day two, because they're a little more accurate – we like to check FSH, and Estradiol. and we find that getting several values gives us a better sense of ovarian reserve. Also, chronological age is another component to that. Not knowing an FSH on a patient, I can tell the patient that, at age 30, in our program, we have a delivery rate of about 60%. At age 40, that number is 27%. That's what happens with age. That, in a sense, is the description of ovarian reserve in the sense of looking at a population, now. I have 30-year-olds who are infertile because they have no ovarian reserve, and I have 44-year-olds who get pregnant with one cycle of IVF. So, when you're looking at population data, you're looking at a population. When you look at a patient, an individual patient, I think statistics are not that useful, other than helping them get a sense of expectations.

But at the end of the day, I tell a couple, "Look, your chances are 30% or 20% or whatever, whether it's 100% or 0%. And what you really need is one good, quality embryo to land in the right place in the uterus, and you'll have a baby. It's more about odds, though there is some dumb luck and statistics involved.

Ovarian reserve means that the higher the FSH values you have, the less likely you are to be successful with your own eggs. Those are just the facts. It doesn't mean you shouldn't try, necessarily, but it depends totally on the patient, it depends on the environment, it depends on the circumstance. And that's some-

thing – you don't make a general, blanket statement about. You talk to a couple, and you make a decision. You talk to an individual, and help to make a decision. You know, "Here are the choices, here are the options, here are what the expected results are with the different options. What do you want to do?"

Jl: I don't know how much you know about my story, but I was 42, and actually, my FSH was also 42. I have written a number of articles on elevated FSH and pregnancy and have worked with that diagnosis a great deal.

But I do appreciate what you are saying. To a degree, even though I didn't feel that way at the time, it turned out to be a gift that the physicians that I saw were honest, and they basically said, "We can't help you."

The way they said it and the certainty of their prognosis, "You'll never have a biological child," was not very useful, but that's a whole other subject...

JG: Generally, we aren't very good at that. We like giving good news, and patients like getting good news.

So I think that's always a problem. But I don't think that there is a gentle way to drop a bomb on someone's life. You can be as sensitive and compassionate as you can be, but once that hits, the experience is awful.

Jl: And at the same time, I think it's more honest. And without these doctors telling me what their truth was, I wouldn't have embarked upon this journey that I'm still on after all these years, which really turned into a birthing journey like no other. So, even though I didn't like it at the time, looking back, I'm grateful to the doctors who, as you say, really just told the truth. Their truth.

JG: I think that generally, most of us are honest and really try to share that in a way that is as compassionate as can be.

Jl: Jamie, I hear stories of messages being left on people's voice mails, saying, you know, "By the way..." So it's good that you're delivering it in a compassionate way, but unfortunately that's not always the case.

JG: I've had patients who think that I'm better than them, and I'm a great guy, and patients who think I'm a bum, and part of it depends on what ends up happening in the end. Probably the most angry patient I've ever had, you know was a woman who I treated years ago. The most remarkable thing for me was getting a letter from her, and I swear, I didn't sleep for a week after I got this letter. It was a 41-year-old woman who came to see me, and she had two high FSH values. And I honestly spent a lot of time trying to explain to her what this meant and what choices she had, and I gave her the option of trying ovulation induction and/or IVF, although I didn't want to be too optimistic, because I didn't want to be misleading and give false hopes.

You know, it's a really fine balance. The bottom line is we did a cycle of injectable medicines, and she barely responded, she didn't get pregnant, and then decided she wanted to try an IVF cycle, and I said, "As long as your FSH is good, we can try it." And she came in, and her FSH was 24, and I said, "We're not starting the cycle," and she was pretty angry about it, but I said, "Look, just wait. This isn't the right cycle. I don't want you to waste your time, energy, or money. Let's bring in another cycle." And we tested her on the next cycle, and her FSH was 12.

We gave her a lot of drugs, she made two follicles, and before the retrieval, I tried to tell her that her chance with insemination was probably as good as IVF with this kind of stimulation, and maybe she should consider not having the anesthesia, and not spending the extra money for not much of an advantage. But she wanted to go through with it, and we did, and she had two eggs, and two embryos, and lo and behold, she had twins!

Jl: Wow, what a great story that is!

JG: I remember doing her pregnancy scan and saying to her how wonderful this was, and that I was so happy, and that these are lucky babies to have parents who are so willing to try hard, and not give up, and, you know, congratulations to you and your lucky children, and that was the last I spoke to her.

And I got a Christmas card a year later, and I got a funny letter from her when her babies were 18 months old, and she'd reported me to the New York State office of

professional medical conduct, and said that I had no understanding of what it's like to have a high FSH, and that I shouldn't be allowed to speak to patients the way that I speak to them about FSH, and that I made her feel as if she had no chance, and that something ought to be done about that. I was in total shock, because, first of all, I let her try. You saw the outcome, I obviously let her try, but I was being totally honest about the statistics because we have the data, and you sit there and take the data and try to make it compassionate, but data is cold and clinical. There's no way around it. I was totally shocked, and I had to call her. I called her, and said, "I'm really distressed by this letter. I don't understand." And after I spoke to her for a while, she began to realize, "Oh my god, maybe I'm being a little bit harsh here." And not only had she not realized she had been harsh, she didn't realize that reporting me to the state, having investigators then come after me, well...

Well, it's a huge problem for you to be in that situation. At the end of the day, we had a few conversations, and eventually, she wrote a letter and said, "Scratch that complaint. I'll take it back." I tell you this story because it illustrates the point that no matter how hard you try, no matter what you say, you still don't know how your message is going to be heard.

Jl: People are going to create you in their own image.

JG: Well, they have to, and you know, I get that. I understand that sometimes my job is to be the person that the patient yells and screams at...

Jl: The punching bag.

JG: They're angry, and I get that. It doesn't feel good, but it helps them.

Jl: Well, the patients who come to my workshop, they sing the rage chant, Jamie, so they do it that way. You have to send them to Woodstock, because we do a lot of punching and releasing the rage in a more compassionate way toward ourselves and our doctors. And yes, sometimes we need to yell at our doctors, but we do it in the privacy of our own hearts. We do it so that the rage doesn't deplete us of energy. We get to channel the anger into constructive behavior.



You know, I still have a lot of questions here, and we'd better get some of these questions answered.

This beautiful young woman is asking: What is the best timing, for inseminating using frozen donor sperm (which lives, at most, 24 hours), using IUIs at the doctor's office or ICI (intra-cervical inseminations) at home?

JG: The way I like to handle that situation, since there's a lot involved in making a cycle like that happen, I tell patients, and not all of them want to do this, but the fact is, Clomid is relatively cheap. It works very well, and it doubles the natural pregnancy rate. So, I often will do a monitored Clomid cycle and give an HCG shot so you can take some of the mystery or all of the mystery out of the timing, because if you get the HCG shot at 8 o'clock this morning, then somewhere tomorrow afternoon you're ovulating, so we do your insemination somewhere around noon, tomorrow afternoon. And the sperm is there, waiting for that egg, and the donor sperm, in insemination, probably lasts a lot longer than 24 hours. It probably lasts even up to a couple of days, although it's better if it's placed around the time of ovulation. So, during that 12 to 24 hour window, you're still giving yourself a pretty good shot.

Jl: The person who is asking this question is also wrestling with an elevated FSH. I think it's in the twenties.

So, I don't know. Would you still suggest Clomid, or would that not be an option?

JG: I would still use Clomid in that situation. I actually think Clomid works pretty well, for the patient's ovarian reserve. I think that actually in some ways it may work a little better.

Sometimes we combine Clomid with Gonadotropin. Sometimes we just use Gonadotropin or injectables. What's important is that you monitor the response. And also, don't expose the patient to those medicines if they have an FSH of 20. It just doesn't work. I mean, I've been doing this for 22 years. Two patients had a baby on the cycle when they had a high FSH, in 22 years. It's rare.

The denominator is huge. I don't know what the number is, but it's huge. And the data really says that on a high-FSH cycle, you should probably just sit that one

out, if you're doing insemination with donor sperm. If you're with a partner, having intercourse, well, there's no harm in trying. Go for it. But spending time, energy, and money on Clomid or injectables may not be efficient or effective or necessarily a good thing, although the patient has to decide what they want to do. It's about hearing the data, and then making good decisions. Sometimes, the treatment that doesn't work is successful in other ways, i.e., it helps you get through those rough stages so you can move on to what's next, or stop, or adopt.

JJ: It also provides information that might be useful in general.

JG: Exactly. I have a term that I use, and I hope no one's offended by it, because it's not meant to be offensive, but rather is meant to reflect another way of thinking.

I have a thing that I call cycle therapy. Sometimes, doing a cycle has a therapeutic benefit. Because, you as a patient can feel out of control, when all of a sudden, you are doing something that you have a little control over, it helps you feel better. Helping you feel better helps you heal. Helping you heal helps you get beyond the angst and the anger and the grief.

JJ: That's also certainly what the Fertile Heart™ practice aims to do. We ask ourselves what we can do, on a physical level, to strengthen ourselves, and what we can do on an emotional level. How do we take control of the things that we do have control over. That's what I hear you saying.

JG: Yes, this is the message. I learned that in probably my first few weeks of practice. And I learn it every day, again and again and again, because it really is what's important. What's important is to learn to accept what you can have an impact on, and try not to spend time on trying to impact things that you have no ability to change. It makes you very frustrated, and more importantly, you never heal if you get stuck in that loop.

JJ: I would like to go back to another caller.

C1: My question is about IVF for the future, when you have an autoimmune disease. In this case, I have an autoimmune thyroid disease...Graves Disease. Some doctor told me that they might not want to do it because of my Graves, so what is your opinion about that? And also what is your opinion on doing IVF while a person is on anti-thyroid medication?

JG: Well, which anti-thyroid drug are you on?

C1: At the moment I'm on Tapazole, because my body was not very happy with PTU.

JG: Well, here's the problem. With Tapazole, in pregnancy, it's not going to be the ideal medication. So, PTU would be the better medication if you're going to try and get pregnant. But first, you have to get your Graves Disease under control, and that takes some time, unfortunately. Often, you're in a hurry at the time, but I think that while you're on Tapazole, probably IVF isn't the best treatment option. But if you can get to a level with your endocrinologist where your thyroid is controlled, with medications that are safe in pregnancy, then IVF is a very good option.

We have lots of patients who have a history of Graves Disease that's been successfully treated, and you know, they go on to have successful pregnancies. You know, while the thyroid is out of control, it's not going to be a hospitable environment for having a good outcome.

The miscarriage rates are higher if it's out of control and then, for a patient with hypothyroidism, it's very important that their thyroid medication be carefully titrated, actually over-medicated rather than under-medicated, because there's actually effects on the fetus in hypothyroid patients who are under-medicated, that have subtle effects on the babies when they're born in terms of their development. So, it requires that you have a team of people working with you. You want a really good medical endocrinologist to manage your medical condition and then a good fertility specialist to manage that aspect of the treatment.

C1: Yes, now I think I'll try to see what I can do on low doses, if I can stand PTU. I think that is what they will try next. Now, I take very low doses of Tapazole, and I'll try to switch to PTU again and see whether it can help and take it from there, and

see what I need. I also wondered what is the link between Graves and FSH level?

JG: Well, there is a link, but we don't understand it very well. I've had a lot of patients with thyroid disease who also have fluctuations in FSH, and for 25 years, I've been saying, "I wish I could understand this." We've tried in the research lab to understand the physiology of that is, and we haven't gotten there. But it's clear there's a contribution. I've seen patients with out of control thyroid disease have fluctuations in their FSH get better after their thyroid is under control. I wish we could understand the whole disease process better, but we don't.

C1: Thank you so much. That's really very helpful, thank you.

Jl: Good. Is there another caller out there?

C2: It's Heather

Jl: So nice to hear you. Glad you're on the call. Go ahead, Heather.

C2: I don't know what my specific question is, but I'm listening along. Julia knows my story. I'm pregnant now, for the fifth time. I've had four miscarriages prior to this pregnancy, and am potentially looking at a fifth miscarriage. I'm only five weeks and a few days. I have become pregnant every single time naturally, although I have done some Clomid cycles and things like that. And I'm just curious if you have any thoughts on immune work. You know, there are some doctors out here in California who can't decipher whether it's a "quality of the egg" problem or something else. I first got pregnant when I was 36. Now I'm 39. And my FSH, it bounces from being relatively low, like 7, up to 12. Do you have any thoughts as to immune issues being the cause of repeat miscarriages? I haven't considered IVF, because I have gotten pregnant on my own. But I'm curious.

JG: That's a very common thing that we face. I probably see a couple of patients a week with recurrent miscarriages as their diagnosis. It's very critical that the correctable causes of miscarriage be ruled out. And that workup is not that complicat-

ed. It's a lot of blood work. We want to make sure there's no uterine anomaly. It's a chromosomal analysis of both partners to make sure there's no evidence of what's called a translocation, where a piece of one chromosome is stuck to another, and that can make an unbalanced egg or sperm, which makes an unbalanced embryo and a miscarriage.

That's a small percentage of recurrent pregnancy loss but it's a part of it. Then, thyroid disease, and diabetes, not always full-blown diabetes, but even really subtle diabetes can have an impact as well as thyroid disease, hypothyroidism, generally. Rule out infections. Chlamydia, Mycoplasma, you know, a little controversial, but easy to treat, so worth checking. And ovarian reserve, the FSH values, which in your case, it sounds like that's not been that abnormal. So then, you're left with unexplained recurrent miscarriage, the idiopathic recurrent miscarriage. That's about half the patients. Most don't have an identifiable cause for their recurrent miscarriages. However, if you look at that group of patients alone, one of the things that we've done with IVF is we've done genetic testing of the embryo, what's called aneuploidy assessment, or pre-implantation genetic screening, to see if they had chromosomal abnormalities. What we find is a high percentage of the embryos, with those patients, are chromosomally abnormal. Now, you've had a number of miscarriages. Have you had any genetic testing of the miscarriage material, to see about the chromosomes?

C2: All the tests that you've mentioned, I have had. And they come back negative. I've had everything done, and it's all been negative. The only miscarriage that they were ever able to get tissue from, it was chromosomally abnormal—it was a trisomy-16 issue. But the others, unfortunately, they haven't been able to get tissue. One was a blighted ovum. My first miscarriage, they didn't do anything on it. One miscarried very early. I had two where they were heart constricted. Those were towards the end, and I miscarried those naturally, in those cases, because we thought too many D and C's would be a challenge.

JG: I don't think the D and C issue is as big a problem as it's made out to be. You know, about 1% percent of patients who have a D and C after a miscarriage get scarring, and that can cause other problems.

But I'm pretty aggressive at trying to get the chromosomes, because it becomes

really useful. Because if someone keeps having chromosomally normal pregnancies being lost and the rest of the workup is negative, I think, that if there's a group, that immunology is going to be the smoking gun. That's the group. And the data that you've given me so far, in your case, doesn't make me think that in your case it still could be. But, what I usually offer patients in your situation—certainly, you know, there are doctors in New York who do that. There's one in particular, Jonathan Scher.

Jl: He was our guest some months ago.

JG: Yes, and he's spent his whole life, really, looking at the immunology aspects of miscarriage. And as controversial as this is, and I know there's not a lot of good data out there, and though randomized control trials have never shown those kind of treatments to be successful, I am sure there are a group of patients who benefit from either the Lovenox, the baby aspirin, and/or the intravenous immunoglobulin that he sometimes uses. I think there is a group of patients out there that we're not able to clearly diagnose. I'm not even sure that the immunologic tests that we do are that predictive in finding out who those patients are. But really, the recurrent miscarriage patients who have chromosomally normal miscarriages is a group to whom I recommend considering that empiric treatment, despite the fact that the medical literature doesn't, and the New England Journal doesn't, and the Lancet doesn't. Because I've seen lots of patients in that situation be successful with immunologic treatment.

C2: I have done the intralipid and I have done Lovenox, at least in the last two pregnancies. So this is the one pregnancy where I didn't.

JG: At least in your case, I would try and get chromosomes. If patients have had two chromosomally abnormal miscarriages, that's the group of patients that benefits from IVF and pre-implantation genetic screening. What we find, generally, in that group of patients, is a couple of things. One, we keep finding patients who keep making all abnormal embryos. And, you know, those are patients who are set up for more miscarriages. And those patients do very well with egg donors. They have extremely high delivery rates, when all they've had is miscarriages in the past. But

that's not the majority of patients. What we find in the majority of the patients is that the majority of the embryos are chromosomally abnormal, but if we select the ones that are chromosomally normal, and you get pregnant, you're much less likely to have another awful experience with miscarriage. So, I think that's something that should be considered in your case, based on the data that you've given me. Adjuncted to that, you could also consider immunologic treatments, although if you asked ten different people like me, you'd get a lot of opinions. Whenever you are getting doctors who are saying exact opposites, it means one thing: It means no one really knows the answer. Many of us are not always right, but never in doubt. We don't like to share...you say, "What is your deduction," and he says, "I don't know." There are a lot of things we just don't know, and I'm not ashamed to say that as a doctor. In some ways, I think it's frustrating for the patient, but I think it's honest, and I've always found that the more honest you are, the easier life is. The less honest you are, the more complicated life is. So, I've been very frank with my patients. I'll say, "Here's what we know. Here's what we don't know. And I don't know. I don't know the answer to this. And so, not knowing the answer, we have to make some decisions. What are we going to do? How do we make decisions that feel right? And I think that's a good approach; it's the best we can do with the knowledge we have now, and hopefully, we'll be getting more knowledge as we keep fighting to try and understand these processes.

Jl: Thank you so much, Heather. I hope that is helpful. Thank you Jamie. (Note: Heather did miscarry the 5th time and after that miscarriage she and I began working together. Her daughter was conceived the old fashioned way and she shared her story in the free e-book available through our site titled: *Heather's Gift*.)

A couple of quick questions so we can be fair to the other people who are out there. This caller is asking, "Do you have any suggestions on how we can weigh the desire to have a baby and also to avoid having twins?" At what point would you suggest transferring just one fresh embryo? Do you ever do that?

JG: That's a great question. We do that a lot, actually. We've spent the last ten years really trying to perfect the blastocyst technique. Because pregnancy is best when there's a singleton. When there are twins, there's more risk. The good news is, most twins do very well. So, we don't feel too bad about having somebody getting pregnant with twins, but it's not our goal by any stretch of the imagination. In our

clinic now, about 70% of our babies are singletons. 29% are twins, and 1% are triplets. And the reason for that is in the setting of very high pregnancy rates. You set very high pregnancy rates by putting back lots of embryos. The more embryos you put back, the higher your pregnancy rate. We're getting people pregnant with triplets and beyond, and it's crazy. It puts them at incredible risk. If you just look at singletons, one to two per thousand singletons born to a normal person gets cerebral palsy.

Now you would think that with twins, that number's going to be 2-4. Well, guess what? It's 14. With triplets, that number is 39, not 6. So, each fetus that's added to the mix adds a level of risk that is fortunately low, but gets exponentially increased.

So, you don't want to put patients in that position, and you don't want to put babies in that position. You want to try and get a good outcome as best you can. And you also want to err on the side of pregnancy. The dilemma has always been "How many is too many?" and "How many is too few?" And it's a constant, daily dialogue that we have with patients. You know, I spend a lot of my days talking patients down from the number of embryos to transfer. We spent ten years researching blastocysts, because we found that the longer you grow an embryo in culture, as long as your conditions are optimal and ideal, you can identify an embryo that's more likely to make a baby. It's routine in our practice now, for most patients, to go to day five, even in the older patients, and then put back fewer embryos.

So for the group under age 35, we are doing a significant number of single-embryo transfers, because when we get to day five and we see a certain quality of embryo, and on top of that they have a certain number of that quality embryos. We can look at our data set and say to a patient, "Look, we've been here before. When we put two of these back, we get a 60% twin rate. We don't think that's good. However, if we put one embryo back, we have a 70% baby rate, which is better than the 50% I quoted you before we even got anywhere near here.

I think it's probably wise to consider doing a single-embryo transfer. I know you'll regret it if you don't get pregnant. But having twins isn't our goal here. We'll freeze the other good embryos, and they still have a good chance of making you pregnant. And this way, we don't expose you and your baby to risk. And some of the patients say, "Fine, put one." And some say, "No, I want two! I want twins!" And we don't argue with them. They're their embryos, so they have to...



Jl: Make their own decision...

JG: Yes, but in reality, we've done a lot to avoid twins and beyond.

Jl: It's good to know. Here's another IVF related question: Any concrete suggestions or tips on preparing for the egg-extraction procedure?

JG: You know what, you have prepared for it. You've gone through the whole process. You've made decisions and you've gotten yourself into a point where you're going through this complicated, expensive, pretty emotionally challenging process... there's nothing you can do. You know, live healthy, eat healthy. Exercise has to be minimized, because your ovaries are big and swollen, and they can hurt. Lying in bed isn't good. You've got to do something, so you do something light, maybe you walk and you swim and you ride a bike lightly, or something. You eat a healthy diet.

That night, before your egg retrieval, you don't eat or drink, because you're going to have anesthesia the next day. You want to get hydrated the day before. There's nothing more you can do. You've done everything, just to get there. Just getting up every day, going to your doctor's office. Feeling tired, because all of your energy's expended on making eggs. You can't do more than you've done.

Jl: My clients who go through IVF find certain visualization sequences from the Fertile Heart™ Imagery CD and Body Truth meditations particularly helpful in soothing them throughout the IVF process.

Next question: this is a short one, and then we'll round it up. This person is saying that she feels she has lining issues, but they were not addressed by her endocrinologist. And so she's asking if you have anything in particular to suggest for someone with lining issues.

JG: That's a vague diagnosis, but I can talk a little bit about it. If you have a really thin lining, consistently thin? Well, that group of patients doesn't have as high a pregnancy rate, although I have a patient who was told she needed a gestational carrier based on just being stimulated a few times and having a very thin lining,

and I said to her, “Look—that may be true, but we don’t know if IVF is going to work on you unless we try.” And we tried to do some things to make her lining thicker, and it never got over 4 mm, but she had a baby, and now she’s having another baby, because we tried. Even with the thin lining. Now, that can be a problem for some, and it’s not easily fixed. When that’s the case, that gestational carrier does become the best option, but evaluating the cavity of the uterus, there are ways – such as sonohysterography, endometrial biopsy, that can be done to assess the lining. In patients where you suspect that’s the problem, a lot of times, you don’t find anything.

Jl: And if I may add there is a great deal you can do to build up the lining with building up your blood and balancing estrogen progesterone levels with certain foods, for example foods that contain vitamin B6, such as walnuts and wheat germ. It can also help to build up the blood with herbal infusions of nettle, and other herbs. I’m putting together a page on lining on our site, if you’re signed up for the newsletter you’ll be notified when that’s up. But these are just some of the good things to add to your meals, that can I contribute to healthier lining. I don’t think it’s useful to think of food adjustments as some sort of a restricting fertility diet but there is a great deal you can do with food.

JG: There’s a book called The Fertility Diet, as if there’s such a thing as a fertility diet. You know, it’s not that complicated. Everyone knows what healthy food is, and everyone knows what unhealthy food is. Everyone knows about a balanced diet, and you really want to have good sources of protein. You want to mix it up. Meat is fine. You don’t have to eat meat, but there are some good things about it. Too much of anything is no good. But you can eat fish, grains, and combinations of nuts that make whole proteins. Milk, soy. And I think soy is fine. A lot of people say you shouldn’t have soy, but I don’t believe that. Fats are really important. I think this idea of a low fat diet is a mistake. People need fat. You need good fat, though. You need oils, nut butters, you need to minimize saturated fats, but some saturated fats are fine. It’s not that complicated. You don’t need to buy a book. You just need to think about it. Take your prenatal vitamins. Then, you’ve done everything you can do. Then, you work on your stress, on your exercise, and you work on remembering that you still have a life, and you’ve got to live it. It takes over everything. What’s the point? You need to give yourself some slack and say, “Hey—wait a minute, I’m doing everything I can do. I’m going to watch a movie and forget about

this stuff for a couple of hours. I'm going to go out and have a good time and have dinner and be with friends.

Jl: It's funny that this subject came up right now, because before we go, I have to share a story.

This was a client of mine and a patient of yours. It happened about twelve years ago. She was in her early 40's when she first came to the workshop and joined my support group and she has had several miscarriages. She was in my support group for roughly five months, when she scheduled a consultation with you. She said that at some point during the consultation, you suggested that she have a sonogram, and the sonogram showed that she was in early stages of pregnancy. You also told her that although she was in the early stages of pregnancy that the pregnancy looked very strong. You were very excited to see her pregnant, and said that she was one of the very rare cases that you'd seen in your practice, who conceived given her history and her age. She told us that you were going to talk about it at the next conference.

The reason I bring it up is that I've seen this beautiful young woman engage with such passion with the Fertile Heart™ practice in the five months that she was in my support group using the tools, working with food, changing her whole outlook on what she was going through. But she also shared with me that one day, she went out and had a hanger steak on a Friday night, at a great French restaurant, and had a wonderful date with her husband. And that's was when the conception happened. That was when her little girl was conceived.

So, there was a lot that she did on her own and she was glad that you acknowledged the value of the work that she did on her own. Unfortunately, I think that a lot of women don't share with their doctors the work that they do in the Fertile Heart™ practice and other places, because they don't feel that they are going to be taken seriously.

JG: That's a sad statement for the doctors, because I think one good aspect that helps patients a lot is that you just have to feel better so you get through the process. Any adjunctive treatments, any therapy, or relaxation techniques, I encourage in all patients. Whatever works for you. You have to figure it out. Not everything is right for

everybody. You have to figure out what helps you reduce your stress, what helps you feel better and get back in control of your life.

Jl: And what helps you to turn this into a remarkable birthing experience in your life, regardless of the outcome. That's also an important piece.

Thank you so much for the valuable insights you shared with us tonight Jamie. Thank you everyone for joining us. Goodnight!

\*\*\* See article about the link between AMH levels and nutritional deficiencies and the Fertile Heart Ovum Approach to the low AMH challenge:

<http://www.fertileheart.com/low-amh-and-vitamin-d-link-a-step-toward-solving-the-low-amh-puzzle/>

# Jonathan Scher, MD



Julia Indichova: Jonathan, I'm so glad that you accepted my invitation to be our teacher today.

Dr. Jonathan Scher: Thank you for having me Julia, you're such an important voice in this field and it's a pleasure to be here.

Jl: Thank you, Jonathan. Could you share with us how you got to be a miscarriage specialist?

JS: Yes, I have been doing this for along time. For many years, I was just struck by the number of women who had recurrent pregnancy loss or repeated failed in-vitro and I saw how upset they were and that there was so little attention paid to their problem. You know it was "Just try again, it's just nature's way of letting go of something abnormal, you'll hit the nail on the head and succeed sometime." And I kept hearing this and I saw that people were feeling lost. I think this persisted until the early 80's and at that time I started a clinic at Mount Sinai focused on just this problem. We didn't have that many tests then, but still there were things you could look at, to try and make people feel better. Of course since the 80's there's just been an explosion of knowledge and things are improving.

Jl: Sadly, I see the same thing among the women who come to my workshops. Often they are told to simply change protocols, and "Go for it again," without taking a closer look at why they might not be able to carry a full term pregnancy. So, since you mentioned testing, Jonathan, would you give us a brief overview of the kinds of things that you look at?

JS: The first thing to do is to take a very careful medical history from the patient, because even with recurrent pregnancy loss you can get the clue from the history, just like in general medicine. And although they're very sophisticated medical tests, the history tells you which way to go. And, in fact, most of the time you sort of feel the answer even though you haven't started testing. We take a very detailed history from the patient of their problem, of the number of losses, when they occurred, and what tests have been done. We then go for their menstrual history to look for situations like poor ovulation or ovulation at the wrong time, looking for

Polycystic Ovary Syndrome, and so forth. And then, most importantly we go to the family history. We want to know about the siblings' reproduction, we want to know about the mother's problems. Did they have the same thing? Did they take any medications while they were pregnant with the patient? And then we ask for a family history of autoimmune diseases, such as Underactive Thyroid, or Lupus, or Crohn's, or Scleroderma, because these immune diseases sometimes manifest themselves as a reproductive problem many years before the patient actually develops the disease clinically, with symptoms. Although that might never happen; the disease might never express itself, and the patient doesn't necessarily get an autoimmune disorder.

Jl: So the disease might remain dormant?

JS: Yes, it can remain dormant most of their lives and start at old age. It manifests itself in recurrent pregnancy loss, and particularly in cases of unexplained infertility, where the patient's tubes are open and she ovulates, and where the husband's sperm is good, and yet they don't get pregnant, and then they fail treatment. This is because there is an underlying cause that we have to uncover, whether it's a medical disorder, or whether it's an immune disorder, or an infection, or something else going on.

Jl: In other words, whatever it is that is interfering with a full term pregnancy has not yet manifested physically. This is a concrete example of the idea I often speak and write about, that our "infertility" can literally save our lives. If we address these latent autoimmune diseases at their dormant stage, there is a great deal we can do to prevent their full expression later in life.

I often see so called "unexplained infertility," resolved very effectively with the Fertile Heart™ Ovum approach, which is meant to help us make these "invisible obstacles", be they physical, emotional, or spiritual, visible. When they become visible, they can be addressed. Could we hear more about the testing?

JS: We divide our test into a few important areas. Would you like me to go through them?

Jl: That sounds great, Jonathan.

JS: Thank you. For example, the most important group that comes to mind is the genetic or chromosome disorders. These are often mentioned as being 75-80% of the causes. That may be true if the person experienced one pregnancy loss, but it's not true for recurrent losses.

Jl: So are you saying that most recurrent losses are not chromosomal?

JS: They are not chromosomal. As you increase the number, the percentage gets smaller and there is a lot of research to substantiate this. Of course, as a woman ages, the chances of a chromosomal disorder increase. But up until the early forties, it's really not something that must be given as a cause. We must look for other causes besides chromosomal disorders.

Jl: Would you cite an age at which you begin to see recurrent miscarriages linked to chromosomal issues?

JS: Yes, there's a little bit of a jump at 35, and therefore they recommend amniocentesis at this time of pregnancy. But really, we don't see this, in practical terms. If the patient is 43, or 44, then you really start to see it. It's not every embryo that's chromosomally abnormal. People often get told, "At your age, you're 38, you have bad eggs." That may be true for isolated miscarriages, but not for recurrent ones. And that's why we try and emphasize with patients who miscarry, that every attempt should be made to do chromosomal testing on the tissue. That's important, because if the tissue tests as chromosomally abnormal, then you don't need to investigate them further, or do only very minimal investigations, depending on their history.

Jl: I see. This is true especially with younger patients?

JS: Especially with the younger patients, yes. Then, we look at anatomic, structural abnormalities, particularly a weak cervix, which causes a light pregnan-



cy loss, usually after about 12 or 14 weeks, a rapid loss that requires a stitch. And fibroids are not a cause of recurrent pregnancy loss. People often have surgery for fibroids and it is not necessary.

Jl: Just want to make sure this is clear. Are you saying, Jonathan, that fibroids are not linked with pregnancy loss?

JS: If they are in the uterine cavity or under the lining, and they are extensive, then yes, that's a different story. But most fibroids are in the wall on the surface of the uterus, and are really not important. It depends on the location. Fibroids on the sides of the uterus or on the top, may cause tubal obstruction, which you'll tell with a hysterosalpinogram, the standard test for checking if the fallopian tubes are open by injecting them with a dye. Or, you can tell by looking at the tubes and the uterus by laparoscopy.

What I have a little problem with is the patient who has one or two fibroids, and the tubes are open, and the fibroids are not inside the cavity, or just under the endometrial lining pushing into the cavity, and they immediately go for surgery. I think that is so overplayed. With fibroids it all depends on their position. You always have to tailor your tests and the treatment to the patient. That's so important.

Jl: That makes sense, and is certainly true with any healing modality. The right lifestyle adjustments, supplement, elimination of certain foods, the right mind-body intervention, all of that can make a huge difference.

JS: Yes. Then, we make sure the mother doesn't have any maternal disorders like an Underactive Thyroid, or Diabetes, and also what's known as a Luteal Phase Defect. Luteal Phase Defect means poor or irregular ovulation with a short second half of the cycle.

Jl: So is that related to low progesterone?

JS: Absolutely, low progesterone. And this is much more important and common than people have believed. We diagnose this, usually, through the history of the patient,

but also particularly through an Endometrial Biopsy, where you take a pinch of the lining of the uterus. And you see if the tissue corresponds with the day of the cycle on which the tissue was taken. The biopsy should be done within two days of day 21 of the cycle. In other words from day 20 through day 23.

Miscarriages are also often associated with something I mentioned earlier, Polycystic Ovarian Syndrome, PCOS. It's a very common reproductive disorder in women who are menstruating, and we test it by measuring the women's male hormones, and also their fasting insulin and glucose. We get them to fast, and then we draw their blood in the morning for a blood sugar test. It will be normal or low, because they haven't eaten. At the same time, we measure the insulin to see if the pancreas has to produce a lot of insulin to keep it normal, and that's called insulin resistance.

Jl: Yes.

JS: And that's an important cause of poor ovulation, which you can treat with Clomid or with Glucophage Metformin. Everything that I have mentioned has a treatment. Polycystic Ovarian Syndrome has become extremely common, and it's often neglected, and must be looked for.

Jl: I would be remiss if I didn't add that I've seen many, many women resolve issues linked with poor ovulation and polycystic ovaries through lifestyle adjustments and emotional conflict resolution by using the Fertile Heart™ tools. If we only treat these symptoms with pharmaceuticals, we are silencing the body's call for help and we are bound to pay the price further down the line. So, as I see it, no matter how we choose to address these symptoms it's wise to also follow through on exploring why the symptoms are showing up to begin with, and then make changes accordingly.

JS: Right. To garner the causes of the maternal disorders like Diabetes, or Polycystic Ovary Syndrome we certainly should look at environmental factors. There are things in our environment that we can't change, such as acid rain, but we can choose not to smoke, or do any drugs. Smoking is a terrible thing to do if you're having fertility problems or any other problem. The role of caffeine is somewhat exaggerated, so I say it's okay in moderation, up to 300 milligrams a day, which is two

fully brewed cappuccinos or two full cups of coffee. You can have it in the morning if you want to, and in the afternoon. It's not associated with pregnancy loss.

Jl: Not with pregnancy loss, but with fertility issues.

JS: Or with fertility issues.

Jl: On this I would respectfully disagree with you, Jonathan. There is research out there that shows that even one cup of coffee will reduce pregnancy rates. Caffeine is an addictive drug that interferes with the liver's processing of estrogen. Clients of mine who stopped drinking coffee have withdrawal symptoms, so if someone is having miscarriages, that's certainly a good reason to stop drinking coffee.

The other reason I see for giving up caffeine is to see how you function without it. If you really need coffee to function, something is off balance. Perhaps you're experiencing adrenal fatigue or you're hypothyroid, but if you can't function without caffeine chances are your body is not ready for the labor intensive job of gestation, and something needs to be repaired before you even try to conceive.

I'm not alone in advocating this, and I also understand it might be a challenge for some people. But there are so many better ways to get energized than caffeine.

What other tests do you run, Jonathan?

JS: Then we look for blood flow disorders, which we get a clue about from the information we gain from the pregnancy loss. When there's a fetal heartbeat in early pregnancy, and then it disappears, and the chromosomes and the embryo that was lost turn out to be normal, that's a clue. And then, especially, if that's combined with a family history like a sibling or a mother or a father who've had high blood pressure, strokes, or heart attack, we look for inherited clotting disorders. They call them Inherited Thrombophilia. Thrombophilia means anything that promotes interference with blood flow, and we treat that effectively with baby aspirin and a blood thinner called Heparin. Lovenox, is the new form of Heparin. Heparin is quite safe. It's a large molecule. It doesn't cross to the embryo or to the fetus.

Then the next things we go to are infections. Now, infections are not a common cause of fertility problems. The role is not well understood. I mean, they might be involved in one episode, but not in recurrent episodes, except for two organisms: ureaplasma and mycoplasma, which can be in the male genital tract or the female, or both, and that's why we culture the lady's cervical fluid and the man's seminal fluid. That's often neglected because the bacteria can "cross attack" the sperm. I'm sure you heard this from a previous speaker.

Jl: Yes.

JS: A colleague who's in charge of immunology research at the CDC, showed us slides once. You could see that the ureaplasma attacks the sperm, goes into the mother, and sets up a low-grade, inflammatory reaction, and makes implantation very difficult, and ends in a miscarriage. So it's important to screen both the husband and the wife for infections.

Jl: Jonathan, I know that some physicians believe in treating patients prophylactically with antibiotics. Is that something that you believe in?

JS: Yes, we sometimes do that. We sometimes do that in the treatment cycle, because we don't understand all that much about the role of infection. So, to cover the bases, we give both the husband and wife Erythromycin at the start of her period, for two weeks or ten days, so that by the time that she's ovulating, when she's going for treatment, it's out of her system. Or you can use Tetracycline as well, providing they're not pregnant.

So we do sometimes do that. I agree with you, Julia. We do that. I'm trying not to make this too complicated, not too much of a lecture. Is this OK?

Jl: Yes, this is terrific, very useful. In a little while I'm going to open the lines for questions and I also have some questions that people sent in before the call. But before we do that, perhaps you could briefly address the immune issues that are often linked to miscarriages.

JS: First, I'm going to talk about immune disorders and immunology.

All our body-surfaces, the eyes, the intestinal tract, and in women, the vagina, the cervix, the uterine lining, all have immune cells. If they're exposed to any infection, the immune cells destroy the foreign organism.

An immune cell, just to make it easy, is very much like a fire extinguisher that you see in a garage or in a theater. The flame would be the germ, and the foam that comes up out of that little fire extinguisher, which would be the immune cell, is the antibody. And just like the different types of flames, some from wood fires, some from electrical fires, some from chemical fires, inside the body there are different types of foams or antibodies.

We have found some important immune disorders, and the first ones are antibodies against the Thyroid, even if a patient has normal Thyroid function. And then the other one that's important are the antiphospholipid antibodies. These choke off the blood supply to the embryo. These are typical in patients where an embryo won't implant at all, or where they have had a fetal heartbeat at 6 or 7 weeks, and the baby's no longer alive at 8 or 9 weeks, and it's a little small. This is a most important cause and this is the one again in which we give aspirin and the blood thinner.

Jl: Many years ago, there was a piece in the New York Times about women with multiple failed IVF's who were finally diagnosed and treated for antiphospholipid antibodies.

JS: Right. Women who have laparoscopy, the procedure where they look into the pelvis through the belly button, prior to undergoing IVF, are often told they have endometriosis. The immune disorders associated with endometriosis occupied an entire day at one of the American Society of Reproductive Immunology conferences.

People can never understand that the tubes might be open, but if there's even a little bit of endometriosis, and if they don't get pregnant, it's because of immune changes and it's so often ignored.

So, again, antiphospholipids are often found, and probably are the cause of the unsuccessful pregnancies when there is endometriosis.

Jl: You know there's something that you said, Jonathan, that connects with my work and with the idea of really strengthening the physical body, the emotional, and the spiritual body. When we are talking about women in their 40's. Thinking back to clients of mine who were 43, there were several of them that had repeated IVF's, and were told that they couldn't conceive, and they had been through as many as 4 or 5 miscarriages, and at 43, lo and behold, they conceived after those miscarriages, and they gave birth to healthy children!

JS: I've seen this so many times.

Jl: As you said, just because there is some chromosomal damage, it doesn't mean that each egg is damaged.

JS: It can't always be the egg, it can't always be chromosomal, and it can't always be infection.

Jl: It can't ever "always" be any one thing.

JS: Yes, you've got to look. They keep being told it's because they're "old." Put the shoe on the other foot. If you decided you didn't want to have children at 40 years old, you would have to use contraception.

Jl: Exactly.

JS: And there is another thing that reinforces this. Patients get told that their FSH is too high; It's 12 or 14, and we must remember that FSH fluctuates so much, and it's certainly not an absolute thing. Or, they're told that they've got to go for ovum donation, or adoption, and it's absolutely not true. We see this at 43, 45.

Jl: Yes, I certainly have seen it in my work as well. It's kind of ironic because there is all this talk about the mind-body connection, but then people are presented with all these devastating statistics the minute they walk through the door, before they

even begin testing or treatment. .

JS: It's annoying, actually.

Jl: It is a little annoying, isn't it? It's good we get to commiserate on this...

JS: I love the work that you do; I think it's so important.

Jl: Thank you.

JS: Actually one of my interventions that I always discuss is the "mind-body," and being more positive.

Jl: Yes, we talk about it a little differently because the industry has turned it into a "mind-body confusion " but that's a subject for another day. Why don't we see if anyone on line is ready to pose a direct question to you, or, if not, I will read some questions that came in through email. Let's open the lines.

Caller 1: Yes, it's J. from California. Hi. I've had two IVF's recently. I am 40, and they both failed, and I do have low thyroid. I take medication, and I have reoccurring yeast infections, just about every month.

JS: Do you have children?

C1: No.

JS: Just one other thing. Do you produce a fair number of eggs when you're inseminated?

C1: The second one that we did, they got out eight.

JS: Oh, well that's good. 5 or 7 is very good. And the quality of the embryos, when they put them back--did they tell you that they were reasonable?

C1: They said that they were the highest. That gave it a 4.

JS: You see, firstly, you mustn't be scared about taking too much thyroid. The most important thyroid test is called a "TSH," the Thyroid Stimulating Hormone, which must be a low level, which means you have enough thyroid hormone circulating in your blood. And you should also repeat it once or twice, to see that your levels are good. That's important. The other thing about the yeast. That shouldn't contribute to pregnancy loss, and I think you should treat that as if it has nothing to do with your situation. You know you can treat it locally, and try not to stress out, because that will reinforce the yeast infection. I think you need to have some of the tests that we have outlined. You need to be tested for the ureaplasma and mycoplasma, and your husband's sperm needs to be tested

C1: Yes, he was.

JS: You want to look for these anti-bodies; like anti-thyroid, anti-lipid, and make sure you don't have the Polycystic Ovary Syndrome. Because you failed two IVF's and there's no obvious cause, you need a work-up. You need to be tested before you go again.

C1: I don't want to go again.

JS: Well, you don't want to go again because you're so despondent.

C1: I want to, for now, just to work with my husband, but I don't know.

JS: You mustn't be despondent; you must look for the cause. If they put back good embryos, and you're a good egg producer... Before you entered in-vitro, were your tubes OK? And was your husband's sperm OK?



C1: Yes my tubes are fine, my husband checks out fine. Although one thing about his semen is that the fluid does not liquefy. I don't know, but two doctors told us that it was not a factor.

JS: No, I don't think that's a factor. If he's got a reasonable count, there are some tests we do, beyond that, on the sperm: DNA Integrity Tests. We look to see if the sperm is of a good quality, just as you do with the woman's egg--you can check that out. You can talk to your in-vitro doctor about that. Have your husband checked by a urologist to see if he has what is called a varicocele which is a varicose vein of the scrotum, which can interfere with the fertilizing capacity of the sperm. So that's something worth doing. And you should have his seminal fluid cultured for these ureaplasma. They're not some sexually transmitted disease; they're a sort of bacteria. They're a cross between a bacteria and a virus that can live in the man or the woman. So there are tests you need to do, because it sounds like you can do it, you're only 40 years old.

Jl: You're very young.

JS: You're very young and you've just got to make sure there's nothing that's treatable before you go again.

C1: I asked the urologist to do a culture of my husband's semen and he looked at both of us and said, "I don't think your husband has a problem."

JS: You see, that's just the point. That is the point. Do you know if you have endometriosis or not?

C1: Yes, I was told that I do, and I did have some surgery.

JS: OK, that's fine to try to remove it. But you need to have this testing done, because endometriosis is associated with immune factors or problems that can be treated, like these antiphospholipid antibodies. And for this treatment, you need a work-up.

C1: Okay. Thank you.

JS: Don't give up. You are the type of patient that we see all the time.

Jl: I would ask myself what the recurring yeast infections are about.

JS: Yes.

C1: Yes, I've had them for so long.

Jl: Let's see if there is anybody else that would like to ask a question.

Caller 2: I would like to ask a question if I might...

Jl: Please.

C2: Dr. Scher, thank you so much for donating your time. Julia, I'm enjoying your book.

JS: Julia's book is great, isn't it?

C2: Yes and it's so good, so refreshing, to hear somebody saying you're young at 40- it's unbelievably encouraging. I'm 42, and in November I'll turn 43. My RE keeps saying, "You're too old; your eggs are too old." Well, anyway, despite of all of that, I got pregnant and had a miscarriage at 11 weeks. Turns out that it was chromosomal.

JS: Which is age related.

C2: And the doctor keeps saying, "It may happen again, you may have another mis-

carriage because of that,” which I understand is a major possibility, but all kinds of tests have been run. I had fibroids. They were removed. I had a myomectomy and some endometriosis. In spite of all of that I got pregnant in June and they haven’t found any other problems at all. All the tests have been OK. No thyroid problems, no anti- bodies, nothing. The only thing they have been able to find was some deficiency in folic acid. I think it’s some sort of mutation they talked about.

**JS: Yes it’s an MTH mutation. It sometimes causes a raised homocysteine. You need to supplement with folic acid.**

C2: Yes, that’s exactly what it is. That’s what I’m taking on top of my prenatal. But now my question is, I’ve had 2 IUI’s and I got pregnant naturally, that’s another plus, and my FSH for about a year was between 11 and 12.5, and the month I got pregnant, it went down to 6.5.

**JS: There you go.**

C2: I’m doing so many things that you had talked about, Julia. Your book, you know, the diet, and everything. I’m feeling really good, despite the miscarriage; I’m feeling back on track again.

**JS: Good.**

C2: I don’t feel at this point that I should do in-vitro again; number one, because I got pregnant and number two because they are not finding any problems. Even though I am 42 and I will turn 43 in November. My question to you: realistically speaking, how much more would you say I probably should try naturally, and when, maybe, I should go back again to trying IUI’s, and then maybe in-vitro.

**JS: OK, how long did it take you to conceive? Was that a long time?**

C2: Not really. There was a possible pregnancy in December that made it so they still couldn’t tell. Even so, he recommended two months of rest. That was in March. I

was ready to go, and I got pregnant in April, so it really was our first try.

JS: You know what you should do? You read Julia's book and follow her advice, and say to yourself, "I can do it," because you can do it. If you didn't want children, you would have to go on the pill or use contraception, so look at it that way. Have intercourse mid-cycle, and try to relax. And if you're not pregnant because of your age in say, 3, 4 or 5 cycles, I would then talk to the RE about a few things, some further testing, but also about maybe trying to stimulate production of more than one egg. So as you get older, if there are chromosomally abnormal eggs, at least if one's chromosomally abnormal and you ovulate two or three it enhances your chances. So you might want to then have an injectable with IUI, and if that doesn't work, then you can consider IVF.

C2: And what you said about having a miscarriage because of chromosomal issues--that doesn't guarantee that all eggs are going to be chromosomally damaged?

JS: No it never is, in fact, I can't tell you how many women one sees who are pregnant in their middle forties. I would say that you should just do what I suggested, and you'll do it, and if you don't, then you'll want to go to the next step to have injectables with IUI and then IVF. But all your eggs are not chromosomally abnormal at 43 or 44, that's absolutely not true. I mean, just in practice, without talking about recurrent miscarriages or infertility. How many women have had babies in their middle 40's? Because if you didn't want a child, you would have to do something about it!

Jl: Yes, absolutely. That's a great point. If you are ovulating and you're in your mid-forties, chances are you use contraception. We will take a couple of more questions. Is there someone else out there who is burning to ask a question?

Caller 3: Yes.

Jl: OK.

C3: I'm calling from Florida. You were talking about this Antiphospholipid Syndrome?

JS: Yes.

C3: And there's a treatment for it, you said?

JS: Yes.

C3: Is that something that you need to be doing as you try to get pregnant, or only after?

JS: Oh, that's a great question. As you try to get pregnant, that's the trick. You know, very often you hear patients who've been given the treatment and they say, "It doesn't work," or, "I still miscarried," or, "It didn't go well." And the reason is, that it's often started once you've had a positive pregnancy test, so once there's a heart-beat, that's really too late in most cases. It must be in your circulation at the time that the embryo is implanted, because that's when it comes in contact with your circulation. So in a natural cycle, you want to start with about day 18 of your cycles. And if you don't get pregnant, you stop. It's a subcutaneous injection, it comes in a pre-fold instant syringe, and it's a little uncomfortable, but not really uncomfortable.

C3: Should we take baby aspirin and Heparin?

JS: Baby aspirin, we usually start on day 14, and the Lovanox, or the Heparin on day 18, because an embryo can only implant between days 21 and 24 of your cycle, so you want it in your cycle. That's the way you want to go.

C3: So there's no danger in taking it?

JS: No, there's no danger from Heparin. The Heparin molecule cannot cross the embryo or alter a fetus late in pregnancy. The baby is called a fetus after 10 weeks, and before that, an embryo. It doesn't cross. As regards the mother, there are

some potential minor side effects. So every month of pregnancy, you need a blood test to see if your platelets don't drop and then come back if you stop the drug. We had 1 in 300 when we looked at this, once; it's not at all common. And the second thing is, these drugs have the potential to thin your bones, so make sure that if you're on Heparin you have at least 1500mg of Calcium a day, like 3 extra strength tabs, to stop the bone loss. Although the low molecular Heparin (the very new one is called Lovenox), which you may have heard of, that one doesn't thin the bones. Still, take the calcium. It's good for you and the baby.

C3: Is there any amount of time you can take this? Indefinitely? For years?

JS: What to keep trying?

C3: The Lovenox, yes.

JS: Yes, certainly. If you're pregnant, you usually take it at least (it depends on your blood test) until about 20 weeks, or sometimes until about a month before you deliver. But it depends on what your tests have shown.

C3: Is this common knowledge? Doctors are learning this? Because I was told by a doctor not to do it, that there's risk to it. I can hemorrhage...

JS: No, no, no. As long as you get watched and you see that it doesn't make you bleed. Heparin prevents clotting. It's not like someone who has a deep thrombosis, or a heart attack, who had to have high doses and increased the bleeding times. It doesn't make you bleed. The clotting factors remain normal, so it's not actually dangerous.

C3: Thank you.

Jl: Jonathan, you have given us much good news.

JS: It's been so much fun.

Jl: OK. Let's see if anyone out there has another question?

Caller 4: Hi, this is R. from Montreal. I'm wondering...I've gone for a few months where I don't even think that I've ovulated. And I have a high FSH of 25. So I'm wondering if there's even a chance to conceive at this point...

JS: How old are you?

C4: 43.

JS: OK. You know, firstly the FSH fluctuates a lot; so make sure you measure that, and your serum estrogen level.

C4: That was normal.

JS: Less than 50?

C4: The doctor said that it was normal.

JS: OK. If you don't ovulate at all, but you're obviously not menopausal, then he should look to find the cause. He should check you for the Polycystic Ovary Syndrome, and try and induce ovulation. Have you tried that?

C4: No. How do I do that?

JS: Maybe your doctor hasn't tried it because your FSH is high. Has it ever been lower than that?

C4: It's the only test I ever had.

JS: You've had it once?

C4: I'm going back, next cycle.

JS: Get it tested repeatedly, because at your age you should be ovulating, if not every month, then occasionally. So, I think he'll want to induce ovulation.

C4: OK.

JS: And repeat your FSH each month for the next 2 months or 3 months and see what happens. Because we see patients pregnant with very high FSH levels. You heard one guest earlier talking about the FSH, and she was pregnant and re-measuring. It was fine.

Jl: Well in my case the month I became pregnant my FSH was quite high, over 29.

JS: There you go! It should not stop you from going further.

Jl: You're saying that R. should look into inducing ovulation...

JS: Yes. She should take a look and take some of the advice from your book, Julia. If the FSH is very high, they're reluctant to give injectables, because really that's what you're giving. They could try something like Clomid.

C4: We tried that...

JS: It didn't induce ovulation?



C4: No.

JS: Well, the next thing to go for is to measure your insulin resistance and take some Glucophage Metformin. That may well induce Ovulation when Clomid doesn't...

C4: I'm sorry, what was it?

JS: Glucophage Metformin...and they should measure your insulin resistance.

C4: OK.

JS: That's by measuring a fasting blood glucose, and then insulin. And Glucophage Metformin There are some IVF people that give it to their patients when they fail, because it's really a safe drug. And the other thing you want to do is get your doctor to measure something called the Anti-Ovarian Antibody. That's an Antibody that if raised, can cause poor ovulation, no ovulation and even pre-mature menopause. So, you want that measured. It's fairly new, it's called the Anti-Ovarian Antibody, and if you've got it, you want to try to suppress it.

C4: All right.

JS: All right, so there are a few things. Don't say to yourself, "Oh well, I'm old and my FSH is raised, and I can't do it." That is a defeatist attitude. You can do it, and if you don't do it, at least you tried everything in five years' time. And I have a patient (and she tried for a long time), and she just had a beautiful daughter, and that's at 47! That's the oldest I've seen be successful with her own eggs, spontaneous. I've seen 46 a few times, but never 47.

Jl: That's wonderful. Yes, that's what I see as well, that those late-40's pregnancies, most of them happen naturally.

JS: Naturally, yes, because that's when those people have given up...

Jl: Yes, that's when they let go, and the body unclenches and knows what to do.

JS: At 43 or 44, I don't think you should say, "My eggs are all old, and I can't do it."  
You must have some testing, and some treatment, and follow a good diet, and do all those things.

Jl: Wonderful!

JS: You know to program someone is bad, to program them for disaster...

Jl: Programming us for failure, yes. Our industry is very good at that.

JS: So, go back to your doctor, please.

C4: I will, thank you.

Jl: I want you on our side. Jonathan, this has been, the cheeriest teleconference we've had in a while.

JS: Well if you're not enthusiastic for the patients, which I know you are, then, then....

Jl: Why do it, right?

JS: Why do it at all? If you don't enjoy it, and you're not positive, don't do it.

Jl: Thank you so much, Jonathan. I really am so grateful.

JS: Thank you, it was a pleasure.

Jl: Thank you everyone, I look forward to connecting with some of you on Monday night.

**Dr. Sami David** received degrees from Columbia University and Columbia College of Physicians and Surgeons before completing his residency at New York Hospital-Cornell Medical Center. He went on to complete his training as a reproductive endocrinologist at the University of Pennsylvania and is currently affiliated with Mount Sinai Hospital in New York City, where he performs any necessary fertility surgeries. Dr. David is a member of the American College of Obstetrics and Gynecologists, American Society of Reproductive Medicine and American Society of Reproductive Immunology, He's the co-author of *Making Babies*.

**Dr. Jamie Grifo, M.D., Ph.D.** is Director of the Division of Reproductive Endocrinology; Program Director of the NYU Fertility Center; and Professor of Obstetrics and Gynecology at the NYU School of Medicine. Dr. Grifo's career in reproductive medicine began in 1988. For almost twenty years he has focused his research on preimplantation genetic diagnosis, resulting in the first U.S. baby born following these procedures. Today he is considered one of the top infertility specialists. Dr. Grifo received his doctorate in biochemistry, and his medical degree from Case Western Reserve University. He completed residency at the New York Hospital- Cornell Medical Center and fellowship in reproductive endocrinology at Yale University. Board certified in obstetrics and gynecology, and reproductive endocrinology, Dr. Grifo also is accredited in advanced operative laparoscopy and hysteroscopy. A Phi Beta Kappa graduate, Dr. Grifo has received many honors during his career. In 1996, he received the President's Award from RESOLVE. He has been named one of the "401 Best Doctors for Women in America" by Good Housekeeping magazine, and has, since 1997, been designated one of the best doctors in New York by New York Magazine. Dr. Grifo has published more than 130 medical and scientific articles, and speaks frequently at medical-scientific meetings and symposia. He is an active member and has held office in the American Society for Reproductive Medicine and is a past president of SART.

*Jonathan Scher, MD, is an attending ob-gyn at Mt. Sinai School of Medicine in New York City and has a private practice in Manhattan. He is a board-certified Fellow of the American College of Obstetrics and Gynecology and also an honorary Fellow of the Royal College of Obstetrics of London, England. His specialty is the research and treatment of couples that miscarry recurrently. He is the author of two books, including Preventing Miscarriage: The Good News, numerous scientific publications in peer-reviewed medical journals, and has contributed chapters to medical textbooks. He is on the board of two major magazines and the American Infertility Association. His quotes and articles have appeared in numerous national magazine including Time, Newsweek, and most of the major women's magazines.*

*Julia Indichova, a reproductive health educator and activist, is the author of Inconceivable and The Fertile Female, the creator of the Fertile Heart™ Ovum Birthing Practice, and the founder of [www.fertileheart.com](http://www.fertileheart.com). She is also the director of the Fertile Heart Studio in Woodstock, where she teaches day-long intensives and workshops. Julia's work and story have been featured on the The Oprah Winfrey Show, Good Morning America, Oxygen, NPR's 51%, in Natural Health, San Francisco Chronicle, Health magazine, People magazine, Health magazine, USA Weekend, and other outlets.*

# FertileHeart Article Links

## **Alkalize for Fertility and Health**

<http://www.fertileheart.com/alkalize-for-fertility-and-healthtilting-the-scale-toward-an-alkaline-conception-friendly-holy-human-loaf>

## **DHEA Triples Fertility: Facts and Fiction on DHEA Benefits**

<http://www.fertileheart.com/576>

## **Low AMH and Vitamin D Link: A Step toward Solving the Low AMH Puzzle**

<http://www.fertileheart.com/low-amh-and-vitamin-d-link-a-step-toward-solving-the-low-amh-puzzle>

## **Does a Low AMH Level Indicate Infertility?**

<http://www.fertileheart.com/does-a-low-amh-level-indicate-infertility>

## **FSH Levels and Menopause: Getting Pregnant with High FSH Levels**

<http://www.fertileheart.com/fsh-levels-and-menopause-getting-pregnant-with-high-fsh>