

***Help Me Overcome
Infertility - Naturally***



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Introduction

For those who have never experienced it, the heartbreak of infertility is difficult to put into words. Of course, you know you'll be good parents. But yet you look around your house and there are no children to call your own.

You go outside. You see happy children, happy couples and happy families. Why aren't you one of them?

Is it fair?

Of course not. But that's the bad news. You're infertile. There is a silver lining -- at least that's what you keep telling yourself. And that's the fact that the time period in which you live is blessed with the most modern technology, making even the seemingly impossible act for you -- getting pregnant -- a possibility.

And as long as you haven't exhausted all your possibilities, you're going to keep hoping and praying that one day -- very soon -- you will be pregnant.

And that's not false hope. If you would have lived a hundred years ago, your infertility would have been a foregone conclusion. Today a wide variety of options are at your disposal that may very well help you turn the corner from childless to loving parent.

And while I'm talking right now specifically about modern conventional - in some cases high tech - treatments. Those aren't the only options available to you.

Don't dismiss out of hand the seemingly simple, common sense ideas that may come your way as well. These very many times come in the form of a more natural approach anyway.

You Are Not Alone

I'm sure this doesn't make you feel any better, but you're not alone in what must surely seem to you at times as a desperate attempt to conceive and give birth.

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Consider the following statistics if you will. There are approximately 7.3 million women between the ages of 15 to 44 - those peak childbearing ages - who experience some problems with getting pregnant. These individuals are not infertile, but they are, nonetheless, experiencing problems conceiving.

Another 2 million women or roughly 7 ½ percent of the population in the 15 to 44 demographic are, indeed, infertile.

It's for these women and their partners that this book is written. No one can imagine the individual heartbreak each couple is experiencing. And no one for sure really knows how many unions have been broken due to infertility problems.

The scope of the problem, the many facets of the subject - by sheer volume alone - prevents any in depth presentation of the problems and its possible solutions.

The book though does represent a jumping off point, if you will, a primer of sorts for the subject of infertility, providing you with the start of an overall wide ranging education.

Think of ***Help Me To Overcome Infertility – Naturally*** as your informed introduction to the topic - your first along a journey in your attempt to define and solve your problem.

In addition to the chapters on causes, treatment - both conventional and alternative - you'll find resources. They are your next step solving your infertility problems.

And Good luck!

Chapter 1: Am I Really Infertile? An Overview

Life seems unfair sometimes doesn't it? As you walk through the park you ask yourself why that couple playing with their son on the swing were able to have a child. You question why that woman sitting on the park bench was able to conceive.

You and your partner, on the other hand, have been trying to have a baby for more than a year now - and there is still no pitter patter of little feet in your house.

Of course you're frustrated, confused and downright angry! Who wouldn't be! And of course you have questions - it seems like an infinite list of questions - about the whole process.

Doctor, why can't I get pregnant? Is it me? Is it my husband? Is it temporary? Will I ever be able to have children?

For many women, getting married and having children is the center piece of a life well lived. For many couples, the desire and joy of having a baby, raising them, watching them grow and sharing a natural, extended love, is something they have dreamed about for years.

But that dream for about 10 to 15 percent of all couples in the United States is just an empty promise. These couples are infertile. Try as they might, they are unable to conceive.

The medical community defines infertility as the inability to get pregnant after at least one year of repeated, frequent attempts. In other words, if you and your partner are not using any type of birth control, have had sex for at least a year and you still have no child, medically speaking you're considered infertile.

Is it a dead end? Does it mean that you'll never be able to have a child? Even though you may think so right at this moment, actually nothing could be further from the truth.

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Here's some good news for you!

In reality, you actually stand a good chance of conceiving a child in the future. Many medical experts tell couples that very often what's preventing a conception is a condition or problem that is quite treatable.

Let's take a quick look at some of the normal conception statistics. You may be shocked to see that even for healthy couples, the odds of getting pregnant in any given month are really stacked against them.

The success rate of achieving conception in any given month for a healthy couple hovers between 15 and 20 percent. Surprised? Many are. You can see then that it may take several months - to say the least -- to overcome these seemingly dismal odds.

Generally speaking, about 70 percent of couples conceive after they've been trying for six months. Eight-five percent of couples are successful at the end of one year or 12 months.

But now, here's the surprising part. After two years of trying, nearly 95 percent of couple are successful and have gotten pregnant. Two years! So, in some ways, if you've only been trying to one year and have not conceived, it's not . . . well, inconceivable that you can still have a baby. In fact, the odds are very much in your favor.

I've presented more detailed statistics in a chart that maps out these statistics quite clearly. Included in this table are not only the number of months a couple has been attempting to have a baby, followed by the percent who have not conceived during this time period.

The table, though, also reveals the percent who have conceived. And it also shows the percentage of couples who can expect to conceive within the next 12 months.

Even though the table can be found easily in Appendix I, I can't help but cite this one statistic for you. At the end of five years of trying, statistics show that only 0.6 percent of couples have not gotten pregnant.

That means 94 percent of them have. The success rate per month is low at this point - a measly four percent. But, looking to the future, the proportion of those couples who can *still look forward to conceiving in the following 12 months* is still a rather healthy figure of 36 percent.

The problem may be subfertility

Now, let's look at the definition of infertility again. You can clearly see that after only a year of trying all hope is not really lost. Some medical experts, after viewing these conception statistics want to call the problem ***subfertility*** instead of infertility.

Barring any physical disorder on either the woman or man's side, conception is still a distinct possibility. The problem lies more in the timing of the pregnancy than in the lack of it. The event just isn't happening as quickly as you would like.

That's not to say that at the end of a year of trying you *shouldn't visit your doctor*. At this point it's wise. At the very least, you can *exclude* the possibility of some insurmountable health problem preventing the event.

Your infertility may very well be due to one simple, single cause present either in your system or that of your partner. Or, the fact that you can't conceive may be the result of several factors that when discovered and treated will allow you to enjoy all the delights of parenthood!

All of this becomes much clearer once you understand infertility better.

Symptoms of infertility

Of course! It almost seems stupid to say it, now doesn't it? But the main and overriding symptom of infertility is the inability to get pregnant. But beyond that there are tell-tale signs that may indicate your infertility - whether you're a woman or a man.

For example, many infertile women have irregular menstrual periods. This symptom alone would make it difficult to conceive. Men who are infertile may exhibit signs indicating hormonal problem. This condition could appear as a change in hair growth or even sexual function.

For most couples, the time to visit a doctor about this problem is after a year of struggling to have a baby. There are several exceptions to this suggestion though. Don't wait until a year has passed if you're a female older than 30 and have had no menstrual periods for six months. Visit your doctor as soon as you can.

Similarly, visit your physician before the completion of the year of trying to conceive if, as a woman, you've had a history of irregular or painful

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periods. This would include pelvic pain, pelvic inflammatory disease (PID), endometriosis, and even a history of repeated miscarriages.

Men should visit their doctor prior to that one year mark if they know they possess a low sperm count or have a history of testicular or prostate problems or sexual problems in general.

For any of these conditions, there's no need to wait for a year of failed attempts. The sooner you enlist the aid of your physician, the sooner he can discover the root cause - and hopefully - send you on your way, one step closer to family bliss.

Doctor, what causes my infertility?

When people refer to the *miracle of birth* it really is more than just a phrase - it's a fact. The human reproductive system is miraculously complex. If one considers everything involved in getting pregnant, you're in awe that anyone of us was born at all.

A possible pregnancy starts anew every month when the pituitary gland in a woman's brain signals her ovaries to prepare an egg for ovulation. This releases the follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Once the pituitary gland secretes these, thus stimulating the ovaries, a woman is fertile.

Generally speaking, this occurs about midway through a woman's menstrual cycle. If you have a 28-day cycle, this event happens at approximately day 14.

Once the hormones have prepared the ovaries, the woman's egg travels through her fallopian tube in anticipation of being fertilized. The window of opportunity here is usually 24 hours. The odds of conceiving are higher when intercourse takes place one, even two days, before the actual ovulation occurs.

While the female is fertile, it's necessary for the sperm to unite with the egg in the fallopian tube. The sperm, by the way, is capable of fertilization for up to 72 hours following its release. Obviously, the sperm need to be in the tube at the same time the egg is there.

But that's not all (and here's where Mother Nature gets real particular!), not only does there need to be a significant amount of sperm present to ensure conception, but the sperm needs to be just the right shape . . . and

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it needs to move in the proper way. Those are the requirements on the man's part.

For the woman, she needs to have a healthy vagina and uterus in order for the sperm to travel to the egg!

It's only when all these criteria are met that the egg is fertilized. .You would think that's the end of the story, but no, the process isn't quite complete, yet. This fertilized egg now must move into the uterus. Here it attaches itself to the uterine lining. And that's when the nine months of growth begin. Finally!

Whew! As you can see, both the sperm and the egg are working on rather a tight schedule here - a matter of hours really. The *miracle of birth* is a rather appropriate description of the entire process. Seen in this light, you have the inclination to look around you, thinking that any of us was able to show up in this world is pretty amazing!

The process goes awry

You can easily see how a small "malfunction" in any one of these steps can result in the failure of the egg to get fertilized.

It's customary when you think of infertility to automatically assume that the problem lies with the female reproductive system. But, you may be surprised to learn that the cause of infertility on average is equally found in females and males alike.

In about 40 percent of the cases, in fact, the failure to get pregnant lies with the man. In another 40 to 50 percent, the problem is with the female reproductive system. And surprisingly, for up to 20 percent of the couples, the problem involves both partners in some way.

What puts you at risk for infertility?

And yes, to answer that question that is undoubtedly on the tip of your tongue right now, there are certain risk factors, as the medical community likes to call them, that may make some individuals more susceptible to this condition than other individuals. And some of them may be rather surprising and - at the very least - eye opening to you!

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Age

The first risk factor is age. Once a woman reaches a certain age, her fertility potential gradually declines. And believe it or not, it's at a relatively young age - 30! That's not to say that you'll never get pregnant once you hit this magic marker. Obviously that's far from the truth. But it does make the process harder for some people.

This tendency toward age-related infertility may be due to a higher rate of problems with the chromosomes occurring naturally in the eggs as they age. But, consider also that as a woman ages, she may have more general health problems which interfere with the ability to conceive. Another fact to keep in mind as well is that as a woman ages her risk of miscarriage increases.

While I've only mentioned women, the same can be said for men. As a man ages, he may be less fertile than his younger counterparts. For men, this seems to occur once he reaches his fortieth birthday.

Smoking

Another risk factor for infertility involves smoking tobacco. Both men and women who smoke cigarettes appear to reduce the odds of getting pregnant. Not only that, but if they smoke while they are receiving fertility treatment, this also affects the chances of the treatments effectiveness.

And along those same lines, miscarriages more frequently occur in women who smoke than those who don't.

Alcohol

Alcohol may also play a role in contributing to infertility. I'm not going to beat around the bush here. Once you're pregnant there is absolutely no "safe" limit on drinking. Even a little alcohol is too much.

The same, you may be surprised to learn, goes for the period in which you're trying to get pregnant. If you've been attempting to conceive, but you haven't sworn off drinking yet - even if you drink only a little - give it up completely to increase your chances of having a baby.

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Weight

I'm not just talking overweight here! If you're either overweight or underweight, this may indeed interfere with your chances of getting pregnant. For many women - especially in the United States - infertility is, in part, due to the sedentary lifestyle and the corresponding problem of being overweight.

The same though can be said for men. A man's sperm count may be adversely affected by his carrying extra pounds.

If you're underweight, you may also experience problems with conception. This is especially true of women who are plagued with eating disorders like anorexia nervosa or bulimia.

But you may also find it difficult to get pregnant if you've put yourself on any severe, calorie-restrictive diet as well.

Even women who are vegans seem to be at a greater risk of not being capable of getting pregnant. For these women, it's very often the lack of a specific nutrient, like vitamin B-12, folic acid, zinc, or iron which is causing the problem.

Excessive exercise

Okay! Okay! You say. If I sit around all day and eat candy I will increase my risk of not being able to get pregnant. Now, you tell me that if I exercise too much, I may not be able to conceive, too.

As confusing as it may sounds, yes! But, let's get this straight, it's not that half hour walk that you *should be taking daily* that's hindering your ability to have a baby.

Several clinical studies indicate that a woman who spends more than seven hours a week exercising may have problems with ovulation. If you exercise that much, consult your physician to see if that could be an obstacle.

Caffeine

Currently, this seems to be an ongoing debate within the medical profession. Could too many caffeinated drinks be associated with a greater risk of infertility? It's still an open question.

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On the one hand, several studies have shown that fertility decreases when caffeine intake climbs. Other studies have shown no such correlation exists. One thing seems fairly certain: if there is a correlation, it affects women more than men.

Your doctor visit

It is natural, after a full year of trying, to make an appointment with your gynecologist, or your husband's urologist about your infertility problem (or sooner if you have any extenuating medical issues!). But before you even set your appointment, you should prepare for it.

Your medical advisor undoubtedly will ask you some questions. Anticipating these and having other details ready for her will make your session less awkward and flow smoother.

For example, prior to your office visit, list the details concerning your attempt to have a baby. This information is vital if your doctor is to help you and to get at the root cause of your problems.

He'll ask you things like when you first started trying to conceive, how often you have intercourse, and how are they planned in relation to menstrual cycles. Don't be embarrassed. These are natural questions that he only has a purely medical interest in.

In fact, below is a list of potential questions he may ask you. By preparing ahead of time, you're providing your physician with the most accurate information possible.

- How long have you been having sex without birth control?
- How long have you been seriously trying to have a baby?
- How often to you have intercourse?
- Do you use any lubricants during this time?
- Do either you or your partner smoke?
- Have either of you been treated for any medical conditions, including sexually transmitted diseases?
- What are your stress levels like?
- Are you both satisfied with your personal relationships?

Your physician will then turn to each of you individually and ask you certain questions. For the woman, these questions may include:

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- What age did you begin having periods?
- What are your periods like? Are they regular? How long are they? And do you bleed excessively (are they heavy)?
- Have you ever been pregnant prior to this?
- Have you been evaluated for infertility previously?
- Have you been charting your ovulation? How many cycles?
- Are you currently being treated or have you ever been treated for other medical conditions?
- What medications, if any are you currently taking? Include in your answer any dietary supplements, vitamins, minerals and herbs?
- How are you eating? What's your typical diet like?
- Do you exercise - and how much?
- Has your body weight changed in the last several months or so?

These questions are asked to evaluate you for the risk factors involved in infertility. Similarly, he'll ask the male a few questions as well.

- At what age did you start puberty?
- Do you now or have you had any sexual problems in your current relationship? Are you having difficult maintaining an erection, do you ejaculate too soon or not at all?
- Do you use recreational drugs? Do you use marijuana? If so, how often?
- What, if any, prescription medications are you currently taking?
- What supplements are you taking, including vitamins, other nutrients and any herbal ones?
- Do you regularly take hot baths or steam baths?
- Have you ever conceived a child with a previous partner?

When you walk into your doctor's office two things will happen, almost guaranteed. He'll ask you some of the questions we've just covered. And you'll have a head full of questions of your own to ask him.

When it comes to the second part, I'll give you one piece of advice - write your questions down on a piece of paper. Oh, yes! I don't know what it is about a doctor's office, but once we step foot in there, our brains disengage so that we can't think of even the simplest question we had for him.

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Then, once we walk out, get in our cars and head home, all the questions come flooding back. It happens every time.

So, even though you *think* you'll never forget to ask this question or another, you just might. But if you write it down - even the most obvious - then not only can you get your questions answered, but you don't have to strain to remember them in the first place.

Here are only a few of the questions that most couples ask when they walk in for a consultation. Some of these questions no doubt are already on your mind, but others might not be yet.

- Why can't we conceive?
- Do we need to undergo tests? If so, what kinds?
- Do you have any idea yet what our first line of treatment might be?
- Are there any side effects associated with this particular treatment?
- If we use this treatment, is there a chance (and how great of one) that we'll end up with a multiple birth?
- How long will we be on this treatment?
- What if this doesn't work? Is there something else we can try?
- What, if any, are the long-term complications of this treatment?

Diagnosing the problem Involves testing . . . testing and . . . more testing

That about sums up what to expect on your visit to the doctor's visit. If you're serious about conceiving then you need to know that the process of attempting to decipher what exactly is wrong and if it can be overcome may be a long tedious process. The ordeal certainly will test your level of commitment to having a baby.

You also need to know that the outcome in about one third of the cases is that there is no specific cause - at least none that your physician can discern. If you turn out to be a part of this one-third you may very well feel

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cheated and lied to. That would be a natural reaction. But you must work past that.

And if you're still serious about having children, then look at all the options that are available to you in an entire gambit of settings.

Another word of caution with regard to the tests you are about to undertake: none of this comes cheap. Evaluation, even today, is still very expensive. And in many cases, your doctor may be performing tests not covered by your insurance.

As you can see testing for infertility is not something to be entered into casually. Indeed, it requires a degree of commitment on several levels, including time, money and emotions.

Both partners are evaluated during this process. For a man to be fertile, his testicles must be healthy enough to produce sperm. Not only that but the sperm must be ejaculated effectively into the woman's vagina. That's basically what your doctor will be evaluating.

Whose infertility is it, anyway?

It all starts with a general physical examination. In addition to questions about your medical history, any illnesses you may have had in the past, as well as any disabilities, your doctor may also ask you questions about any medications you're taking and your sexual habits.

One of the first tests you're likely to undergo a semen analysis. This particular test is considered one of most important exams. Don't be taken aback if your physician requests more than one semen specimen in order to get an accurate reading from this test.

One of the most common ways of obtaining this specimen is through masturbation. Another often-used method is through the interruption of intercourse and ejaculation into a clean container.

The semen specimen is then delivered to a laboratory which analyzes it for several criteria, including quantity, color and the presence of infections or blood.

In addition, the lab closely examines the sperm itself. The process determines the number of sperm present as well as the possible presence of any abnormalities in both the shape and the movement of the sperm.

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At times, two samples are requested simply because it's not unusual for sperm counts to fluctuate from one sample to the next.

The doctor also requests a blood test - aimed at determining the level of testosterone as well as a variety of other hormones.

You may also be put through an ultrasound test as well. A transrectal and scrotal ultrasound helps your physician find any possible evidence of conditions like retrograde ejaculation and ejaculatory duct obstruction.

And lest you complain about the tests you're going through as a man, your female partner is enduring a battery of her own. A woman's fertility depends on the release of healthy eggs - on a regular basis - as well as a reproductive tract that allows both the eggs and the sperm to pass into her fallopian tubes to get fertilized. Her reproductive organs, naturally, then must be healthy and functional.

To this end, the woman undergoes ovulation testing. This is a simple blood test that measures hormone levels that ultimately determine whether she is ovulating.

The condition of the uterus and fallopian tubes

As a woman you undoubtedly will go through a test with an excruciatingly long name - hysterosalpingography. This particular exam evaluates the condition of both your uterus and your fallopian tubes. In this exam, fluid is injected into your uterus, an x-ray is then taken to determine whether the fluid actually travels out of your uterus and into your fallopian tubes, the natural path the egg and sperm must travel.

If the fluid doesn't travel down this "path" it could signal a blockage or related problems. Sometimes, if this is determined to be the cause of your infertility, this blockage can be easily corrected with a simple surgery.

Another test, a bit more invasive and requiring a general anesthesia, is a laparoscopy. In this, a thin viewing device is inserted into your abdomen and pelvis for the purpose of examining your fallopian tubes, ovaries as well as uterus.

A small incision, usually eight to 10 mm in length is made right beneath your navel. A needle is then inserted into your abdominal cavity. The attendant then injects a small amount of gas - usually in the form of

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carbon dioxide - into the cavity which creates space for the entry of the laparoscope. This is an illuminated, fiber-optic telescope which can detect such problems as blockages or irregularities in both the uterus and the fallopian tubes.

One of the most common problems this test picks up is the presence of endometriosis and scarring. More often than not this test requires outpatient status.

Women, like their partners, also undergo hormonal testing. Used as a tool to check levels of hormones basic to ovulation, the tests also cover the thyroid and pituitary hormones.

A test that actually reviews the potential effectiveness of the eggs after ovulation, the ovarian reserve test, often includes a hormone test at the initial stages of your menstrual cycle.

Genetic testing may also occur simply to determine if there's a genetic defect presence that could be at the cause of your infertility. And finally, most women also endure a pelvic ultrasound. This particular procedure specifically looks for diseases in either the uterine or fallopian tubes.

Now before you start running in the other direction from the doctor, take solace in knowing that you may not be required to undergo all of these tests. It may be that the first test you take reveals the nature of your infertility.

The exact tests you actually take, as well as their specific order, depend on the various discussions you and your physician have as well as the agreement the two of you have made.

These tests also tell the doctor what kind of treatment would be best for your particular problems. Those tests form the basis of an entire chapter later in the book.

In the meantime, your mind is probably swirling in a hundred different directions - many of which are wondering if there were anything else you can do.

Chapter 2: **Let's Talk Miracles:** **Medical Treatments for Infertility**

I'm sure that was the treatment that Rene and John King were prescribed for their infertility. That doesn't mean that your treatment is going to be a carbon copy of that. That couple is quite a few years older than you, right?

No, don't just assume that Roseanne and Bill's treatments for infertility will work for you either - or that the doctor will even suggest them. Why not? For one thing, that couple is a few years younger than you - and the cause of their problems are different from yours.

So what can you expect, you ask?

It's natural to be nervous prior to engaging you and your partner into treatments for infertility. And I suppose it would make life a lot easier for everyone involved if there were just one all-around treatment for infertility.

But the truth of the matter is that treatments for this common problem are as varied and as unique as the couples are who are experiencing it. How your team of doctors and specialists handle your infertility depends on several factors, not the least of which are the root cause of your problem, how long you've actually been infertile, your age as well as that of your partner, and your own personal input into the treatments.

You need to know right from the beginning that some cases of infertility just can't be corrected. A woman, nonetheless, may stay become pregnant thanks to the marvelous increases in modern technology though. Talk about miracles!

The #1 Option: **Fertility drugs**

The first option most doctors present to couples unable to have a baby is taking fertility drugs. These drugs are of the greatest help to women who experience infertility due to ovulation disorders. The purpose of these

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medications is to regulate ovulation or in some cases actually induce the system into ovulation.

In many ways they affect your system like a natural hormone would -- especially the follicle-stimulating hormone, FSH, and the luteinizing hormone, LH. This is a very simple and noninvasive method. It makes sense it would be the first avenue that the medical community tries.

What type of fertility drugs?

Just what drugs you may be advised to take varies. There's a list of about nine medications that your prescribing physician may suggest you take.

The first one is called clomiphene. The brand names these go by include Clomid and Serophene. Taken orally, this particular medication is especially useful for women who need their ovulation stimulated because they suffer with polycystic ovary syndrome. But it may also be prescribed for other ovulatory disorders.

It works by triggering the pituitary gland to release more of the hormones FSH and LH, which in turn stimulate the growth of an ovarian follicle which contains an egg.

The drug human chorionic gonadotropin, or hCG, is usually given in conjunction with this drug. hCG stimulates the follicle to release an egg.

There's another medication, called Human menopausal gonadotropin or hMG, which doctors may prescribe you as an injection. This particular drug works best for those women who can't ovulate because the pituitary gland itself. For these women, the pituitary gland fails to stimulate the monthly cycle.

This drug bypasses the pituitary gland to influence the ovaries directly. Not surprisingly, hMG - which is probably given to you under the brand name of Repronex - contains both FSH and LH.

Another method of stimulating the cycle of the ovaries is simply through the use of giving your system FSH independently - without any other medication. You'll recognize if you're taking this through the brand names of Gonal-F and Bravelle.

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Don't be surprised if along with your prescription of FSH, your physician also hands you a second one for hCG. These two are often used in combination.

If the cause of your infertility is a menstrual cycle that's irregular or erratic, then you may be receiving Gn-RH, known as Gonadotropin-releasing hormone analogs. This specific treatment is quite often used for those women who ovulate prematurely. By that, I mean she has her period before the lead follicle is mature enough.

This form of treatment supplies the pituitary gland with the Gn-RH, enabling the doctor then to induce follicle growth through the use of FSH.

Another medication that you may be given orally is called Metformin - you'll probably discover the brand name is Glucophage. It's recommended when your physician believes that your infertility is caused by insulin resistance. Insulin resistance, by the way, is suspected as a cause in the development of polycystic ovarian syndrome.

If your menstrual cycle is irregular because you have higher than normal levels of prolactin, then you may very well find yourself taking the medication Bromocriptine. Sold under the name of Parlodel, this is the hormone which triggers milk production in women who have just given birth.

You may find that your doctor wants to prescribe a medication called an aromatase inhibitor. This class of medication, which includes letrozole and anastrozole, has not been approved by the U.S. Food and Drug Administration for use for the problem of infertility.

Aromatase inhibitors are drugs made specifically for breast cancer. Many doctors though prescribe it when clomiphene citrate is not effective. This is reserved for women who can't ovulate on their own. You need to speak with your physician about this if he recommends this drug. The manufacturer itself has warned physicians to refrain from using this. Its use may cause adverse health effects including birth defects and miscarriages.

Fertility drugs: So how many children may I have?

Ah! The question has crossed your mind. The use of fertility drugs may mean that you're giving birth - and that's what you want. But it may also

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mean you may have a multiple birth. This is especially risky when you use the types of drugs which are injected into your system. While the oral medications also increase the odds of you giving birth to more than one child, they are not as high as with the injections.

Now that's not to mean you'll end up with eight children. Not by any stretch of the imagination. But you may have twins or even triplets.

That's why - and you'll discover this as you take the treatments yourself - your specialist monitors the use of these drugs very carefully. While you're on these drugs you'll be taking blood tests, hormone tests and ultrasounds. The last of these is to measure the size of the ovarian follicle.

Multiple births raise the risk of your babies being born prematurely which in turn put them at a greater risk of health and developmental problems.

Reducing the risks of multiple births

There are some ways in which the risk of experiencing a multiple birth can be mitigated. For example, if a woman is taking hCG injections, the ultrasound shows the physician the amount of follicles that have developed. If it appears that there are too many - which increase the risk for a multiple birth - the physician may withhold an injection.

If too many babies are actually conceived, physicians may also remove one or more the existing fetuses. Called multifetal pregnancy reduction, this gives the remaining fetus better odds at survival - and at thriving.

This procedure though also carries serious emotional and ethical questions for many couples. This is one of those possible complications in fertility treatment that is best discussed before treatment begins. It's a decision that just cannot be made lightly.

Surgery as an option treatment

Depending on your cause of infertility, your physician may recommend that you undergo surgery. Used in many instances to remove blockages in the fallopian tubes, new laparoscopic techniques allow delicate operations on the fallopian tubes that prior generations could not have imagined.

The art of ART

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ART has arrived and it has revolutionized the way doctors now approach and treat infertility. Every year thousands of babies are born to couples formerly unable to have children thanks to Assisted Reproductive Technology (ART).

These couples are now blessed with their own biological child or in some cases children. ART is indeed an art form in itself. This approach to infertility is a team approach.

ART is most effective when the female part possesses a healthy uterus and responds well to fertility drugs. It's also effective when the woman ovulates naturally, or uses donor eggs.

For the male partner's part, these varied techniques stand the best chance of succeeding when he has healthy sperm, or through the use of donor sperm.

ART loses some of its inherent effectiveness as a treatment for couples after they turn age 35.

A couple using this treatment has on their team not only their physician, but psychologists, embryologists, laboratory technicians, nurses as well as a variety of allied health professionals to assist them.

Fast Facts: IVF

IVF is most popular with women younger than age 35 who aren't experiencing problems with their partners' sperm.

Using IVF may help a woman avoid surgery on her fallopian tubes. IVF, in fact, has reduced the need for this surgery by nearly 50 percent.

About 63 percent of women using IVF give birth to single babies; 32 percent of births are twins and 5 percent are triplets - or more.

Safety? Despite previous studies which found that children conceived through the IVF method possessed a slightly increased risk of genetic disorders, the most recent research shows otherwise.

Nearly 1,000 children, conceived through this process, in five European countries were monitored, from birth to their fifth birthday. They were every bit as healthy as children conceived naturally, the study showed.

In vitro fertilization -- IVF --

The most effective technique

Assisted reproductive technology takes many forms, depending on the specific needs and situations of the couples involved. One of the most popular of these is in vitro fertilization or IVF for short. It's not only one of the most popular treatment for infertility, it's also recognized worldwide as the *established therapy* for this condition.

Considering its popularity, you may be surprised to learn that less than five percent of the infertile couples use this procedure.

If you and your partner are considering this procedure, you'll discover that the first step is the administration of hormones designed to stimulate your ovaries into producing several eggs.

Once the eggs have been produced then a surgeon inserts a needle through the vagina and on into the ovaries in order to retrieve the eggs as well as the fluid the eggs in which the eggs are residing.

While you've not give a general anesthetic for this portion of IVF, you may be given a sedating medication of some kind.

What If . . . IVF Doesn't Work for Me?

And this does happen at times. There is always the possibility that you go through this prolonged and emotionally exhausting procedure - only to discover that for some reason, you really aren't pregnant.

You have a huge emotional investment in this process. Don't be embarrassed or ashamed of being emotionally overcome if this doesn't work.

Now what? You confront and manage the emotional aspect of this procedure. Having a baby means too much to you to just sweep the failure under the rug.

It's very likely that you told very few people except your very closest family members and your most trusted friends. And that's to be expected.

But now that means you're facing one of the most emotionally draining moments of your life with very few people to lean on.

Consider joining a support group. With the marvelous technology of the internet you have the choice of joining a group like this whether you can find one in your area to physically attend or not.

Sometimes even the "cyber-support" of others who have gone through what you have or are going through it now, can be of great value to you.

I've included some resources in Appendix II of this book that may help you in locating either a local group or an online support group.

You may also want to ask your doctor for the names of any well-qualified counselors you and your partner may visit.

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Testing occurs to insure that eggs are indeed within the fluid.

At the same time, the male partner provides the laboratory with a semen sample. He's requested to refrain from sex for several days prior to his giving this sample. The sperm, then, are separated from the semen itself.

Now, is the moment you've been waiting for. The sperm are combined with the eggs in a laboratory dish. This is the part of the procedure from which we get its name: in vitro fertilization. The "in vitro" part of the name refers to a process (and technically any process) which occurs in a laboratory outside a living creature.

Surprisingly, it takes only 18 hours to know if the sperm has fertilized the eggs and if they have begun the process of growing as embryos. If the sperm "have done their job" then the eggs are incubated. Laboratory staff then carefully monitors the progress for the following two to three days.

After that, the doctor transfers what are now referred to as embryos from the laboratory dish into the uterus. He or she does this by going through the cervix using a catheter. For an hour after this occurs, you need to stay in a resting position.

For the two weeks which follow, you'll be given more hormones. If the implantation takes hold, the eggs actually attach themselves to the uterine wall and continue to grow. You'll be given a pregnancy test, to confirm that indeed that everything is on course. And yes, it'll show loud and clear that you are indeed pregnant. Congratulations!

When IVF is most useful

This procedure is often recommended when both fallopian tubes are blocked. It's also used in the presence of endometriosis, cervical factor infertility, and various disorders which disruption regular ovulation. A doctor may also recommend this procedure when the cause of fertility can't be established or when the infertility is caused by some disorder of the male.

The only disadvantage to this treatment is the increased risk of multiple births. And it only goes to reason since there is more than one fertilized egg being implanted into the female partner. IVF requires quite a bit of monitoring as well, in the form of frequent blood tests and daily hormone injections.

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ICSI, or Intracytoplasmic sperm injection (now you see why it's been shortened to ICSI), is another form of ART. In this one, a single sperm is injected directly into an egg for the purpose of fertilization. Once the egg is fertilized then the IVF process is used. Especially effective in couples who have tried all the other standard treatments, ICSI it's also extremely helpful for those situations in which the man's concentration of sperm is low.

The gift of GIFT

Isn't that an appropriately named procedure - GIFT? Of course you know it's an acronym. And wouldn't you know its real name leaves most of us in the dark: Gamete IntraFallopian Transfer.

Yeah, now that's romantic. Well, it might not sound romantic, but the gift of GIFT has allowed many couples to experience, ultimately, the gift of a biological child of their own.

This procedure resembles IVF very closely. But where IVF fertilizes a woman's egg outside of her body, this technique allows the egg to become fertilized in her fallopian tubes.

Let me explain. Both the male and female germ cells - or gametes - are injected into the woman's fallopian tubes specifically for fertilization. In a man, a gamete is the sperm. A woman's game is the eggs, or ova.

Specifically, health professionals stimulate the female eggs using various medications. Then they're collected using a process called aspiration. From here, three or four of the eggs are combined with no less than 200,000 sperm inside a catheter and then transferred inside the fallopian tubes of the woman using a surgical procedure called a laparoscopy.

GIFT is classified as a more invasive procedure than IVF because it does make use of the surgical procedure. It's most useful when ovulatory disorders or cervical problems lie at the core of the couple's infertility problem.

But it's also a very useful procedure if the male is experiencing a low sperm count.

You've probably already guessed that the success of this procedure depends upon the health of the woman's fallopian tubes. If the tubes are blocked, this would not be the appropriate treatment.

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But many females experiencing endometriosis find this to be successful for them.

So just how successful is GIFT?

Approximately 35 % of the couples who use this procedure actually get pregnant, and 27 % of the couples experience a live pregnancy

Couples are drawn to this particular technique because it allows them to deliver a baby as close to natural means as possible. Some women prefer GIFT for the sole reason that it allows for the fertilization of the egg inside their bodies, instead of in a "cold, sterile lab."

As with any procedure, there are some disadvantages to it. One of them is the more invasive nature of the technique compared to IVF. GIFT also possesses a greater risk of multiple births, which in turn can create pregnancy complications - some of which may be serious.

Babies produced in this manner in general have a lower birth weight than those conceived through other techniques. But not only that, there seems to be a greater risk of the baby being born with some type of birth defect.

Used in men with spinal cord injuries - an ART procedure called electric or vibratory stimulation has been very effective for some couples. The electric stimulation helps to facilitate the ejaculation in order to obtain the necessary semen.

Another method of retrieving sperm from the male is called surgical sperm aspiration. This technique actually removes sperm from an area of the man's reproductive system, such as the vas deferens, testicle or the epididymis. In this way the sperm is retrieved should the ejaculatory duct be blocked.

Remember the phrase artificial insemination?
Well, it's now called Intra-uterine insemination.

Confused? Many couples are. However confused you may appear to be initially, it's worth your time and effort to take a look at IUI - intrauterine insemination.

This is by no means a new technique. But did you realize that it's been an option for couples since the 1940s. Who knew?

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IUI can be a very effective treatment option for certain couples. It's especially effective when the female partner is younger than 41. If you have any of the following problems though, this procedure isn't viable::

- Ovarian failure (either natural or premature menopause)
- Severe male infertility
- Blockages of the fallopian tube
- Severe endometriosis

IUI, in fact, is usually the treatment of choice for infertility that has no apparent cause. But it has also proved to be a godsend for those couples in which the woman is suffering with endometriosis or other problems with ovulation as well as infertility caused by the disorders of the cervix.

IUI may also be used if the infertility has been determined to be on the part of the male.

According to many medical specialists, Insemination is a logical treatment to use in the initial stages of infertility therapy. Used for a maximum of four months on women who are ovulating - that is producing and releasing an egg every month, it can be used longer in some special incidences.

A woman with polycystic ovaries (PCOS) for example, or who is currently taking drugs to stimulate ovulation, may find that IUI therapy lasts for longer than this recommended length of time.

Now that I've prepared you for IUI, you're naturally curious to what's actually involved in the process. And that's reasonable.

Your first step in the IUI technique is taking medication that stimulates the development of more than one egg. The insemination is then timed to coincide with your ovulation or the release of your eggs.

The male partner produces a semen specimen through masturbation following a minimum two day period of abstinence from ejaculation.

This sample is then "washed" in the laboratory. You'll hear this part of the technique referred to as either sperm processing or sperm washing. In this procedure, the sperm separates from the other parts of the semen so it can be concentrated into a small volume. Sperm washing is performed through a variety of media and techniques. It doesn't take long, at most 60 minutes.

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The vagina is prepared for entry and the cervical area is gently cleansed. This part of the procedure may vary from individual to individual. Your doctor may choose to place the sperm in your cervix, in which case, this procedure is technically an intracervical insemination or an ICI.

If he instead places it farther up in the uterine cavity, then it's technically called an intrauterine insemination. In either version, he'll use a sterile, flexible catheter to accomplish the placement of sperm.

And the last option used in Assisted Reproductive technology is called 'assisted hatching'. Even though it sounds as if it's something performed in a chicken coop, it's a treatment for infertility that gets relatively good results. The technique assists with the implantation of the embryo into the lining of the uterus.

Are there any complications with ART?

As with any medical treatment some couples may experience complications. One of the most prevalent is multiple births. The number of quality embryos kept and then matured to fetus status and birth is in the final analysis made by the couple themselves.

It's not an easy decision to make - and it's a decision most couples don't have a lot of experience in making. If too many babies are conceived, the couple does have the option, as we stated earlier of removing one or more of them. Called multifetal pregnancy reduction, this may improve the chances that those fetuses still in the mother will survive.

Another possible complication of these treatments is ovarian hyperstimulation syndrome, or OHSS for short. A woman's ovaries, if over stimulated, may enlarge causing her bloating and pain. While treatment is seldom necessary for the mild to moderate symptoms, the actual pregnancy may delay the woman's recovery.

In rare instances, fluid accumulates in the woman's abdominal area as well as the chest. This causes abdominal swelling as well as shortness of breath.

But there are other problems that can arise from this fluid accumulation as well. This includes a depleted volume of blood and a low blood pressure. In some severe cases, emergency treatment is necessary.

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The younger the woman undergoing this treatment, the greater the odds are that she'll experience these complications. Additionally, women with polycystic ovary syndrome also find themselves at a greater risk of OHSS.

Every invasive procedure carries with it the risk of excessive bleeding or acquisition of an infection. This can be said for any of the ART techniques as well.

Some research reveals that there may be an increased risk of birth defects when couples conceive through an ART procedure. Currently, there is not enough research confirming this. This piece of information needs to be in the front of your mind while you're weighing your treatment options.

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References

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Go to <http://hormoneinfertility.com/sales.html>