

Commonly Asked Questions and Answers About Infertility

Robert B. McWilliams, MD

Reproductive Endocrinology and Gynecology
7400 Fannin, Suite 1180
Houston, Texas 77054
Phone (713) 790-9900
Fax (713) 790-99011

- 1. Are infertility rates on the rise?** No. Infertility is a condition that affects 10-15% of the population of reproductive age (12-50 years of age). Infertility **appears** to be on the rise as there are more couples in the United States than in the past, and more of these infertile couples are seeking professional help. As reproductive technologies continue to improve fertility over the recent years, more couples become informed and seek help to eliminate their inability to conceive.
- 2. How long do eggs and sperm live once they are released?** Ovulated eggs live 18-24 hours while sperm live up to 3 days in the reproductive tract. For this reason, frequency of intercourse is recommended on an every other day basis the week preceding and including the day of ovulation.
- 3. What is the most accurate way to assess ovulation?** By assessing blood hormone levels such as estrogen and progesterone, using urinary LH predictor kits, and pelvic ultrasounds, approximately 90-95% of the time, appropriate ovulation of a fertilizable egg can be determined per cycle. This compares to 50% when BBTs (basal body temperatures) are used alone.
- 4. What is the definition of infertility?** Infertility is the inability to conceive after one year of unprotected intercourse. Approximately 85-90% of couples will conceive by the end of one year if no infertility factors exist.
- 5. Does the use of birth control pills (BCPs) decrease my future fertility rates?** No. Since BCPs work by the prevention of ovulation, decreasing benign ovarian cysts, affecting cervical mucus to limit the migration of some sexually transmitted diseases, and lowering the ovary's production of hormones, many feel that women might actually be more fertile after years of BCP use.
- 6. What is the fertility rate of fertile couples?** Fecundity, the ability of a couple to produce a child on a monthly basis, is 20-25%. After 3 months, it is 50%; after 6 months, it is 65%; and after 12 months, it is 85-90%.
- 7. How do BBTs (basal body temperatures) work and are they accurate?** When a woman ovulates, hormonal production of progesterone from the ovary causes the temperature to rise approximately 0.5 degrees F. Unfortunately, a woman's basal body temperature can rise even though no ovulation takes place. The release of a fertilizable egg is the definition of ovulation. Luteinization is a process whereby progesterone is produced by the ovary. In many instances, up to 50% of the time, a woman can produce progesterone at mid-cycle and still not release an egg. Together with the fact that BBTs remind the couple of their infertile status daily, many physicians no longer recommend BBT charting.

8. **Is it true that “if you just relax and stop worrying, you’ll get pregnant right away?”** This most common myth about conception is false. As the single most counterproductive piece of advice given to infertile couples, it places more guilt on the already stressed couple. Stress is, and has always been, a major cause of suppressing egg and sperm production.

9. **Isn’t infertility usually a female problem?** No, approximately 30-40% of the causes of infertility is female related. That same percentage, 30-40% is due to male factors, 20% is combined and 5% is unknown. For this reason, it is imperative that the male be assessed by semen analysis early in the infertility workup.

10. **Are we taking a risk of becoming infertile if we “wait to have our children” until the mid 30s?** Possibly. Many females experience a significant reduction in their fertility by their mid 30s secondary to their inability to produce fertilizable eggs. Fortunately, the ovary’s ability to produce quality eggs can be assessed by blood tests known as endocrine profiles and CCT, clomiphene challenge test.

11. **How do environmental factors affect fertility?** Long-term exposure to toxic chemicals may affect female and male fertility in addition to increasing birth defects. Production of quality gamete (eggs and sperm) production within the ovaries or testes can be compromised with long-term exposure. Exposure to heat can interfere with a man’s ability to produce quality sperm. Exposure to radiation can affect both men’s sperm and women’s egg production.

12. **How does recreational drug use affect fertility?** Heavy use of any and all recreational drugs may cause detrimental effects to the production of quality sperm and eggs. Even some prescription drugs such as anticancer chemotherapy, steroids in high doses, certain ulcer prevention drugs such as cimetidine, some antibiotics, and DES (diethylstilbestrol) can cause major suppression of gamete production. The same is true for the excessive use of tobacco, alcohol, and caffeine.

13. **In addition to the best known STDs (sexually transmitted disease) gonorrhea, syphilis, and AIDS, what other STDs can cause a loss of fertility?** Chlamydia, the most prevalent form of STDs (three times more common than gonorrhea) is an example of a symptom less pelvic infection that can reside in the cervix of a woman for many years. If gone untreated, this infection can lead to PID (pelvic inflammatory disease) with damage to the fallopian tubes. Ureaplasma urealyticum, mycoplasma hominis, trichomoniasis, yeast, and bacterial vaginosis are other forms of STDs that help create a “hostile environment” within the vagina or cervix thereby limiting passage to adequate sperm through the cervix for fertility to take place. Genital herpes does not directly affect fertility but does make intercourse painful and can affect the fetus if exposure occurs.

14. **Why is it important to see a fertility specialist?** As with any profession, the more time one spends in developing skills to diagnose a problem and treat it successfully, the more successful the outcome. Reproductive endocrinologists are obstetrician/gynecologists who have had extra training (a fellowship in Reproductive Endocrinology) in understanding all aspects of reproduction. Having a single physician who understands your needs is very important. He/she serves as your communicator as well as your coordinator and counselor/consoler for the many diagnostic and treatment modalities necessary to identify your particular causes of infertility.

15. **What is meant by “the basic 5-step workup of infertility?”** Based on the most common causes that lead to infertility, the five steps of a basic diagnostic infertility workup include: 1) assessment of the woman’s ovulatory function by the use of hormonal testing, urinary LH kits, and pelvic ultrasonography; 2) assessment of the male’s fertility by use of a semen analysis; 3) ability of the sperm to move through the cervix (mouth of the uterus) by performing a PCT (postcoital test); 4) assessment of the uterine cavity and fallopian tubes by an HSG (hysterosalpingogram); and 5) assessment of the female’s pelvis to rule out anatomic or untoward hormonal factors associated with infertility by an outpatient surgical procedure known as a laparoscopy.

16. **Are drugs used to help a woman ovulate dangerous?** If properly used in appropriately screened anovulatory patients, ovulatory drugs are safe. Depending on the patient’s needs, past history, and discovery of any significant risks factors, these drugs have not been shown to increase health risk to either the patient or her offspring.

17. **What is endometriosis and how common is this disease among infertile women?** Endometriosis is a condition that exists in more than 25-30% of the female population where uterine lining cells (endometrium) are found outside the uterine cavity. It is a poorly understood disease that is found in approximately 50% of women who suffer from infertility. The most widely held theory on how endometriosis begins is that small amounts of endometrial tissue escape up the fallopian tubes into the abdomen during a woman’s menstrual period. This process probably occurs during most menstrual cycles in all women. The body’s ability or lack of its ability to protect itself from the infertility consequences of this ectopic “out of place” tissue is currently under extensive investigation.

18. **Is the use of clomiphene citrate (Clomid, Serophene) a good alternative for couples with “unexplained infertility?”** Not necessarily. The synchronization of the ovulatory process depends on proper communication between the brain and ovaries/testes. To add clomiphene citrate to the regimen of a couple’s treatment before diagnosing the causes for poor ovulatory functioning can only make the couple even more infertile. Furthermore, acting as an anti-estrogen, many negative effects on cervical mucus, endometrial lining, and even the LH surge preventing ovulation can exist in patients using Clomid. For this reason, many specialists have named this drug, “the most commonly abused fertility drug.”

19. **What is an average cost for a single IVF cycle across the United States?** According to many who have looked into this issue, an average cost of approximately \$9500. This figure does not include drug costs.

20. **What is an average “take-home baby rate” for a single IVF cycle across the United States?** According to the SART (Society of Assisted Reproductive Technology), the average live baby rate per IVF cycle is approximately 35-40% today. This percentage has continued to improve over the past 20 years as newer techniques in the office and the gamete laboratory have come closer to mimicking nature’s own ability to conceive.