

## Chapter 1

# Where, Oh Where, Can My Baby Be?

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### *In This Chapter*

- ▶ Understanding infertility
  - ▶ Exploring the odds of getting pregnant
  - ▶ Researching your family tree
  - ▶ Adding up the costs of infertility
  - ▶ Realizing why getting pregnant can be hard today
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**I**f you're reading this book, the odds are good that you want to have a baby. You may actually have been trying to have a baby for a while without success, and maybe you're becoming frustrated, annoyed, and a little scared — are you *ever* going to have the family you've dreamed of?

We want to help make this process easier for you — less stressful and more successful. In this chapter, we tell you the official definition of infertility (it may surprise you!), show you statistics on infertility today, show you how to shake your family tree for genetic problems and talk about the cost of infertility — the emotional cost as well as the monetary cost.

## *Defining Infertility*

Infertility as defined by the experts may surprise you. According to guidelines established by infertility specialists, you're not considered to be infertile until you've been trying to get pregnant for one year, if you're under age 35. That means that trying to get pregnant last week and not having signs of pregnancy this week does *not* mean that you're infertile.

However, since the modern world is one of immediate gratification, it can be hard — if not downright impossible — to try to get pregnant for a full year without getting impatient, discouraged, or just plain panicked. There's nothing wrong with going to see your gynecologist to talk about why you're not getting pregnant after just a few months; in fact, your co-authors, being fairly impatient people themselves, would consider you to be a candidate for sainthood if you could wait a year without talking to your doctor. One year is, however, the official definition.

## *Infertility in America — Looking at the Statistics*

Most women know that the older you get, the harder it is to get pregnant. But what about race, socioeconomic status, geography and heredity as fertility factors? In the next sections we look at how infertility affects different groups.

### *Making babies: An inefficient process at best*

You may think of Mother Nature as a pretty efficient woman, but the truth is, the path to pregnancy is an inefficient one even under the best of circumstances. For example, out of 100 couples under the age of 35 trying to conceive, only 20 will get pregnant in any given month, and of those 20, 3 will miscarry. In other words, if you're under 35, every month you have a 17 percent chance of walking out of the maternity ward with a baby nine months later. Obviously, nature is not as efficient as people think.

Looking at 100 women under age 35 trying to get pregnant, the breakdown will look like this:

- ✔ 80 will be pregnant within one year
- ✔ 10 more will be pregnant after two years of trying without medical intervention.
- ✔ 10 won't get pregnant without some help from the medicine man.

High-tech infertility treatments, such as in vitro fertilization, claim a success rate of about 50 percent for those under age 35, which means 5 out of 100 women will not become pregnant, even with medical intervention.

### *Age and infertility*

If you're over 35, you're in good company; 20 percent of all first-time moms in the United States are over 35! Despite this, Mother Nature doesn't make it easy to get pregnant past age 35. (We look more at age and infertility in Chapter 6.)

For example:

- ✓ By your late thirties, 10 percent will get pregnant in any given month and 17 percent of those will miscarry.
- ✓ If you're over 40, the pregnancy rate, per month, slips to 5 percent, with 34 percent of those miscarrying.
- ✓ By age 45, your chance per month of conceiving is less than 1 percent, and 53 percent of those will miscarry.

### *Race and infertility*

Does your racial background affect your chance for pregnancy? There is a slight difference in infertility rates, with Hispanic women under 35 experiencing a 7 percent infertility rate, Caucasians a 6.4 percent infertility rate, and African American women recording a 10.5 percent rate of infertility. These differences could be due to socioeconomic factors, such as poverty, poor nutrition, or lack of physician care, rather than strictly racial issues.

### *High-tech treatments and infertility*

If you're already frantically reading your insurance booklet and shaking the piggy bank in hopes of finding a few spare thousand dollars to pay for high tech infertility treatments, you might take comfort in the following statistic: only around 3 percent of infertile couples end up doing high tech treatment like in vitro fertilization (IVF) to get pregnant. (You can find everything you need to know about IVF in Chapters 15 to 18.)

## *Shaking Down the Family Tree*

It may seem silly to look to your family tree for signs of infertility that could be inherited; after all, *you're* here, so how could your parents have had fertility issues?

### *Putting together a family birth history*

Most of us don't ask our parents about their road to parenthood until we're trying to become parents ourselves. But you might be surprised to learn that

it took your parents a number of years to have you or your siblings. It's also possible that people in your family tree may be adopted or the product of artificial insemination, issues that often weren't discussed a few decades ago.

While family lines who are completely infertile tend to die out in a generation (for obvious reasons), some families may be sub-fertile, with less than average sperm counts or ovulation issues, and still manage to have a child or two.



Ask the most talkative member of your family for a family "birth history." You may be surprised what you learn. And remember, sometimes a vehement denial, such as "there's never been any problem in *our* family," may be a clue to dig a little deeper and find out why everyone is so defensive.

## *Finding out important information*

Researching your family history can provide valuable information. For example, you may learn of family genetic tendencies that could cause problems on your own reproductive road. Or you may find out that everyone in your family took six months to get pregnant, a fact that may put your mind at ease, particularly around month number five of trying without success.

Before trying to get pregnant, you'll want to know whether any diseases occur more than once on your family tree. This disease may be caused by a dominant gene that you could pass on, if you carry it, even if your partner doesn't carry it. Depending on how open your family is, finding out this information can be difficult. Many families don't discuss anything related to pregnancy, especially not problems getting pregnant, pregnancy losses, or genetic defects. Just a few generations ago, parents of children with genetic abnormalities were encouraged to put them in a home and tell the relatives the baby had been stillborn.

If your family tree does hold a genetic problem or a birth defect that shows up more than once, you'll probably want to have genetic testing done. A gene map, which can be done from a blood test, will show whether you carry abnormal genes that could cause problems for your child.

Sometimes the only thing you learn from family records is nonspecific, such as "all the Smith boys died young." Try and pin down why they all died young: Did they have hemophilia or muscular dystrophy, or did they all fall out of the same apple tree?

You may also want to ask your mother whether she took any pills during her pregnancy, or whether her doctor gave her anything to prevent miscarriage. Women whose mothers took DES, a synthetic estrogen hormone, to help prevent miscarriage may have a T-shaped uterus, which may make it difficult to carry a pregnancy. Almost 5 million women were given DES by their doctors

between 1938 and 1971, and as many as 50 percent of their daughters may have infertility issues related to DES exposure. Studies are now beginning to be done on problems that affect DES sons and their fertility. The following male problems may be linked to DES:

- ✔ **Varicocele:** An enlarged vein in the testicles that can affect sperm production
- ✔ **Undescended testicles:** Testicles that fail to descend into the scrotum
- ✔ **Hypospadias:** A misplacement of the opening on the end of the penis



Don't be too hard on Mom for not telling you everything. Many women aren't even aware that they took DES until their children enter their reproductive years and begin experiencing problems. Asking the doctor what was in the pills he gave you wasn't something many women did in the 1950s and 1960s.



If you and your partner are blood relatives, it is especially important to see a genetic counselor before getting pregnant. You may carry more of the same abnormal genes than unrelated partners would, which may make you more likely to have a child with a genetic problem. The risk for serious birth defects is 1 in 20 for second cousins and 1 in 11 for first cousins.

## Checking the stats of your race

Even if you're not aware of genetic illnesses in your family, certain populations tend towards specific issues. For example, while sickle cell anemia occurs in 1 of 8 African Americans, cystic fibrosis can be found in 1 out of 26 Caucasians and at an even higher percentage among Ashkenazi Jews. Other diseases such as Tay-Sachs and Gaucher are also prevalent among the Jewish population.

Many OB/GYNs suggest screening for the most likely diseases based on your heritage. It doesn't hurt to get this done *before* you become pregnant. While many genetic diseases are recessive, meaning that both parents must carry the gene in order for the baby to develop the disease itself, should you turn up to be a carrier, your partner can be tested right away. If both you and your partner are carriers, each child from your union holds a 25 percent chance of inheriting both genes and thus the disease. Fifty percent of your children will be carriers of the disease and twenty-five percent will not have *or* carry the disease.

Remember, these are all statistical numbers. Some families where both parents carry a recessive gene disorder have multiple children in a row who have the disease, despite the 25 percent odds per child. Other families don't. Statistics are based on large numbers of people and the likelihood of any one event occurring. You and your family may fall into the statistical pattern or not.

## The good news about inherited diseases

When it comes to inherited diseases, you have options your grandmother and mother never did. You can receive pre-pregnancy genetic counseling or have early pregnancy testing of the fetus for abnormalities. Your grandmother, who may have had children well into her 40s, was more likely to have a baby born with chromosomal abnormalities. Such problems are more common in women over 35, and there was no way to test for them during pregnancy in earlier generations. Your mother may have been afraid to have more than one child if she knew

there was a family history of cystic fibrosis or muscular dystrophy. The problem that your aunt had during pregnancy from an inherited bleeding disorder is now a condition that can be diagnosed and treated during pregnancy, increasing your chances of having a healthy full-term baby. Rh factors may have caused fetal death just two generations ago, but they can now be easily prevented by an injection of RhoGAM, which prevents the growing fetus from having its blood cells attacked in utero.



In the case of diseases such as cystic fibrosis, just because you don't see evidence in your family tree doesn't mean it isn't there. Eighty percent of families who give birth to a child affected with cystic fibrosis have never had an incidence of the disease in their family. That's because recessive disorders require two carriers in order to produce the disease in their offspring. Even if two carriers do reproduce, there is still only a 25 percent chance per child that any given baby will have the disease itself. Thus, carrier status can be passed along for generations without ever showing up as the disease itself. Testing is the only way to know for sure.



If you do uncover a "bad" or questionable gene through testing, don't panic. This is the reason for testing in the first place. Before you make out a will or go hunting down your mother, father, or great-great-aunt to give them a piece of your mind, remember this:

- ✓ Not all gene mutations are disease causing. Some are merely benign changes. These differences are what make us all unique individuals.
- ✓ If you're a carrier of a recessive genetic disorder, you're carrying only one gene and will not get the disease. You're simply a potential conduit.

## What Causes Infertility?

Infertility has many causes, and figuring out which applies to you may be very simple — or very difficult. Although women used to bear the brunt of

blame for infertility, the truth is that male and female factors share equally in infertility. Consider the following statistics:

- ✓ One third of infertility is caused by female factors
- ✓ One third of infertility is caused by male factors
- ✓ Around 20 percent of infertility is unexplained
- ✓ Around 10 to 15 percent of infertility is caused by a combination of male and female factors

Among women, the main causes of infertility are:

- ✓ Ovulatory disorders — no ovulation or irregular ovulation
- ✓ Tubal disorders — blocked or infected tubes
- ✓ Uterine issues — fibroids, polyps or adhesions

For men the most common causes of infertility are:

- ✓ Low sperm count
- ✓ Decreased sperm motility
- ✓ Abnormally shaped sperm
- ✓ No sperm at all in the ejaculate

Each of these categories of infertility can be caused by a number of things; for example, a decreased sperm count can be caused by a disease such as diabetes, by a birth defect, or by trauma. A woman can have blocked tubes from endometriosis, pelvic inflammatory disease, or from a congenital malformation. Anovulation can be caused by polycystic ovarian syndrome, premature ovarian failure, or by over-exercising. While it may be fairly obvious what the problem is, finding the reason for the problem may be more difficult.

## *Diagnosing Infertility*

You may think this is a no-brainer: If you're not getting pregnant, it seems like you've already diagnosed yourself with infertility! However, diagnosing a lack of pregnancy is the easy part; figuring out why you're not getting pregnant is the hard part.

After reading through Chapter 5, which discusses simple techniques for increasing your pregnancy odds, or Chapter 10, which explains some of the tests used to diagnose infertility, of this book, you may be able to diagnose

the reason for your difficulty in getting pregnant without any help from your doctor. For example, you might be having sex at the wrong time of the month — your “infertility issue” may be solved with a calendar, a thermometer and an ovulation predictor kit! Or you may not have realized how irregular your periods were — 35 days apart one month, 40 the next, 60 the next — maybe you're not ovulating on a regular basis.

Your gynecologist can run a few simple blood tests to help determine whether or not you're ovulating. Ovulation is, after all, the first step in getting pregnant, and usually blood tests or observation of your own cervical mucus and temperature (see Chapter 4 for ways to figure this out) can help you figure out when you're ovulating so you can time sex accordingly.

If you're still not pregnant after six months of “hitting the mark,” it's time for more testing; your doctor may suggest a test to see if your tubes are open and testing on your partner to see if “his boys can swim.”

This process of looking for the problem and then seeing if it's fixed can take a few months. Only 20 percent of infertile couples never have a definite answer to why they can't get pregnant, so the odds are your favor.

## Getting Pregnant: More Difficult Today than Yesterday?

Sometimes things seemed easier in Grandma's day. Large families were common, and it appeared that everyone had children. In fact, getting pregnant may be harder today, for several reasons:

- ✔ **People are having children later in life.** Over age 25, there is a slight but definite decrease in fertility in women, a decrease that increases dramatically over age 35. Men are also less fertile at older ages.
- ✔ **Due to better medical management, people are living longer and getting pregnant (or trying to) despite the presence of serious chronic disease, such as diabetes or lupus.** In the past, just the *presence* of these conditions would have precluded the possibility of pregnancy.
- ✔ **Male infertility, related to decreased sperm counts, has increased.** Many theories circulate as to why this is occurring, with environmental factors being carefully studied.
- ✔ **The incidence of sexually transmitted diseases has increased.** Some of these diseases, such as chlamydia, cause serious damage to the reproductive organs.

- ✔ **More men and women have had either a vasectomy or a tubal ligation at a young age and then decided to have another child.** Needless to say, they immediately face fertility issues due to their previous choices.
- ✔ **It may seem as if everyone had children years ago, but start asking questions and you'll get a different story.** You may find out that Uncle Charlie wasn't really Aunt Jo's son; he was her sister's child, whom she raised after his mother died young, and on and on. Everyone may have been raising children, but many of those children may have been extended family members.
- ✔ **People today talk more.** Just because you never heard about your grandmother's stillborns or your mother's miscarriages doesn't mean they didn't happen. Pregnancy talk today is big business, and everyone in the world seems to be in the news talking about their babies, lack of babies, adopted babies, and how they got pregnant. This focus puts a constant in-your-face emphasis on pregnancy. It also makes you feel, when you're trying to get pregnant, like everyone else is doing it — and doing it better than you are!

Relax, this is only the beginning for you, and we do our best to help you start baby making with the best of them.

## *Calculating the Cost of Infertility*

Infertility costs a lot. We're not just talking money here; the emotional toll is usually much higher and longer lasting than any hit to your pocketbook. In the next sections, we look at the costs of infertility on your self esteem, your marriage, and last of all (because it's really the least important) on your wallet.

### *The emotional costs of infertility*

Infertility is not for the faint of heart. Will it test your mental, physical and spiritual strength? Um, possibly. Will you come out a better person than before? No guarantee, but as with all of life's challenges, the better prepared you are going in, the more likely your psyche is to survive and thrive.

In this book, we discuss a lot about support, be it your partner, friends, family, professionals, or online networks. It doesn't matter in what shape it comes, everyone needs a little help from their friends, no matter who those friends may be.

You might decide to let just a few close confidantes know of your situation with trying to conceive. You might tell anyone who will listen. Regardless, know that at some point, someone will say something wrong. Set the ground rules now. If you don't want to be asked how *things* are going (secret speak for "Are you pregnant yet?"), tell your network up front that you will let them know when there is something to know. Their over-enthusiasm may annoy you time and again, but they are probably almost as excited as you are to hear about your success.

While you don't want to anticipate a long, arduous battle with your fertility, or lack thereof, don't set yourself up to expect that within a month you'll be shopping online for maternity clothes. Decorating the baby's room at this point is probably not a great idea either. If all goes well and success finds you early, that's great . . . and we promise you that you'll have plenty of time to find the perfect maternity wardrobe and baby collection. If not, you will only set yourself up for disappointment, and the goal is to keep that to a minimum as best you can, in the areas over which you do have control. Your thinking is one of them.

## *And it's not just you!*

Whether the infertility issues are yours, your partner's, or something you share, be certain that you most likely will share the ups and downs of baby making. Infertility is tough on the most resilient of individuals and couples. It will find the weak spots in you and your relationship. Steady yourself and your union for what could be turbulent waters ahead (this includes success *and* a new baby!).

When it comes to baby making, sooner is often better than later, but keep in mind that this is from a biological perspective. And although you may hear the biological clock ticking away, ready-or-not is not the best way to make your decision about when to conceive. The state of your union is an issue we revisit throughout this book, as it is one of the most important aspects in dealing with fertility, infertility, and baby makes three (or more). And although biology is a key issue in deciding when and if you're ready to conceive, maturity, financial security, and stability are equally important, whether your challenge is trying to get pregnant or trying to raise said baby in a difficult and expensive world.



The quality of your partnership is the foundation for your family. Take the time to make sure that it's solid before moving on to the next level. Re-visit it often to make sure it's staying secure through the ups and downs of trying to conceive.



Just keep talking! As with all other areas, communication is key in the decision to add on to your family, whether you're successful right away or not. If you find yourselves at an impasse, enlist the help of an outside party: a member of the clergy, a therapist, or a physician to help you sort out feelings and facts.

## *The costs of treatment*

Talk about rubbing salt on a wound. Infertility treatments can be difficult enough. Now throw in the “opportunity” to spend anywhere from a few hundred to tens of thousands of dollars, and you have the makings for a truly bitter pill.

Like everything, infertility costs vary and can depend on where you live, which physician/practice you see and most importantly, whether your treatment is small, medium, or large.

When you're starting out, expect to pay \$10 to \$15 for an ovulation predictor kit and about the same for home pregnancy kits. A basal body thermometer will run you about \$10 to \$20. This is the easy stuff. We haven't brought in the professionals yet.

What about insurance you ask? “What about it?” we answer. Only 15 states have mandated coverage for infertility, meaning that for those who aren't fortunate enough to live in one of these areas, infertility treatments are paid for out of pocket . . . yours that is. Even if you have insurance coverage, you may be amazed to see how little of your bill is covered. Some insurance plans cover only monitoring, meaning the frequent blood draws and ultrasounds. Because these can run well over \$2,000 per cycle, this coverage is a help. Other plans cover only the medications, which is a help, but not by any means relief from the total cost.

Many insurance plans, however, will cover the tests and procedures related to diagnosing your particular infertility problem. This can be very helpful as well because many cases of infertility require blood work, ultrasound, and even exploratory surgical procedure, to determine a cause for infertility . . . a mere starting point for treatment. This generally applies to both you and your partner, but double-check this with your insurance company prior to signing up for the “party platter” of tests.

Once diagnosed, and even if you escape diagnosis (20 percent of infertility is unexplained), that's when the real costs can kick in. Should your problem be resolved quickly and easily, you may get by with the cost of a few months' worth of Clomid (a pill that causes super ovulation in order to push your

ovaries into producing one or more follicles that can be fertilized), a few ultrasounds (which generally cost anywhere from \$200 to \$500 depending on where you live and which physician practice you frequent) and approximately \$200 per blood draw for the basic tests needed to monitor your cycle. If you need IUI (Intrauterine Insemination), the cost is generally \$500 per insemination.

If you are to be monitored via blood work and ultrasound throughout the month, some clinics offer “package” prices which can range from \$900 to \$1500 for blood work and ultrasounds for one month.

If your cycle require injectable gonadotropins (Repronex, Follistim, Gonal F to name a few), you are looking at a cost of \$50 per vial. Most of these drugs are sold in five-vial boxes, although some are available in larger multidose containers. You could use as few as one vial per day for 5 to 10 days of your cycle or as many as six vials per day for 12 days. It all depends on your issues, protocol, physician, and response.

If you are also adding in luteal support (which occurs after the egg has supposedly been fertilized), progesterone and estrogen may run you a few hundred dollars per cycle (a bargain compared to other costs!).

Keep in mind that these are all approximate costs. Later on in the book, we discuss places to purchase medications that may offer better deals and other methods that you can use to cut your costs.

If you move up to the big time, keep in mind that the average IVF cycle costs between \$8,000 and \$15,000. Of that, about \$4,000 to \$5,000 is spent on medication, and another \$4,000 to \$10,000 goes to your clinic.

But, for now, let's take it one step at a time. You've bought this book and if you get pregnant from the information you find here, consider it a great bargain!