

# CHR VOICE



Clinical Care - Research - Education  
www.centerforhumanreprod.com  
Twenty Years Leading in Fertility Care

JUNE 2001

An employee/patient newsletter provided by the  
CENTER FOR HUMAN REPRODUCTION

## IN THIS ISSUE...

- 1 Launch of CHR Website
- 1 CHR Opens New Facility
- 2 Embryo Adoption
- 2 Physician Forum
- 3 The Haps
- 3 CHR in the Media
- 3 Patients, Not Statistics

## EDITORIAL:

### NEW WEBSITE RELEASED

Throughout the summer months, CHR will be celebrating the release of a newly launched website. The site will not only benefit employees, but also existing patients, future patients and egg/embryo donors.

Some helpful information included on the site is an overview of the company, services provided at CHR, insurance information, biographies of CHR physicians, frequently asked questions, scientific literature contributed by our physicians and inter-

esting real-life stories of past patients.

Another asset allows potential egg donors to submit an application via the website, with total confidentiality.

One of our goals at CHR is to maintain open lines of communication with our patients and employees, keeping everyone up-to-date on the happenings at CHR. We can only hope the new website will aid in this effort.

Please visit us at:

[www.centerforhumanreprod.com](http://www.centerforhumanreprod.com).

## CHR-NEWS:

### FROM FASHION TO FERTILITY

*CHR purchases townhome on Manhattan's Upper East Side for new clinic site*

CHR is proud to announce the opening of a new center on Manhattan's Upper East Side in New York, which happened early in July of this year.

The building, a "grand old townhouse," according to an article in *The New York Observer*,\* was acquired back in February. CHR plans on using the first 4

floors for treatment of patients and the upper floor for V.I.P. suites.

Located at 21 East 69<sup>th</sup> street, the building has remained empty for several months since it was home to a fashion boutique dubbed, "Romeo Gigli House."

Reportedly, the boutique's owner, Romeo Gigli, dressed up the building with "Murano glass" making it "lavish"; also donning its windows with clothing that was "romantic" and even "splashy," as

described in the aforementioned *Observer* article.

A fertility clinic may not normally be described with the adjectives above—however, in the relatively calm neighborhood patients now will be able to find instead of flashy garb—quality care; and most important of all, a sense of hope.

\* Schoeneman, Deborah; Netburn, Deborah; McGeeveran, Tom. There's a Doctor in the House! *The New York Observer*. February 19, 2001; 29.



CHR's new facility in Manhattan, New York.

# Embryo

# Adoption

CHR is one of the leading fertility clinics in the United States. Therefore, we pride ourselves in offering programs our physicians helped establish. A subject matter recently receiving media attention is a concept called, “Embryo Adoption”—also a program offered at CHR.

Somewhat parallel to the “Oocyte/Egg Donation” program ([www.centerforhumanreprod.com](http://www.centerforhumanreprod.com)), couples having trouble conceiving may “adopt” another couple’s embryo, already frozen in our storage facilities. CHR, unlike most other companies, also accepts

frozen embryos from other in vitro fertilization programs.

However, because of the limited amount of embryos donated, there is always a waiting list. Nevertheless, embryo adoption is yet another avenue down which couples may venture after several unsuccessful attempts at conception.

To learn more about our Embryo Adoption program, please visit our website at:

[www.centerforhumanreprod.com](http://www.centerforhumanreprod.com).

# Physician

# Forum

Your questions answered by CHR  
Physicians

**Q: Do medications, given to egg donors, have any side effects?**  
-via email, April 2001

**A:** The medications an egg donor will take during an egg donation cycle are principally the same as those an infertility patient would take who herself goes through in vitro fertilization (IVF). The only difference lies in the fact that donors, due to their young age, may require lower medication dosages.

This point is important because it demonstrates that all the medications taken by egg donors have been used on large numbers of women safely over many years. They, therefore, can be considered as extremely safe.

At the same time, any medication can cause side effects. Fortunately, such side effects are very rare with any of the medications taken during a donation cycle, but they, of course, can vary with amount of medication and also predisposition.

The potentially most dangerous complication is the so-called *ovarian hyperstimulation syndrome* or, in short, *OHS*. This complication can occur if a donor’s ovaries respond too much to the fertility drugs given to stimulate them. These fertility drugs are called gonadotropins and their function is to stimulate the ovaries to produce a large number of eggs—a so-called *polyfollicular response*. In contrast, a

natural cycle will result in a so-called *monofollicular response*; i.e. only one mature egg will be produced.

In an attempt to produce a good polyfollicular response, some ovaries can become overstimulated. Fortunately, this happens only rarely in competent hands but can, at times, be basically unpreventable.

When such an overstimulation happens, the donor needs to be watched very closely, on even rarer occasions in a hospital setting.

Other side effects are of much lesser consequence, though they may, in fact, happen a little bit more often. Like with any kind of hormone treatment, some women get a little

“moody,” others get a little “blue.” Some women feel bloated, as their ovaries increase in size during the stimulation.

Most importantly, however, there is *no* evidence that using these drugs on an egg donor affects the donor’s future fertility. And, remember, once again: these medications have been used by hundreds of thousands of women over many years. If there were to be any serious side effects, we would know by now.

-Norbert Gleicher, MD  
CHR New York & Chicago

FOR FURTHER INFORMATION REGARDING SPECIFIC SIDE EFFECTS OF SPECIFIC MEDICATIONS, PLEASE CONSULT THE PHYSICIAN DESK REFERENCE (PDR), MEDICATION INSERTS OR OTHER AUTHORITATIVE MATERIALS.

## CHR in the Media

**Norbert Gleicher MD**, CHR's founder, was cited as one of Chicago's "Top Doctors" in the January 2001 issue of *Chicago\** magazine. Dr. Gleicher was listed along with five other MD's as one of the best in town to visit with reproductive endocrinology concerns.

\*Chicago's Top Doctors. *Chicago*. January 2001; 132.

ABC 7 News in Chicago featured a May story by reporter Kathy Brock on *Embryo Adoption\** (see page 2). The report included real-life stories of couples on both sides of the fence--donors and recipients. **Norbert Gleicher, MD** was interviewed for the feature about CHR's embryo adoption program. The story can be read in its entirety at [www.ABC7Chicago.com](http://www.ABC7Chicago.com).

\*Brock, Kathy. *Embryo Adoption*. ABC 7 News. May 7, 2001.

NBC 7 News in Boston also featured a May story on *Embryo Adoption\**, reported by Janet Wu. The broadcast included an interview with **Vishvanath Karande, MD** along with different couples and their views on this controversial issue. The story can be viewed at [www.whdh.com/news/](http://www.whdh.com/news/).

\*Wu, Janet. *Embryo Adoption*. NBC 7 News. May 22, 2001.

## THE HIAPS:

What's New at CHR?

Chicago was the host this spring for the *21st annual meeting of American Society for Reproductive Immunology (ASRI)*, June 9-12 at the Fairmont Hotel downtown. **Norbert Gleicher, MD** presented an invited round table on the Reproductive Autoimmune Failure Syndrome (RAFS), a term coined by Dr. Gleicher, which now is widely accepted worldwide to describe infertility and pregnancy loss due to autoimmune diseases.

**Vishvanath Karande, MD** will be attending the *European Society for Human Reproduction and Embryology (ESHRE)* meeting this summer in Lausanne, Switzerland, July 1-4.

**Norbert Gleicher, MD** will attend the *8th International Congress of Reproductive Immunology* this summer in Opatija, Croatia. The July 2-6 conference is organized by the International Society for the Immunology of Reproduction (ISIR) and is hosted by the University of Rijeka, Croatia. Dr. Gleicher will give an invited lecture on the Reproductive Autoimmune Failure Syndrome.

## PHYSICIANS

Please remember there are no Grandrounds for the months of July and August.

## CHR-OPINION:

# THE NEED TO TREAT PATIENTS AND NOT STATISTICS\*

The treatment of infertility is becoming increasingly "industrialized," with fewer and larger programs providing an ever-increasing portion of total care. This development should not surprise. And, in fact, many arguments can be made in favor of concentrating, at least the assisted reproductive technology components, in the hands of larger and often better equipped centers. At the same time, this development often leads to the depersonalization of infertility care which, especially in two areas, can have very unfortunate consequences.

As one of the largest provider organizations in infertility in the country, our many patients have taught

us very important lessons over the years. Two of the most important are discussed in this article. Both relate to the patients' basic right to choose their treatments.

### THE ISSUE OF MULTIPLE BIRTHS

Infertility specialist are, rightly, very concerned about the high incidence of multiple births caused by fertility treatments.

Multiple births carry multiple social as well as medical consequences, which all translate into significant cost to individual patients as well as the health care system in general.

The principal medical problem relates to the fact that multiple births carry higher risks to offspring

and, to a lesser degree, to mothers than singletons. Moreover, this risk increases with size of the multiple birth, with the principal danger being premature delivery. The higher the multiple, the higher the risk of prematurity and the earlier in pregnancy delivery will occur.

The more premature an infant, the more short and long term risks exist to his/her physical and mental well being. Infertility specialists worldwide have, therefore, over the last few years mounted a vigorous attack on the high incidence of multiple births, following fertility treatment.

A majority of these multiples occur following ovulation induction, often with accompanying intrauterine

inseminations. Unfortunately, ovulation induction gives physicians only very limited control over the risk of multiple implantations. As we pointed out in a study published in the *New England Journal of Medicine*<sup>1</sup> in July 2000, high order multiple births are practically unpreventable with such treatment.

We, therefore, supported by an editorial by British investigators,<sup>2</sup> suggested that for most infertility patients standard ovulation induction with gonadotropins should be abandoned in favor of in-vitro fertilization (IVF), which allows for excellent control over the multiple risk through the limitation in the number of embryos

## PATIENTS, CONT.

transferred. This study was reflective of our concern about multiple births. Yet, we also feel that low order multiples (i.e. twins) need to be viewed separately from high-order multiples (triplets and beyond).

Many of our colleagues, especially in Europe, have argued that any multiple pregnancy should be considered a treatment failure. Two-thirds of infertility patients would disagree with such a statement since, as we reported in *Human Reproduction*<sup>3</sup> a number of years ago, this is the percentage of patients actually desirous of twins. Almost half of all infertility patients would even welcome triplets and, as one would expect, the desire of multiples correlates with length of infertility and female age.

What does all of this mean to our day-to-day care for infertile patients?

It suggests the need for active individualization of the treatment approach. IVF allows for such individualization and we should make every possible effort to retain the flexibility to do so. Our European colleagues are sometimes mandated by law to restrict the number of embryos, and exceeding permitted numbers is often considered a felony. We have to avoid facing such a situation here in the U.S.

In our organization at CHR, guidelines for women under the age of 35 currently suggest the transfer of only one or, maximally, two high quality embryos.

These recommendations are more conservative than those of professional societies in the U.S. Yet, the final choices have to be made by patients. The embryos are theirs and, if informed consent is offered responsibly, patients overwhelmingly will make the correct decision for their specific circumstances.

### IVF--, YES OR NO

A similar clinical situation, requiring individualization of treatment decisions based on a patient's specific circumstances, also exists in the decision-making process about who should or should not be allowed to enter an IVF cycle.

IVF programs often restrict cycle entry based on arbitrary female age cut-offs or FSH levels. The argument usually is that pregnancy rates in rejected patients are too low to warrant treatment. While this superficially appears to be a valid argument, after a careful examination, it often is not.

Patients should have the right to choose low chance options as long as (1) they reach their decision fully informed about their low pregnancy chances and (2) utilize their own private resources.

A five-percent pregnancy chance may be considered inadequate by many programs (especially those which are extremely concerned about their program's overall pregnancy statistics), but for many well-informed couples these are still odds worthwhile pursuing. We should see it as our responsi-

bility, as the providers of fertility treatment, to offer them the opportunity, even if their cycle outcome may adversely affect our program statistics. After all, we are here to treat patients and not program statistics!

In the U.S., patients usually utilize their own, private resources in pursuing IVF. Even in states with insurance mandates, like Illinois, the number of insurance-covered IVF cycles is restricted. If a patient, therefore, chooses to use her insurance benefit on a low chance cycle, using her own oocytes, in place of a high-chance oocyte donation cycle, this should be her right.

The fact that many of these patients will end up in a donor oocyte cycle, after all, is paradoxically yet another argument in favor of allowing patients to pursue low-chance IVF cycles. Patients who enter the world of oocyte donation have, first, to reach closure in believing with absolute certainty that they have given it all with their own eggs. Only once they have reached this psychologically so important milestone, will they be really ready for donated oocytes. Sometimes, it takes one or two low-chance cycles to reach this point. We have the responsibility to help them in getting there!

The individualization of treatments and the consideration of a patient couple's specific medical as well as social circumstances and wishes should, therefore, be an integral part of how fertility care is offered. In our

well understandable wish to get bigger and better, we providers of fertility services often forget that we are only as big and as good as each individual patient perceives us to be. If we listen to them, they'll see in us only the best.

-Norbert Gleicher, MD  
CHR New York & Chicago

\* This article was prepared for the October 2001 newsletter of the American Infertility Association.

<sup>1</sup>Gleicher N, Oleske DM, Tur-Kaspa I, Vidali A, Karande V:

Reducing the risk of high-order multiple pregnancy after ovarian stimulation with gonadotropins. *N. Engl. J. Med.* 2000, 343:2-7

<sup>2</sup>Bhattacharya S, Templeton A:

In treating infertility, are multiple pregnancies unavoidable? *N. Engl. J. Med.* 2000, 343:58-59

<sup>3</sup>Gleicher N, Campbell DP, Chan CL, et al:

The desire for multiple births in couples with infertility problems contradicts present practice patterns. *Human Reprod.* 1995; 10:1079-1084



Dr. Gleicher shares a smile with one of the children at the CHR reunion last September on Navy Pier in Chicago.

## CHR VOICE

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