CHR is pleased to report the very early stages of pregnancy in what, likely, is the oldest woman ever reported to have conceived through IVF with use of her own eggs anywhere in the world. This patient was just 2 weeks shy of age 48 years when she underwent IVF in a cycle pretreated with human growth hormone. She underwent early egg retrieval, a completely new IVF treatment approach introduced at CHR in 2015 in hopes of improving outcomes in women above age 43.

As this pregnancy is only at an early stage, there is still a considerable risk of a miscarriage. Just that a woman, practically at age 48, still conceived with use of her own eggs is, however, already remarkable, and testimony to the slow but steady progress CHR investigators has been making in treating older and older women. We, of course, are carefully optimistic, and will report on the progress of this pregnancy.

This is not the only excitement at CHR, though it may be the happiest one. In April, for the first time, it became possible to walk through from our old offices into the new building addition floor by floor. The photos to the right demonstrate that now even internal construction efforts are already underway. This means that, as planned, the IVF unit will me migrating into the new building addition in the fall. Once that happens, all the other spaces can be relatively quickly reshuffled.

We are equally exited that our research staff this year submitted no less than 22 abstracts to the annual meeting of the American Society for Reproductive Medicine (ASRM), which will take place in October in Salt Lake City. With May 4 the submission deadline, the preceding month of April was especially busy for all members of our research staff. April was, thus, truly a very good month at CHR, and all we are now waiting for is better spring weather.

CHR's 2015 Clinical IVF Outcomes

In last month’s VOICE, we published the patient age distribution of our center’s IVF patients in 2015, pointing out our patients’ continuously advancing ages. For the first time, over half of all patients were above age 41. We also reported that even in younger patients, a large majority presented with low functional ovarian reserve (LFOR), characterized by abnormally high FSH and/or abnormally low AMH levels.

Like advanced age, LFOR defines patients as demonstrating relatively poor prognosis. Our center’s patient population, based on age and LFOR, therefore, very likely, represents the country’s (if not the world’s) poorest-prognosis patient population to be found in any IVF center. Below listed IVF cycle outcomes for 2015, considering this fact, appear that much more remarkable.

A few disclosures are in order before assessing here presented outcome data: We offer these data to inform patients and colleagues, and not as comparisons to other IVF centers. CHR is in full agreement with ASRM and Society for Assisted Reproductive Technologies (SART) policies, which

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In Focus ..... 9

See CHR’s patient demographics: http://kaywa.me/eEw2x

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Dear Colleagues and Friends,

This Conference has the principal goal of offering an authoritative 2016 update for reproductive scientists and clinicians about important new translational developments in reproductive biology/physiology and clinically relevant patient care issues, while at the same time pointing out paradigm changes and imminent new potential developments of significance. By targeting clinicians as well as basic scientists as audience, this Conference will offer both groups a unique and intimate framework for interaction and exchange of ideas.

David F. Albertini, PhD | Ali H. Brivanlou, PhD, MD | Norbert Gleicher, MD | Zeev Shoham, MD

June 15, 2016 Abstract deadline for inclusion in the Journal of Assisted Reproduction and Genetics (JARG) and eligibility for Young Investigator Award of $5,000

Due to limited space and limited numbers of discounted hotel rooms available during the pre-Christmas season, we recommend early registration and hotel reservation.

Pre-Conference Workshops:

In vitro follicle/oocyte maturation age: From primordial stages | A new paradigm in clinical IVF: Age-specific stimulation and embryology | An in vitro implantation model: Peeking into the “black box” of implantation | The biological basis for the demise of preimplantation genetic screening (PGS)

Sessions:

The future of fertility care | Paradigm change I: Expanding infertility treatments from the gonadotropin-sensitive to earlier stages of follicular maturation | Paradigm change II: Early diagnosis of premature ovarian senescence, offering women more and better reproductive options | Paradigm change III: Reconsidering embryo selection | Paradigm Change IV: Individualization of infertility care | Skeptical of current clinical practice? Here are some answers!

For the full Conference program, registration, and abstract submission, visit the official Conference website: http://frm.cme-congresses.com/
Gene Editing, Chapter Two!

Just two weeks ago, the second report of gene editing in human embryos was reported in the *Journal of Assisted Reproduction and Genetics* (JARG), a peer-reviewed journal initially founded by CHR’s Medical Director and Chief Scientist, Norbert Gleicher, MD, and now the official basic science journal of the ASRM under the editorship of David F. Albertini, PhD, CHR’s Director of Laboratories and Senior Scientist.

Gene editing for the sake of curing human diseases caused by genetic mutations was proposed many years ago when medical researchers first contemplated the use of gene altering enzymes to correct or eliminate mutations believed to be at the heart of monogenic conditions. While many clinical trials were attempted over the past decade, most failed to improve patient conditions, and in some cases were found to be dangerous.

Since these early days, genome technology has undergone a revolution in precision and accuracy of methods that can recognize and modify even the smallest parts of our genome and, by doing so, can specifically target individual genes of interest. This has become possible because of the discovery of a family of proteins known as CRISPR/Cas9. Multiple laboratories, including CHR’s collaborating laboratories at the Salk Institute in La Jolla, California, and at Rockefeller University in New York City, are actively working on improvements to these gene editing procedures.

With this powerful technology being refined on an almost weekly basis, an international conference was held in Washington, D.C. last December to address growing concerns over the prospect of using gene editing technology to modify human embryos. Though the conference decided on an absolute ban on any such work that might lead to implantation and birth of a genetically modified human embryo, there was general consensus that basic research with human embryos should continue to cautiously advance and evaluate the impact of this technology. We discussed this conference in the VOICE before.

Among other scientists, Dr. Albertini was recently interviewed by science writers at the journal *Nature* to solicit feedback regarding the newest research and to provide perspective, as these and other advances in molecular biology progress ever so slowly into the realm of reproductive medicine, thereby raising ethical concerns and questions that could not have been anticipated even a year ago.

As Dr. Albertini noted in his comments, the responsibility to educate physicians, scientists, and the public on the status and prospects of new technologies like gene editing lies squarely on the shoulders of journal editors, the media, and clinical research centers like CHR. This is one reason why the VOICE has given so much space over the last year to CRISPR/Cas9.

This is where the two CRISPR/Cas9 studies from China suddenly became so relevant: The first appeared in a somewhat obscure journal to much fanfare in April of 2015, and actually prompted the above noted conference of scientists last December. JARG now published the second paper, authored by Prof. Fan and colleagues from Guangzhou University, where attempts are described to introduce a mutation into early human embryos that could confer resistance to the AIDS-causing HIV virus (*Kang et al., Introducing precise genetic modifications into human 3PN embryos by CRISPR/Cas9-mediated genome editing, J Assist Reprod Genet 10.1007/s10815-016-0710-8*).

... affected women are often misdiagnosed with the so-called “unexplained infertility”

**Mitochondria Study**

**DO YOU CARRY A MITOCHONDRIAL DISEASE OR KNOW SOMEBODY WHO DOES?**

If you do, please call us at 212-994-4400 for a free consultation in person, by phone or via Skype. CHR is searching for a way to prevent inheritance of these awful diseases in collaboration with colleagues at the famous *Salk Institute for Biological Studies* in La Jolla, CA. The Salk investigators are on the forefront of genetic editing, which has a significant potential in eliminating genetic diseases and help infertile women conceive. You may be able to help!
emphasize for patients and physician providers alike, that IVF outcomes between centers cannot be accurately compared because different centers serve very different patient populations. Different centers have very different mixes of good-, intermediate- and poor-prognosis patients. ASRM/SART, therefore, rightly prohibit member-IVF centers from using their data in such comparisons, and strongly encourage the lay public from not doing it either.

As differences in distribution of good- intermediate- and poor prognosis patients ultimately determine cycle outcomes at IVF centers, comparisons between centers will not become possible until these statistical variations can be properly considered in statistical comparisons between centers. In reforming current national reporting systems, ASRM is attempting to reach such a point; however, even with recently introduced reporting reforms, objective comparisons between centers is not yet possible. Here reported data, therefore, should not be used for such a purpose.

As already noted above, CHR’s patient population is likely at the unfavorable prognosis extreme. Since in poor prognosis populations, many patients’ ovaries do not respond to stimulation and/or patients do not reach embryo transfer for other reasons, these patients are not included in here reported outcome numbers. It, therefore, is important to recognize that here reported outcomes only reflect patients who did reach embryo transfer.

In clinical studies of general patient populations, we strongly advocate use of “intent to treat” reporting of outcomes (i.e., outcome per cycle start). However, in very poor prognosis patients who are clearly advised that in every IVF cycle, they are running a considerable risk of not reaching embryo transfer if they do not produce at least one embryo for transfer, such reporting makes little sense. Such patients understand that their even small pregnancy chance depends on availability of at least one embryos for transfer, and usually want to know what then their chances are if they do produce at least one embryo for transfer. CHR developed this information, even based on how many embryos such a poor prognosis patient has available for transfer, and published it in 2015 (Gleicher et al., Fertil Steril 2015;104:1435-1441).

Considering CHR’s very adversely selected patient population, at approximately 20%, the rate of patients not reaching embryo transfer is actually surprisingly low. This rate, however, obviously greatly varies based on age, prevalence and severity of LFOR. The older a patient and the more severe her LFOR, the higher will be her cycle cancellation rate prior to embryo transfer. As we recently reported in the above-cited study, in worst prognosis patients, approximately 35% of cycles are cancelled prior to embryo transfer. If poor prognosis patients want to know what their clinical pregnancy chances might be per “intent to treat” (i.e., with reference point cycle start rather than embryo transfer) at CHR, they, therefore, likely will be between 20-35% lower than the here reported outcomes.

Finally, since live birth data for 2015 will not be known till the end of this year, it is important to recognize that here reported data are only clinical pregnancy rates. While many, especially early, miscarriages occur before a pregnancy is classified as “clinical,” some miscarriages (at our center ca. 15%) occur after such a designation. Live birth rates, therefore, should be assumed to be approximately 15% lower than here reported clinical pregnancy rates.

**COMMENTARY:** As table and figure demonstrate, CHR’s clinical pregnancy rates in practically all age groups are surprisingly high, considering how adversely selected CHR’s patients are. As the figure demonstrates, pregnancy rates, as expected, gradually decline with advancing age, though the age group of 36-37 years demonstrates a significant dip in comparison to younger and older ages. This may be a statistical artefact or, more likely, represents the fact that at approximately that age range young women with premature ovarian aging (POA), also called occult primary insufficiency (oPOI) usually run out of redundancy in their FOR and, therefore,
Especially remarkable are here reported clinical pregnancy rates in older patients above age 40 years, and again in women at age 43 (8.3%) and ≥44 years (5.9%). The latter group included patients up to age 49. It is also noteworthy that here presented 2015 data only partially reflect the changes in CHR’s IVF protocols implemented during the year 2015 for older women as well as younger women with POA/oPOI, which entailed switching to “early” egg retrievals at smaller follicle sizes. These changes were based on the recognition by CHR investigators that women with LFOR usually mature their follicles (and oocytes) at enhanced pace (Wu et al., J. Endocrinol 2015;226:167-180). We are, therefore, hopeful that with full implementation of this practice change throughout 2016, we will be able to add a few additional outcome points, especially in older women.

In parallel, we see more demand for gender selection in association with egg donation, often from single women, desirous of a female child. Gender selection also lowers pregnancy chances because of the need for additional embryo manipulation and because embryos of the undesired sex are not transferred. Combined, these two developments have resulted in a decline in pregnancy rates in oocyte recipient cycles over the last two years. That decline is, however, well compensated as the FETO rate of 34.0% in the table above demonstrates, with eSET and FETO cumulatively producing clinical pregnancy rates at least as good as a 2ET transfer produces. It is important to understand that with 2-ET, and without preimplantation genetic screening (PGS) for gender selection, donor cycles at CHR persistently over the last five years have been in the 60-65% range.

**COMMENTARY:** Clinical pregnancy rates for IVF cycles involving frozen-thawed embryos are separated into routine frozen-thawed cycles (FET), cycles involving donor eggs (FETO) and third-party donations of frozen embryos (FETA). Once again, considering CHR’s patient population, it is actually surprising that there are any frozen embryos available for transfer at all. Here reported pregnancy rates in these cycles are surprisingly good; so good, indeed, that especially FETA cycle outcomes, based on small cycle numbers, may be exaggerated.

**Frozen-Thawed Cycles**

<table>
<thead>
<tr>
<th>FET</th>
<th>FETO</th>
<th>FETA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.0%</td>
<td>34.0%</td>
<td>50.0%</td>
<td>27.0%</td>
</tr>
</tbody>
</table>

**PGD & PGS Cycles**

<table>
<thead>
<tr>
<th>PGD/PGS Cycles</th>
<th>Pregnancy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGD/PGS Cycles</td>
<td>31.0%</td>
</tr>
</tbody>
</table>

**COMMENTARY:** In contrast to many other IVF centers CHR does not utilize PGS in attempts to improve IVF outcomes (see also story on next page). Most of CHR’s PGD/PGS cycles involve either detection of embryos with single gene diseases or gender selection. As already noted, PGD/PGS requires significant additional embryo manipulation and, therefore, to a degree reduces pregnancy chances. Moreover, patients undergoing PGD/PGS at CHR are usually also relatively older. Consequently, the clinical pregnancy rate of 31% has to be considered excellent.

In summary, considering CHR’s extremely adversely selected patient population (over 90% of new patients have failed IVF cycles before coming to CHR, often at multiple centers), 2015 IVF outcomes have to be considered exceptionally excellent. “Fighting for every egg and embryo” is not only a slogan at CHR; it is engrained in the daily practice of the center and reflected in here reported outcomes.
The PGS Discussion Continues

Because CHR strongly feels that IVF patients all around the world are harmed by utilization of preimplantation genetic screening (PGS), the VOICE has dedicated disproportionate space in recent months to the increasing utilization of PGS. *Fertility and Sterility*, the official peer-reviewed journal of ASRM, just published the electronic version of a study by CHR investigators (Kushnir et al., Effectiveness of in vitro fertilization with preimplantation genetic screening: a reanalysis of United States assisted reproductive technology data 2011-2012. Fertil Steril 2016; 2016 Mar. 4. pii: SOO15-0282(16)140-0), in which CHR demonstrated that a prior analysis of national PGS data by investigators from the Centers for Disease Control and Prevention published in the same medical journal had been incorrect.

CHR’s reanalysis demonstrated that during 2011-2012, utilization of PGS in the U.S. not only did not, as proponents of PGS are claiming, improve IVF outcomes but actually significantly reduced the chances of live births in association with IVF. Moreover, observed improvements in miscarriage rates with PGS, likely, are not the consequence of PGS but of favorable patient selection in patients undergoing PGS.

Not surprisingly, some very vocal proponents of PGS immediately reacted to the CHR study on the official *Fertility & Sterility* forum. (The journal no longer prints letters in response and encourages comments to published articles on this online forum.)

They, however, really had no valid arguments. All they offered were rehashed and already repeatedly rebutted arguments, which, simply, make no sense. CHR’s investigators, therefore, held their response to the response by Grifo et al relatively short. It, however, nevertheless summarized well the absurdity of many of the arguments made by proponents of PGS. We decided to reprint the CHR response here mostly because it refers to a recently published mouse study, which strongly supports the position of CHR in this PGS debate:

We sincerely appreciate the repeated interest of Grifo and associates in our PGS work but repeating incorrect facts over and over (and referencing their own writings in support) does not change the reality that in over 10 years of two PGS generations, contrary to their representation, not a single properly designed study of PGS did demonstrate any IVF outcome benefits. The alleged prospectively randomized studies they quote as demonstrating efficacy of PGS are, as we in our recent publication in detail documented, so badly flawed in design, that it is difficult to understand that Grifo and associates still quote these studies in support of their positions. Scott et al (2012) and Forman et al (2013) employ inadequate patient selection and outcome assessments with reference point embryo transfer, thus excluding all patients who do not reach embryo transfer, and Yang et al (2012), to their credit, themselves note the preliminary nature of their study because of small patient numbers and selection of only good prognosis patients.

It also does not change the fact that our manuscript very clearly demonstrates that the initial analysis of PGS effects by CDC colleagues was mistaken. Grifo et al criticize our concentration on intent to treat analysis and question the method of our analysis without pointing out where our calculation went wrong. Yet, is there really anybody left besides Grifo and associates who does not believe that IVF outcomes should be presented by intent to treat (i.e., with reference point cycle start)?

It is also important to point out that data are currently in the publications pipeline which, using national IVF registry outcomes, offer evidence that even in donor/recipient cycles (i.e. best outcome cycles) PGS actually significantly negatively affects IVF outcomes.

We, however, want to direct the interested reader in this subject to a very important and very elegant recent publication in Nature Communications (Bolton et al., Mouse model of chromosome mosaicism reveals lineage-specific depletion of aneuploid cells and normal developmental potential. 2016;7:11165). Since aneuploid cells highly preferentially accumulate in the trophectoderm rather than the inner cell mass of embryos, their study demonstrates why PGS for biological reasons simply cannot work. A single biopsy of trophectoderm cannot accurately determine whether any single biopsied cell island in the trophectoderm really reflects the chromosomal make up of the inner cell mass. In other words, because of much higher mosaicism in trophectoderm...
Influenza vaccination during pregnancy reduces stillbirths

These pages regularly report on the importance of a normally functioning maternal immune system for normal reproduction. Here is further evidence: In a recently published study in the specialty journal *Clinical Infectious Diseases*, a group of Australian infectious disease investigators reported that administration of seasonal influenza vaccinations during pregnancy reduces the chance of stillbirth by a whopping 51% (*Regan et al., Seasonal trivalent Influenza vaccination during pregnancy and the incidence of stillbirth: Population-based retrospective cohort study. Clin Infect Dis 2016;62:1221-1227*).

Interestingly, however, the only conclusions the authors of the study reached were that this study supports the safety of seasonal influenza immunization, and confirms protective effects of such vaccinations during pregnancy. Since Influenza vaccinations during pregnancy until quite recently have been controversial, these conclusions are important, and the study, rightly, for those reasons alone, deserved the wide exposure it got in medical as well as lay media. Neither authors nor media recognized, however, the much more basic importance of this study for explaining the still unresolved biological paradox of how a normal maternal immune system is able to tolerate a fetal semi-allograft for nine months without rejecting it.

Here is why this study contributes to a better understanding of this paradox: Were a woman to receive a solid organ transplant from her partner, in almost all cases her immune system would quickly and violently reject the transplant without appropriate immune-suppressive treatment. Yet, in normal pregnancies, a rapidly growing transplant - the fetus is in its genetic composition 50% "foreign" to the mother - is not being rejected at least until onset of labor.

CHR’s Medical Director and Chief Scientist, Norbert Gleicher, MD, has extensively written on this subject, repeatedly pointing out that normal onset of labor, usually occurring at approximately nine months gestational length, likely, represents the end of timed immunological tolerance of the fetus. Interestingly, just as it has remained largely unknown how exactly immune tolerance is established at the time of implantation of the embryo, so is it still unknown what induces labor. Dr. Gleicher has argued in his writings that, as a period of timed tolerance ends, the maternal immune system, in a sense, initiates rejection of the fetal semi-allograft, thereby inducing labor. He has also demonstrated that maternal autoimmunity, as is widely accepted, not only can cause initial problems with induction of immunological tolerance during implantation and early pregnancy, leading to miscarriages, but also in practically all autoimmune diseases will lead to premature labor, which he defined as premature termination of maternal tolerance of the fetal semi-allograft (*Gleicher N, Does the immune system induce labor? Lessons from preterm deliveries in women with autoimmune disease. Clin Rev Allergy Immunol 2010;39:194-206*).

Now Regan et al. report that Influenza immunization in pregnancy clearly “boosts” the maternal immune response in pregnancy and reduces still births by a remarkable 51%. This observation, therefore, suggests that activating the maternal immune response through an Influenza immunization reduces still birth risk to a highly significant degree, raising the question: How does the maternal immune system accomplish this?..
Influenza vaccination: Continued from Page 7
The answer is, of course speculative, but highly suggestive: Stillbirths can have many causes but late third-trimester pregnancy losses very frequently are associated with autoimmune abnormalities. Late, so-called sudden deaths in utero, fortunately are rare events, but have also been strongly associated with autoimmunity, especially with presence of anti-phospholipid antibodies, and, as already mentioned, autoimmunity is also highly associated with premature labor. It, therefore, is very tempting to hypothesize that Influenza vaccination in some way boosts the immunological pathways in the mother that control immunological tolerance, thereby extending the length of immune tolerance toward the fetal semi-allograft, otherwise in some patients abnormally shortened, leading to stillbirths.

The study by Regan et al, therefore, deserves follow-up studies in which immunizations (immunizations other than Influenza vaccinations may also be effective) are used to “boost” the immune system of pregnant women at risk for premature termination of immune tolerance.

If Dr. Gleicher is correct in his hypothesis, such immune “boosters” in pregnancy would not only be effective in reducing still births, as reported by Regan et al., but may also be helpful (i) in establishing pregnancy in infertile women with implantation problems, (ii) in preserving pregnancy in women with repeat pregnancy loss, (iii) in preventing premature labor in general and particularly in women with autoimmune diseases and/or subclinical autoimmunity and (iv) in preventing complications of pregnancy he has attributed to premature failures of maternal tolerance, like the preeclampsia/eclampsia syndromes in all of its forms, including the so-called HELLP syndrome and various dermatoses of pregnancy.

Zika Updates

The news about the Zika virus are unfortunately getting progressively worse. Most recent news suggest that the brain damage caused to newborns is even more severe that just regular microcephaly. It now appears that affected infants, in addition, have significant brain damage: investigators described the damage as the virus eating away on the brain, creating fluid filled cystic spaces. ASRM recently published a Guidance Document, and we are reprinting some of its key points:

- Women with Zika symptoms should wait at least 6 weeks, men for 6 months, before attempting reproduction.
- Both sexes should wait at least 8 weeks after possible exposure (i.e., after having been in a Zika-endemic area), even if they do not have any symptoms.
- These time lines also apply to couples in infertility centers, using their own gametes (eggs/sperm).
- Current FDA guidelines declare a potential egg/sperm donor ineligible for 6 months following diagnosis of Zika virus infection or of having had high probability of exposure.
- Testing for Zika virus is complicated, not universally available and routine serological testing is currently not recommended.
- In Zika-endemic areas, using contraceptives to prevent unintended pregnancy is essential.
- Physicians should counsel and educate their patients on Zika and update their informed consent procedure to reflect that counseling.

Areas with Zika transmission

As of May 7, 2016, CDC reports active Zika virus transmission in the purple areas, including the Caribbean and parts of Latin America, as well as Oceanic and Pacitic islands. Source: CDC.

Except for a small number of sexually transmitted Zika infections, the continental USA so far has not reported any Zika cases. Within the U.S., only Puerto Rico and The U.S. Virgin Islands are currently considered endemic areas for mosquito-transmitted infections. So are, of course, all the other Caribbean Islands. We, therefore, address above outlined 7 key points especially to those who have traveled to and/or are planning on traveling to Zika-endemic lands and/or have sexual partners who recently have travelled or are planning to.

Follow the latest CDC recommendation: www.cdc.gov/zika
ASRM comments on newly released 2014 ART outcome data

With release of the 2014 national outcome report by the SART, an ASRM Bulletin was issued, reporting “increases in effectiveness and safety.” Number of assisted reproductive technology (ART) cycles reported to SART increased to 190,384 (from 174,962 in 2013) and births increased from 63,286 in 2013 to 65,175 babies. A continuing trend of transferring fewer embryos further reduced multiple births, including triplets as well as twins. In 2014, 78% of births were singletons, up from 75.5% in 2013.

The Bulletin also noted that the annual report has been “completely redesigned in order to provide patients and physicians with a view of outcomes that more accurately reflects the way infertility is now treated using IVF.”

CHR applauds the many changes made in the new reporting format and, to some degree, takes at least partial credit for some of those changes since they followed a number of CHR publications that pointed out glaring shortcomings of the previous system, which allowed some reporting IVF centers to report highly inflated outcomes. The new system will make such abuses more difficult, though CHR’s initial review of the new reporting system suggests that many opportunities for abuse still exist. Though the newly introduced reporting system represents a significant improvement, CHR assumes that ASRM/SART will continue to improve their reporting system in efforts to plug remaining holes.

Even though these reports, as ASRM/SART clearly state, should not be used to compare IVF centers’ performance because different centers treat different patient populations, the public does use them for such comparisons, often not understanding that treatments will have different outcomes in younger or older patients, thinner and overweight patients, women with normal or low ovarian reserve, etc. Who a center treats, therefore, will be reflected in the center’s outcomes. For example, a center that only treats women with normal FSH and AMH levels will have better outcomes than a center that treats mostly women with high FSH and/or low AMH. A center that serves a much more obese patient population will also be at disadvantage. Even the racial/ethnic makeup of patient populations matters; for example, women of African descent have significantly lower pregnancy rates in IVF than Caucasian women.

Continued reading on Page 10
IVF centers, of course, understand these outcome differences and often select their patients accordingly. Until ASRM/SART (as well as the CDC, which publishes its own annual outcome report) can fully adjust their reports for all of these important co-variables, it will be difficult for the average lay person to understand the true capabilities of a given IVF center. We, however, strongly suggest that those who use ASRM/SART and CDC reports to compare centers, carefully assess what restrictions a center maintains for entry into their IVF program. For example, if a center treats hardly any women over age 42 with use of own eggs, that center, very obviously, “selects” patients.

Though it does not affect CHR, most disturbingly, even some insurance companies are using these outcome reports now to select IVF centers as providers. If insurance companies do not understand the shortcomings of current ASRM/SART and CDC reports, even though both organizations openly warn from using their reports for center comparisons, who then can blame the public from doing the same. The shame is, however, on the insurance companies, which, supposedly, are professionals and should know better! 

- The CHR

Fighting for every egg and embryo!