INFERTILITY

Evaluation of infertility is a process which must involve both partners and takes about five to six weeks. The baseline evaluation of this situation in the female involves laboratories on day 3 and day 24 and test for tubal patency in the pre-ovulatory period.

Day 3 laboratories assess the patient's baseline hormones. These include LH, FSH, prolactin, and TSH. She will be checked for immunity to Rubella and immunized before therapy is instituted if non-immune. She will also have Pap and cultures for gonorrhea and Chlamydia.

The patient will also have test of tubal patency prior to ovulation (before mid cycle). This would likely include fluoroscopic hysterosalpingogram but may also include sonohysterography in the office setting.

The patient will then have a progesterone level on cycle day 22 to 24 to see if she is spontaneously ovulating.

Male partner examination should also include semen analysis and cultures including gonorrhea and Chlamydia. The male partner is usually responsible for approximately 30% of cases of infertility, and therefore it is essential to involve the male partner in infertility evaluation at the outset.

Counseling regarding lifestyle issues must be offered. Patients should cease drinking, smoking, and use of other medications which are not warranted in the periconceptional period. Patient is urged to time her cycles. In a typical 28-day cycle ovulation occurs on approximately the 14th day. LH detector kits are recommended to time the LH surge (precedes ovulation by 12 to 20 hours) and base coitus on this timing mechanism. LH testing is commenced at approximately the 11th day. The day that the test turns positive, the patient should attempt coitus that evening and again the next morning. LH kits increase likelihood of conception by assuring coitus in a woman's period of greatest fecundability.

Follow-up will be directed at actual etiology(ies) of infertility uncovered in the evaluation. Should idiopathic infertility be diagnosed, Clomid cycles may be offered. Dosing begins at 100 mg/day cycle days 5 – 9 and increasing in 50 mg/day increments up to 250 mg/day for a total of four ovulatory cycles. Should conception not result or the patient fail to ovulate at the maximum dose referral to a Reproductive Endocrinologist will be made.

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