

## "Infertility Is..." Blog Contest Winning Entry

By Christine Penzone

In this week's Resolve New England member email, I noticed a blog contest. The title "Infertility is..." reminded me so much of an assignment I asked my students to complete that I had to write about it. During our poetry study, I ask the students to write abstract to concrete poems. They need to take an abstract concept like happiness, friendship or confusion and create a poem using concrete examples of these ideas. Well I'm not going to write a poem, because I care way too much for all you to make you read it, but I do want to write on the idea. I have to say that this comparison came from a friend on an infertility board, but since she brought it up, I cannot picture infertility any other way.

Infertility is...winter. It may come on slow, a few flakes on an October day, or it may hit you all as once, a nor'easter that follows a day of warmth. No matter how it starts, winter quickly begins to drag. The long nights and cold short days often make it incredibly difficult to stay positive. It isn't long before you begin wondering if you will ever get to feel the warm sun on your body again. However, deep in your heart, you know that spring will come, followed by summer. The problem is you truly know when the cold and snow will be gone. Will Mr. Groundhog give you relief and make spring come early, or will he enjoy the torture and run and hide, keeping winter longer.

Sean and I were lucky in that we were able to hold out hope for many months that our winter would never come. There were snowflakes of warning here and there, but we both hoped we could bypass that darkness. But as every New Englander knows, you cannot avoid the cold and snow. It will come and there is nothing you can do about it. When we started testing and treatment, it was all new and slightly exciting. Every treatment gave me hope that this would be an enjoyable and quick process, but even snow days get old after a while. At this point, we are in depths of winters. The snow is burying us. The roads are icy. The nights are long and cold. No amount of warmth can take the chill fully out. All that being said, I still hold out hope that the end of our winter is out there; I just don't know exactly how we will find it. Hopefully we can wait out this winter right where we are, but if we need to make a change and move we will do it. There will be an end to our winter, but exactly where we will be when it ends, I do not know.

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**DON'T MISS RESOLVE NEW ENGLAND'S DONOR EGG / SURROGACY AND ADOPTION CONNECT & LEARN SEMINARS**  
JANUARY 28, 2012 9:00 AM - 5:00 PM  
VISIT US AT  
[WWW.RESOLVENEWENGLAND.ORG](http://WWW.RESOLVENEWENGLAND.ORG) TO  
LEARN MORE AND TO REGISTER ONLINE!

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*This newsletter is published quarterly (winter, spring, summer, fall) with a circulation of approximately 1,200.*

## EDITORIAL POLICY

This newsletter is primarily a vehicle for regional news, events, and articles of interest. Our readers, including professionals, are encouraged to submit comments and articles. The editor reserves the right to edit all submissions.

## SUBMISSION DEADLINES

Spring 2012

February 15, 2012

Summer 2012

May 15, 2012



We welcome newsletter article submissions, especially personal experience articles, via email. Articles should be no longer than 750 words and must be approved by the editor. [admin@resolvenewengland.org](mailto:admin@resolvenewengland.org)

We reach 1,200 members and professionals quarterly.

Please call or go online for more information about becoming a RESOLVE New England member, or to request information to advertise in upcoming issues.

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### CONTACT

RESOLVE NEW ENGLAND  
395 Totten Pond Rd, Ste 403  
Waltham, MA 02451

**E-mail:** [admin@resolvenewengland.org](mailto:admin@resolvenewengland.org)  
**Telephone:** 781-890-2250  
**Fax:** 781-890-2249

**Website:** [www.resolvenewengland.org](http://www.resolvenewengland.org)  
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# New Year, New Beginnings...

The start of the New Year is a time to look forward to what lies ahead. It can be an exciting time with endless possibilities as well as a time of anticipation. It can also be a time of quiet reflection. What did the past year bring and what do you want to change for the next year?

Dealing with infertility can be disheartening and leave you feeling empty. Make a promise to yourself to fulfill your wishes outside of infertility. Take 15 minutes each day for yourself. Make a promise with your partner to have regular 'date nights' – even if it consists of staying home to watch a movie together. Volunteer for RESOLVE New England (RNE); giving back to others may fill you in a way you couldn't imagine. Whatever you decide, try to look at the year ahead with hope. And RNE will be here to help you along your path to parenthood.

We at RESOLVE New England are looking forward to a number of positive changes in 2012! Here are a few of the changes that you will see in the year ahead: RNE will be launching a new website in the first quarter of 2012! Our new website will have a streamlined look with additional content that will feature a weekly blog and much more. RNE will also be adding to our educational programming and peer groups. We will be looking at ways to better educate you on topics that matter most to you during your infertility journey.

We are hopeful that you are looking forward to what lies ahead in 2012. We know it is going to be an exciting year for RESOLVE New England and we hope it is an exciting one for you personally as well!

Warm Regards,

Erin Lasker

Executive Director

RESOLVE New England



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Are you 'friends' with Resolve New England on Facebook and Twitter? If not, consider 'liking' our Facebook page and following our Twitter page. We post updates on all our peer groups, events and the latest information in the infertility world!

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[www.twitter.com/ResolveNewEng](http://www.twitter.com/ResolveNewEng)

# CONNECT & LEARN SEMINARS

## Seminar Fees and Registration Information:

RESOLVE New England members: \$100 per person, \$175 per couple. Non-members: \$125 per person, \$250 per couple.  
Visit [www.resolvenewengland.org](http://www.resolvenewengland.org) for registration forms.

New: Pay for one Seminar, attend sessions from BOTH Donor Egg/Surrogacy and Adoption Seminars on the same day!  
*Financial assistance is available for those in need (RESOLVE New England membership required).*

Contact us for more information at [admin@resolvenewengland.org](mailto:admin@resolvenewengland.org).

## ADOPTION CONNECT & LEARN SEMINAR

This one-day program will guide you through the maze of adoption issues and options. You will be able to gather information from top adoption professionals in one place, and have the opportunity to speak with others making the same kinds of decisions to form their families, as well as speak with those who are parents through adoption.

**Saturday, January 28, 2012 – 9:00 a.m. - 5:00 p.m.**  
**9 Hope Avenue, Waltham, MA 02451**

- 9:00-11:15 Session 1 - Domestic Adoption:** An overview of the adoption process, and insights on how people make the many decisions along the way. A panel of New England domestic adoption professionals will cover how to choose an agency, the home study, costs, and the range of openness in adoptions today. There will be an overview of the different players in the field including traditional in-state agency adoptions, out-of-state agencies, attorneys, facilitators, and state departments of social services that help identify children and their birth parents looking to make an adoption plan. The panel will conclude with Q&A.
- 11:30-12:45 Session 2 - Adoption from Foster Care:** An overview of the foster care system and the adoption process.
- 12:45 - 1:45 Lunch:** You are welcome to bring your own lunch. A list of local restaurants will be provided.
- 1:45-2:45 Session 3 - International Adoption:** An overview of the differences between domestic and international adoption. A panel of international adoption specialists will provide an in-depth discussion about the process of international adoption and the latest information on the international adoption reforms. Topics will include the factors in choosing a country (including age of parents, travel and time requirements, age and experiences of pre-adoptive children, and medical issues) and the realities of trans-racial and trans-cultural adoptions. Q&A will follow.
- 3:00-5:00 Session 3 - Adoptive Parents Talk about Adoption:** This session will be a panel discussion with parents who have recently adopted. The panel will share their stories and lessons learned along the way, followed by Q&A. Wrap-up will include discussion of next steps and how to find continued support.

## DONOR EGG / SURROGACY CONNECT & LEARN SEMINAR

This one-day program is for those who are considering donor egg and/or surrogacy as a family building option. The program will provide “how-tos” and cover the medical, ethical, emotional, legal, and parenting issues of these family building choices. Meet others who are considering these options and speak with those who are parents through donor egg or surrogacy.

**Saturday, January 28, 2012 – 9:00 a.m. - 5:00 p.m.**  
**9 Hope Avenue, Waltham, MA 02451**

- 9:00-10:30 Session 1 - Preparing the Way for Egg Donation and/or Surrogacy:** This session covers the medical overview of the egg donor and surrogacy process, and information about screening and the coordination with the recipient. Known and anonymous donors will be discussed.
- 10:30-11:30 Session 2 - Finding a Donor and Gestational Carrier:** Finding a donor / surrogate using an agency, how the process works, and the costs involved.
- 11:45-12:45 Session 3 - Legal Issues and Contracts:** Legal issues will be covered.
- 12:45-2:00 Lunch:** You are welcome to bring your own lunch. A list of local restaurants will be provided. Informal brown-bag luncheon discussion on family building through donor egg and surrogacy will be offered.
- 2:00-2:30 Session 4 - Donor Sperm:** Finding a sperm donor, how the process works and the costs involved.
- 2:30-3:30 Session 5 - Psychosocial Issues:** Psychosocial Issues: A therapist discusses the emotional issues for men and women, and the ethical issues to consider. Secrecy vs. privacy will be discussed and deciding how/when to talk with your child and others about donor egg / surrogacy.
- 3:45-5:00 Session 6 - A Group Discussion about the Issues: Recipient Parents Speak:** A panel consisting of parents through donor egg and surrogacy will talk about their experiences and answer questions. Included will be a discussion of how parents talk with children about their origins.

By Rebecca Goddard

When I found out I was pregnant in July of 2010, I was ecstatic. I assumed, as anyone would, that we would have a perfect pregnancy, and a perfect baby. I mean, why wouldn't we? It was kind of ridiculous how quickly we got attached to the idea of the baby. There was belly whispering, planning, and even writing in early details in a pregnancy journal. There was a precious innocence during that brief period that I treasure, in retrospect.

Then, my baby was gone. Two early ultrasounds failed to find a heartbeat, despite seeing our perfect little peanut on the monitor, just waiting to grow and become ours. The searing pain of that time can not be underestimated - both physically and emotionally. It was as though a hole has been drilled where our hearts used to be. But, there was more to that experience than the actual miscarriage. Subsequently, there was an incredibly long and drawn out d&c process due to complications. But more importantly, when I lost my baby, I also lost that unadulterated joy and the last bit of naive hope I had for ever having a normal pregnancy experience. I not only felt the loss of the pregnancy, but I felt the profound loss of that pure happiness. Poof, the joy disappeared. I was gypped, robbed. Because, instead of feeling overwhelming joy, I will now feel overwhelming fear when (and if) I get pregnant again. There will be excitement again, but mostly, I will be afraid of the worst case scenario, because I have been there. I have felt my stomach drop when there is no heartbeat on the screen. I don't think that fear will end until a healthy baby is in my arms. So, no matter how much people tell me, "Don't worry. Lightning doesn't strike twice," I just can't.

There is no feeling of failure quite like that of having your body be the one that fell down on the job. We, as women, are told our whole lives that having a baby is our biological right. Although I thought for many years I was not going to be someone who chose to have a child, I never realized that choice might not be within my realm of control. I mean no matter how hard I yell, I just can't seem to make my ovaries listen. They are stubborn little suckers that just won't give up any eggs.

Infertility became a part of my life after the miscarriage. Although irregular ever since going off the pill, I stopped having periods altogether. None. I kept pushing my then OBGyn to help me figure out why, but after months of arguing about it, I took matters into my own hands. I hunted down a well-known Reproductive Endocrinologist, and began baseline infertility

testing to figure out why my ovaries seemed to have skipped town. There was a wide variety to these tests. Mine, including various blood, ultrasound, and dye tests, were not as fun as the one test in a dimly lit room that my husband had to "endure." Within a few days, I was diagnosed with PCOS and have been through the ringer of fertility drugs, inseminations, setbacks, mood swings, and crying fits ever since.

But, as with any challenging life experience, you figure out ways to cope. Some people are incredibly private about struggles with infertility. They tell no one other than their spouse and medical team and quietly work through the stress alone. On the opposite end of that spectrum, you would find me. I opened up to friends (both online and in real life), close family, and a few co-workers. Leaning on my incredibly patient, optimistic, and supportive husband gave me the will to keep getting out of bed, and leave the house. I also found a permanent spot on my psychiatrist's couch, ate massive amounts of pasta and chocolate, and started blogging about my experience. Mostly, I found humor to be the best coping mechanism. At a certain point, if you can't laugh when the parking attendant at the RE's office knows you by name, you will go seriously insane.

Reaching out to others about infertility is a double-edged sword. Although well-intentioned, those who have not experienced the inability to become a mother rarely understand it. They may have sympathy, but most often a wall is erected between friends, with me on one side, and the mommies on the other, with a stroller and a Baby Bjorn. Because of this, I wrote some reflections on what I have learned in the last two years. Some are helpful hints, and other are just for those who wish to better understand the plight of the childless-not-by-choice. My series of lessons (in no particular order) would look something like this:

## **Lesson learned #1: Getting an education you never wanted**

There are not many areas in my life on which I feel I have a lot of expertise. However, due to my ongoing battle with infertility, specifically Polycystic Ovarian Syndrome (PCOS), I have reached near-mastery on a topic with which no one should be forced to become acquainted.

Need to know anything about basal body temperature charting, cervical position and fluid, acupuncture, Chinese herbs, and supplements? I am your girl.

*Continued on page 8*

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## 6 PEER GROUPS - GENERAL INFERTILITY & TOPICS

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**GENERAL INFERTILITY DISCUSSION GROUPS:** General infertility discussion groups are open to those—women and men, couples and individuals—who have primary infertility (those with no children).

**Boston, MA:** Morville House, 100 Norway St. (near Symphony Hall)  
Times: Wednesdays, 6:00-8:00 p.m. Dates: January 18, February 15, March 21, 2012

**Longmeadow, MA:** First Church of Christ, 763 Longmeadow St. (Buxton Room)  
Times: Mondays, 7:00 p.m. Dates: January 2, February 6, March 5, 2012

**\*NEW\* - North Andover, MA:** Caron Family Chiropractic, 1005 Osgood Street  
Time: Mondays, 7:00 p.m. Dates: January 23, February 20, March 19, 2012

**Plymouth, MA:** Plymouth Professional Center Bldg. 116 Court St, 3rd floor of Plymouth Village  
Times: Wednesdays, 6:30 p.m. Dates: January 4, February 1, March 7, 2012

**Waltham, MA:** RESOLVE of the Bay State Office, 395 Totten Pond Rd., Suite 403  
Times: Tuesdays, 7:00-9:00 p.m. Dates: January 10, February 7, March 6, 2012

**Westborough, MA:** St. Luke's Parish, 1 Ruggles Street, Parish Center, Classroom #25, 1st Flr (Room subject to change - Room change is posted by the entrance to the parish).  
Times: Tuesdays, 7:00-8:00 p.m. Dates: January 10, February 7, March 13, 2012

**East Providence, RI:** Church of the Epiphany, 1336 Pawtucket Avenue, living room (basement)  
Times: Thursday, 6:00-7:30 p.m. Dates: January 5, Feb (no group), March 1, 2012

**Farmington, CT:** UConn Health Center/Dowling South Bldg., 2nd floor Education Rm., 263 Farmington Ave  
Times: Thursdays, 7:00 p.m. Dates: January 19, February 16, March 15, 2012

**\*NEW\* - Concord, NH:** 160 Dover Road, Suite 5 Chichester, NH  
Times: Mondays, 7:00pm Dates: February 6, March 5 2012

**Derry, NH:** Marion Gerrish Community Center, 39 West Broadway (Don Ball Room)  
Times: Wednesdays, 6:30 – 8:30 p.m. Dates: January 4, February 1, March 7, 2012

**Portland, ME:** Maine Medical Center, 22 Bramhall St., Dana Education Center  
Times: Tuesdays, 6:30 – 8:00 p.m. Dates: January 10, February 7, March 13, 2012

**TOPIC DISCUSSION GROUPS:** These are informal discussion groups that focus on a particular topic and are led by a volunteer with experience in that subject. Groups meet in our Waltham, MA office, 395 Totten Pond Rd., Suite 403, unless otherwise noted.

**Pregnancy Loss Discussion Group:** For those who have experienced a miscarriage/stillbirth/ectopic pregnancy, or recurrent pregnancy loss. Discuss the impact of loss and find support for the emotional experience of grief.  
Times: Wednesdays, 7:00-9:00 p.m. Dates: January 11, February 15, and March 28, 2012

**Adoption Discussion Group:** For those exploring adoption, informal discussion about the issues and concerns surrounding this family building option, led by an adoptive mother. Gain answers and strategies, connect with others.  
Times: Thursdays, 7:00-9:00 p.m. Dates: January 26, March 8, 2012

**Donor Egg Discussion Group:** For those considering donor egg as a way to build a family, a discussion of the issues, decisions, and emotions surrounding this family building option. This group is led by a donor egg mother and author.  
Times: Mondays, 7:00-9:00 p.m. Dates: January 9 and February 13, 2012

**Pregnancy After Infertility:** For those currently pregnant, an informal discussion about issues and concerns.  
Times: Mondays, 7:00-8:30 p.m. Dates: January 23, February 27, and March 26, 2012

**Donor Egg Parents Group:** For those currently parenting children through egg donation. Children are welcome. Contact us for address. These groups meet on a rotating basis in the homes of parent volunteers.  
Times: Varies Dates: Sunday, January 22, 2012, Lexington, MA 3:00-5:00pm

**Secondary Infertility Discussion Group:** For those who are experiencing infertility while parenting. The struggles and frustrations of secondary infertility are unique. Join others who understand the challenges.  
Times: Wednesday, 7:00-9:00pm Date: January 18, 2012 (more dates to come)

## MYTHS AND FACTS

You may hesitate to attend a peer-led discussion group because of some assumptions about what happens at the group. Consider these myths and facts:

**Myth:** Attending a RESOLVE peer group is like going to therapy.

**Fact:** A peer group is not designed to offer professional counseling or psychological therapy. It is, however, therapeutic to talk with others about an intense experience like infertility.

**Myth:** I'll have to bare my soul and talk about the most private areas of my life.

**Fact:** It is up to you to decide how much information and emotion to share with the group. You remain in control.

**Myth:** Attending a peer group of infertile women or couples will just make me feel worse.

**Fact:** You will receive support for your pain and disappointment and will also learn new methods of coping that can help you move forward.

*Please check our website [www.resolvenewengland.org](http://www.resolvenewengland.org) for additional peer group schedules and locations. To register: Please e-mail [admin@resolvenewengland.org](mailto:admin@resolvenewengland.org) with the number of people attending. We appreciate advance notice, however walk-ins are welcome. Free to RESOLVE members, and \$5 per person for non-members. Cash (correct change please), or check made out to Resolve New England is appreciated.*

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**Lesson learned #2: It's like I am speaking Greek**

From all my months of trying to get pregnant, I have also gained an entirely new vocabulary. You see, there is a whole wealth of words to understand once you start reading books, blogs, message boards, and websites about trying to conceive. I liken it to learning HTML or the insider language of any profession. Over time, you become fluent. This is especially true when you are emailing and chatting with friends who are also infertile. Don't believe me? For reference, here is a mini glossary of terms in no particular order because I am too lazy to alphabetize it:

TTC - trying to conceive

TTCAL - trying to conceive after a loss

PCOS - Poly Cystic Ovarian Syndrome (i.e.: my darn ovaries are in a state of constant rebellion, rarely popping an egg, and therefore rarely giving hubby the chance to fertilize it)

BD - baby dance = sexy times

IUI - intrauterine insemination (The boy has a date with a magazine and a specimen jar, they wash it up and prepare it, then place it in my cervix, turkey-baster style. Fun times.)

WTO- waiting to ovulate (the constant state I am in since I never ovulate on my own anymore)

TWW- two week wait (the horrible period of time between ovulation and when you find out if you are pregnant or not. Longest 2 weeks ever.)

BFP - big fat positive (refers to pregnancy test)

BFN - big fat negative

**Lesson learned #3: Sometimes, I hate my mommy friends. Just a little.**

I mean, not really. I guess it would be more accurate to say I live with intense jealousy, which turns into hatred at particularly low moments. I love my friends. I (usually) love their children. But they have something that I want more than anything, and I can't have. Sometimes, it hurts so much that I can't breathe, but I keep a smile plastered on my face. I have perfected this as an art form. I should get paid for such talent.

Sometimes I don't remember what my life was like before basal thermometers and ovulation predictor tests. I know it existed, but it feels like a distant memory. The road we have been on for almost two years has been bi-polar - incredibly high highs, and desperately low lows. However, in many ways, it has helped me to find a different sense of self - one that is more complex and confusing. Clearly, I am more empathetic to women in a similar situation, but I'm also surprised to find an unexpected connection to a

mommy friend whose experience did not go the way they tell you it will on thebump.com. Her daughter with special needs has changed her life, but also mine. In the same way infertility can be isolating, so can the journey with a child who does not meet the expected developmental markers, in a different, but eerily connected, way. The realization came that even when getting pregnant goes swiftly and smoothly, the perfect result does not always follow. For someone who craves order and control (AHEM, me), that is a jolting reality. I realized that I had to transition from focusing on timing, gender, and the color of the nursery, to the priority of having any health and happy baby that I might be lucky enough to deliver.

So, for now, I continue to pursue my desire to be a mother, while trying to conceive of a life beyond infertility. It has taken me a long, long time, but I now realize that while I will continue treatment, life also goes on. There are vacations to take, career options to pursue, parties to attend, and a marriage to enjoy. Quite simply, if you let infertility completely eclipse everything else in your life, what will you do if treatment fails? Everyone needs a contingency plan. Ours is not yet clear, but I know it will be a plan that involves love, laughter, and cocktails.

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## Recurrent IVF Failure

By Grace M. Centola, Ph.D., H.C.L.D.(ABB) Laboratory and Tissue Bank Director, New England Cryogenic Center, Newton and Brookline, Massachusetts

Sperm banking is a routine procedure for preservation of sperm for subsequent use in artificial insemination or assisted reproduction. The reasons for sperm banking include fertility preservation prior to cancer chemotherapy or radiation therapy, pre-vasectomy, as well as prior to other surgical treatments that may result in erectile or ejaculatory dysfunction. Cryopreservation of sperm or testicular tissue can also be of benefit to men prior to treatment for systemic non-malignant conditions such as inflammatory bowel disease, kidney disease and organ transplants where cytotoxic drugs often affect sperm production. Furthermore a man may elect to cryopreserve sperm as a backup for IVF in instances of male absence at time of ovulation or prior to military deployment. Sperm banking may also be used in an attempt to freeze multiple low count ejaculates in order to combine specimens and potentially increase the motile sperm count used for inseminations.

One of the most common reasons for sperm banking is to preserve fertility prior to cancer treatment. It is surprising that quite a few men will face a diagnosis of cancer in their lifetime. The incidence of cancer in males less than 15 years of age is 13.3 per 100,000, and for ages 15-39, 82.7 per 100,000! The American Cancer Society, in 2010, reported that 1.5 million new cancer cases were diagnosed. The overall cancer survival rate is reported to be 63%. Men are surviving their malignancies more now than in the past. In the past, the focus was on cancer survival alone. However, with improved detection and treatment for most forms of cancer the focus is not only on survival, but on the improved quality of life after treatment and the potential for procreation.

Male infertility is a common consequence after treatment of many malignancies and non-malignant diseases. With treatment, some patients may temporarily lose reproductive potential, others may permanently lose fertility. Some men are at risk of infertility even prior to cancer therapy. Many men with testicular cancer and lymphomas present with impairment of spermatogenesis at the time of cancer diagnosis. Sperm counts may remain normal or only moderately reduced during the first 2-3 months of treatment. Sterility often appears about 3 months after starting therapy. The effects of chemo or radiation therapy on fertility may be temporary or prolonged depending on the survival of the testicular stem cells and their ability to produce sperm after treatment. While infertility may be

reversible for some treatment regimens, persistent infertility can and often does result after chemotherapy and radiation therapy.

Cryopreserved sperm may be used for artificial insemination, IVF or ICSI. Although use of fresh sperm is thought to be preferable, many studies have been published demonstrating that cryopreserved sperm are just as effective as fresh sperm, particularly with IVF/ICSI procedures. The availability of cryopreserved sperm can be offered to ART patients preventing cancellation of a cycle if the male partner cannot provide a semen specimen due to absence or even stress. There may be social reasons for sperm banking. A man can take advantage of sperm banking if they are being deployed to combat during times of war. Other reasons might be pre-mortem or post-mortem sperm retrieval and cryopreservation to insure that the sexually intimate partner may attempt to have a child with the man's sperm. Most recently, testicular tissue can be cryopreserved from pre-pubertal and adolescent boys, with special freezing methods to preserve the testicular stem cells. It is hoped that in the future, such thawed tissue can be transplanted back into the adult resulting in repopulation of the testicle and resumption of sperm production. This has been successfully performed in animal models, but there are no known clinical trials in the human.

*Continued on page 12*



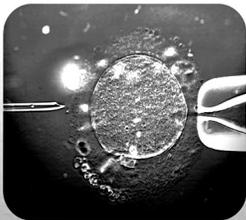
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## Fertility Treatment, Donor Choices, and Adoption Conference: 2011 Wrap-Up and Thank You

By Erin Lasker, Executive Director,  
Resolve New England

On November 5, 2011, over 225 attendees turned out early on a Saturday to gather information and get their questions answered, in a comfortable and compassionate environment.

As in past years, we offered over 40 workshops on topics of express interest, as well as the end of the day Question & Answer sessions, which was an informal opportunity to ask questions of the professionals in those fields. Our 26 exhibitors actively shared their services, information, and products with attendees and provided much-needed financial support for our event.

I want to express my deepest thanks to everyone who helped make this important event possible: to our presenters, for their enthusiastic willingness to offer their time and share their expertise – with special thanks to Dr. Alice Domar, for sharing her wisdom and compassion in an inspiring keynote address; to our exhibitors and supporters for their continued backing for the work of RESOLVE New England – with special thanks to the many volunteers who generously offered their time for conference tasks large and small, and last but not least, to our talented and dedicated staff, Lisa Rothstein, former Programming Coordinator, Vivian Samson, Office Coordinator, Keiko Zoll, Director of Communications & Social Media and Kara Dulin, Bookkeeper. We couldn't have done it without the commitment and enthusiasm of all of you!

Don't forget to save the date for next year's conference: **Saturday, November 3, 2012.**

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The process of sperm banking involves first obtaining the sperm sample. The sperm sample can be collected by masturbation, or use of a non-toxic collection condom with intercourse. A post-ejaculatory urine sample may be checked for retrograde ejaculation, where semen travels into the bladder rather than externally via the urethra. This is a common occurrence in men with diabetes, or those who have had certain surgeries of the urogenital tract. In men unable to ejaculate, such as men with spinal cord injuries, vibratory stimulation or electro-ejaculation may result in ejaculation of semen or retrograde ejaculation with sperm recovery from the urine. If these measures fail, sperm may be extracted directly from the testicle by a testicular biopsy (TESE) procedure, or by fine needle aspiration from the testicle or epididymis (MESA; PESA). For most of these procedures, cooperation between the clinician, the sperm bank and the ART facility is essential.

The semen or tissue specimen is submitted to a sperm bank or ART laboratory for cryopreservation and storage. The cryopreservation procedure involves addition of a special cryoprotective agent which is similar to an antifreeze in that it protects the cells from ice crystal damage during freezing and thawing. Following addition of the cryopreservative, the semen-cryopreservative mixture is added to special vessels such as vials or straws, which are then frozen in liquid nitrogen at -196 degrees C. The vials are always clearly labeled with a man's name and identifying information, date of banking, and the laboratory name so as to allow for complete tracing of the specimen throughout the process, storage and use. A semen specimen can be frozen as either an "ICI" specimen, that is, "un-washed" to be used for a cervical type of insemination. ICI specimens must be further processed if to be used for intrauterine insemination (IUI) or IVF/ICSI procedures. A semen specimen can also be washed prior to freezing, and thus stored as an "IUI-ready" vial. In this instance, the specimen can be used directly for an intrauterine insemination upon thawing.

Prior to sperm banking, a man should discuss all aspects of the procedure and future use of the specimens with a urologist or fertility specialist. The number of individual ejaculates to be frozen will depend on the reasons why a man has elected to sperm bank. Generally, each ejaculate should yield from 3-6 vials, depending on the initial semen volume and the motile count. One vial may be adequate for one insemination, and if two inseminations are done in an ovulation cycle, one ejaculate may yield sufficient vials for about 2 cycles of inseminations. The general recommendation has been to provide at least 3-6 ejaculates for banking. This, of course will be dependent on the time available for banking, especially in cases where cancer

treatment must be started immediately. In cases of testicular biopsy cryopreservation, one biopsy may yield sufficient numbers of vials for multiple attempts at IVF/ICSI.

When sperm banking, a man must pay particular attention to the consenting process, particularly who may use the frozen semen, especially in the event of his death. Although any stored specimens do become part of the man's estate upon his death, a generic consent does not guarantee that any specimen can be used for insemination. The consent must specify that the specimen can be given to the spouse or sexually intimate partner.

If there is no current sexually intimate partner, the specimen cannot be used for insemination of a known or potentially unknown woman (for example, if a man's parents want to use the sperm so that a grandchild may be available to them) unless specific testing for communicable diseases is done as per FDA regulations. Even in cases of a "known donor" acquaintance type of situation, the sperm cannot be used unless communicable disease testing was done at the time of sperm banking. Thus, communicable disease testing is strongly recommended for all men who elect to bank sperm. This may allow future use of the sperm for insemination of a non-sexually intimate person, as long as this was specified in the consent document. A man may also elect to discard any stored sperm upon his death. A man may also withdraw his consent to use banked sperm upon divorce or for other personal reasons. It is thus important that a man consider not only his options for sperm banking, but also the instances that will control the use of his frozen sperm specimens.

The costs for sperm banking and storage vary depending on the facility providing the service. There is usually a fee for processing (IUI versus ICI specimens) of each ejaculate, yearly storage based on the number of vials to be stored, as well as the cost of any disease testing at the time of banking. Insurance coverage for the sperm banking is not guaranteed, and will depend on the insurance carrier and the reasons for the banking, specifically the indicated diagnosis and reason for fertility preservation. There are several organizations that may assist with the costs of sperm banking, particularly for cancer patients. These include Fertile Hope, myoncofertility.org, savemyfertility.org and The American Cancer Society.

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## Comparative Genomic Hybridization for Preimplantation Genetic Screening

By Kim L. Thornton, MD, Assistant Professor  
*Department of Obstetrics, Gynecology and Reproductive Biology Harvard Medical School*  
*Director, Division of Reproductive Endocrinology and Infertility, Beth Israel Deaconess Medical Center*  
*Reproductive Endocrinologist, Boston IVF*

Preimplantation genetic screening (PGS) has been increasingly used to provide genetic and chromosomal information about developing embryos through biopsy and analysis of embryonic cellular material. PGS is designed to identify embryos with numerical chromosomal aberrations in couples at higher risk of aneuploidy. PGS has been performed in patients in an effort to enhance the chance of pregnancy and live birth for couples with repeated IVF failure, recurrent pregnancy loss, or advanced maternal age. Randomized controlled trials, however, in patients who are both good prognosis patients and poor prognosis patients have failed to demonstrate improvement in delivery rates as compared to patients in a control group. This is thought to be a result of the use of fluorescent in situ hybridization techniques (FISH) that only studied 5-12 chromosomes in cleavage stage embryos. More recently, comparative genomic hybridization (CGH), and microarray CHG (aCGH) have been used to evaluate embryos for numerical chromosomal abnormalities. This technique comprehensively assesses all 24 chromosomes at multiple loci within the chromosomes which is thought to reduce the risk error in diagnosis.

Comparative genomic hybridization (CGH) permits simultaneous and complete enumeration of chromosomes from a single biopsied cell without cellular fixation. Standard CGH compares DNA from a test sample and DNA from a normal control. The DNA samples from both the test and control are first amplified using a whole genome amplification technique. Samples are then differentially labeled with a fluorochrome; the test DNA with red and the control DNA green. The samples are then mixed together in equal proportions and allowed to hybridize with a metaphase spread from a normal male control cell line. Specialized computer software then analyzes the ratio of red to green fluorescence along the length of each metaphase chromosome and plots the ratio of red to green for each chromosome. Gains in red indicate a sample that is deficient in either a region of the chromosome or the whole chromosome, whereas gains in green indicate extra copies of a region or of the whole chromosome. While able to provide more information regarding all of the chromosomes, standard CGH is time consuming, taking up to 72 hours



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for the complete analysis. As a consequence, for couples undergoing IVF, embryos undergoing analysis with CGH are required to be cryopreserved until the results of the analysis are available.

Array CGH (aCGH) uses the same principle as standard CGH. Instead of using metaphase chromosomes, however, well defined oligonucleotide probes or genomic clones such as bacterial artificial chromosomes (BAC's) are fixed onto a slide or array. Each probe or clone corresponds to a specific part of the chromosome. The size of the array varies and may contain 100 to 1000 different spots that cover the entire genome. Fluorochrome labeling of test and control DNA are performed, and again the ratio of red and green fluorescence is determined for each spot on the array using computer software. This process is fully automated and can be performed within a 24-hour period. It is a technique that has been used successfully with day 3 embryo biopsy so that patients may undergo a day 5 embryo transfer. In centers that are proficient in blastocyst culture and trophoctoderm biopsy, day 5 embryo biopsy, aCGH and subsequent fresh day 6 embryos transfer may also be used. Currently the time to transport the DNA to the reference laboratory performing the aCGH is the major limitation to a centers ability to offer day 5 embryo biopsy and day 6 transfer. Only centers such who are able to perform trophoctoderm biopsy and aCGH on site or who are in very close proximity to the genetics laboratory are currently able to offer a fresh day 6 embryo biopsy. In New England, Boston IVF is the only center to offer aCGH on site. Unlike day 3 biopsy where DNA is amplified from a single cell, day 5 trophoctoderm biopsy allows for analysis of the DNA from 5-10 cells. This has the obvious advantage of increasing the amount of DNA available for analysis thereby reducing the risk of error due to mosaicism that exists in results from embryos biopsied on day 3. Another potential advantage to day 5 biopsy is the reduced risk of damage to the embryo with the removal of trophoctoderm cells rather than blastomeres.

While the ability to screen the entire complement of chromosomes is a major advantage of CGH technologies, there are limitations as well. CGH may not differentiate balanced translocations unless there are subtle differences in DNA copy numbers that occasionally occur in these and other chromosomal structural rearrangements such as inversions. CGH also may not differentiate whole genome ploidy states such as polyploidy (e.g. 69,XXX) or monploidy (23,X) as there is equal representation of all chromosomes. In general changes in DNA sequence (point mutations, insertions, deletions) cannot be detected if the

gain or loss in the region of the genome is not covered by the microarray.

Whether array CGH is effective in improving live birth rates in patients undergoing IVF with implantation failure, in patients with recurrent pregnancy loss and in women of advanced maternal age remains to be seen. Recent unpublished data have evaluated implantation rates after day 3 blastomere and day 5 trophoctoderm biopsy. While an age related decline in implantation rates persists for normal embryos biopsied on day 3, normal embryos assessed by aCGH after day 5 trophoctoderm biopsy have similar implantation rates irrespective of maternal age. This preliminary data raises the question as to whether it is the impact of the embryo biopsy itself (day 3 or day 5) or possibly the fact that day 3 embryos have a significant amount of mosaicism that is the cause of the difference in implantation rates. To answer this questions as well as many others, it is imperative that randomized controlled trials of couples with implantation failure, recurrent pregnancy loss and advanced maternal age undergo preimplantation genetic screening to further explore the use of aCGH and in particular the efficacy of day 5 biopsy and fresh day 6 embryo transfer in improving clinical outcomes in these patients.



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## Advocacy Update

The fall of 2011 was a fairly quiet time for advocacy within the New England states. However we were very pleased with the successful defeat of the Mississippi Initiative 26. Please read below for more information on this important victory.

RESOLVE New England welcomes anyone interested in becoming an advocate for infertility coverage in New England. If you are interested, please contact us at admin@resolvenewengland.org to see how you can get involved.

\*\*\*\*\*

### Mississippi Initiative- MS26 Successfully Defeated

*Proposed "Personhood" Amendment jeopardized the continuation of fertility treatment in the state of Mississippi*

RESOLVE New England applauds the successful defeat of Mississippi Initiative 26. This "personhood" amendment could have thrown into jeopardy the continuation and future treatment of infertility patients in the state of Mississippi. The vagary of legal protections for physicians, embryologists, and clinicians could have potentially ended the practice of IVF and other fertility treatment procedures altogether in Mississippi.

Had MS 26 passed, it would have emboldened nearly a dozen other states to pursue similar personhood legislation, whose primary objective is to ban abortion but leaves infertility patients in those states in similar peril for pursuing fertility treatment. Even in the New England region, we are not immune to such legislation.

Earlier this year a bill was introduced into the Massachusetts House that proposes to amend the current adoption statute to include the following language: "A person of full age may petition the probate court for the adoption of an embryo." While the bill is not expected to pass, it is still a sobering reminder to our professional colleagues and fertility clinics within the New England community that we must remain vigilant of personhood legislation that threatens the access to healthcare for infertility patients.

RESOLVE New England is committed to leading advocacy efforts to ensure that legislation like MS 26 does not succeed within the New England region. We are committed to remaining watchful of any proposed similar legislation within the region and will provide education and advocacy support to those who seek to join us in our

efforts to oppose personhood legislation within the New England region.

### RESOLVE: The National Infertility Association's Contribution to the Effort

The over-arching role RESOLVE: The National Infertility Association played was in raising awareness that MS26 would hurt couples trying to have children. When personhood was attempted in CO, the opposition had focused on abortion and birth control. RESOLVE was the one to point out that it would also restrict or outlaw IVF. So, when personhood came to MS, we knew this would be an extremely important message in a very pro-life state. We were early members of the Mississippians4HealthyFamilies Coalition; supplied vital information on the effect of MS 26 on IVF; worked on a lot of the extremely effective grassroots involvement; provided media training and interviews; flew our Advocacy Co-chair, Renee Whitley, to Jackson, MS to speak on a legal panel; worked with fertility doctors in MS; and spread awareness throughout MS and all over the country. RESOLVE was up to their elbows daily ... and are so pleased and relieved that the vote came out as described above!

\*\*\*\*\*

### Family Act of 2011, S 965 introduced in the U.S. Senate

*Proposed legislation will remove financial barriers for infertility treatments*

RESOLVE applauds Senator Kirsten Gillibrand (NY) for introducing a bill in the U.S. Senate that would provide eligible taxpayers a tax credit for the out-of-pocket expenses incurred with infertility medical treatment.

Appropriately named the "Family Act of 2011," the bill, S 965, would apply to expenses related to in vitro fertilization and treatments to preserve fertility for cancer patients.

The Bill was introduced just days after RESOLVE's successful Advocacy Day in Washington, D.C. Advocates from across the country met with their Members of Congress to advocate for the tax credit. Enthusiasm was very strong for the tax credit among the Advocates, who see the need for immediate financial relief for infertility patients.

"Infertility Is..." Blog Contest (Continued from page 1)

We are waiting for insurance approval for another (most likely our last) IVF which can hopefully occur, or at least begin, before the end of the year. We are also signed up to go to an infertility & adoption conference in about a week to get all the information we might need on adoption. At this point in time, I am really unsure about how our journey will end, but it will end and our summer will begin.

I want to leave you all with my new favorite quote. I carry it around in my wallet with me; I repeat it at least once a day. It truly keeps me going. I hope you can find inspiration from it as well.

"The moment you think about giving up, think of the reason why you held on for so long."

This post is part of the Infertility Is Blog Contest sponsored by RESOLVE New England. You can find links to all of the submissions online at their website. For more information about RESOLVE New England, like them on Facebook or follow them on Twitter.



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(860) 525-8283



**NOW EVEN MORE WAYS TO CONNECT WITH RESOLVE NEW ENGLAND!**

**FOLLOW US ON TWITTER!**  
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**RESOLVE OF NEW ENGLAND**

## RESOLVE INSURANCE CALL IN HOURS

### RESOLVE NEW ENGLAND Massachusetts Insurance Call-In Hours

Call 781-890-2225 on the date indicated to get your questions answered live.

**Insurance Call-in:**  
**and Mondays, January 16, February 27, April 9, 2012 7:30-8:30**

Having trouble getting insurance coverage for your doctor's recommended treatment plan? Need help framing an appeal letter to your insurance provider? Want to know what the Massachusetts mandate covers? Call for consultation with our Insurance Advocate.

**Fees:** FREE to RESOLVE New England members, or join over the phone with your credit card.  
**781-890-2225**

## *Helping New England couples become parents since 1988*



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Committed to Your Success

*It's easy to become a member of RESOLVE New England. Go to our website and click on "Membership."*

## Household Member Benefits

Household Membership: \$55/year

RESOLVE NEW ENGLAND provides compassionate and informed support, education, and advocacy to people in New England who are experiencing infertility and seeking to build a family. Join those who know what it's like to wish for a baby. You are not alone.

**Chapter Telephone** — Call us at 781-890-2250, for information and support from our Member Services Coordinator.

**Quarterly Newsletter** — includes information about our programs and services, as well as articles of interest.

**Insurance Call-in Hours** — 781-890-2225, for one-on-one assistance by phone with your insurance problems. Check our website or this newsletter for scheduled hours.

**Educational Programs** — reduced fees for varied monthly presentations by experts in the fields of infertility, donor conception, or adoption. Also day-long seminars providing an in-depth look at one topic.

**Monthly Peer Discussion Groups** — open forums held at various locations providing information and support to people interested in learning more about infertility and RESOLVE. Groups focusing on specific topics are held in our Waltham office.

**Discounts** — members can attend all Peer Discussion Groups free of charge and receive substantial discounts on attending all of our programs and for literature.

**Annual Conference** — discounted fee for this day-long educational event with over 40 workshops focusing on infertility treatment, emotional issues, donor conception, and adoption.

**Directory of Services** — a resource book of infertility, mental health, donor conception, and adoption services, published annually.

**Advocacy** — for protection of the Massachusetts insurance mandate, implementation of mandates in New England states without a mandate, and for continued legislative and insurance reform.

**Member-to-Member Connection** — members are matched with member volunteers who share similar experiences or who have a specific area of expertise.

## Professional Member Benefits

Professional Membership: \$150/year

We welcome professionals working in infertility, adoption, donor conception, and related fields to become professional members of RESOLVE NEW ENGLAND, the only organization providing direct services to people experiencing infertility in New England. RESOLVE NEW ENGLAND offers its professional members a number of benefits in addition to those available to our household, consumer members, including:

### AS ALWAYS:

- By purchasing your new or renewed membership through us, **all proceeds stay local** and help us provide services to those experiencing infertility in the New England area.
- Option to advertise/list in our annual printed directory.
- Option to exhibit/advertise at our annual conference.
- Option to write articles for and advertise in our quarterly newsletters.
- Discounted pricing to events.
- Leadership/volunteer/presentation opportunities.
- Indirect benefits: advocacy for preservation of infertility insurance mandates and introduction of new mandates; media efforts on infertility issues.
- Basic alphabetical listing in our online professional directory.

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*Share your experience, support and most of all, HOPE.*

*Please contact us by email or phone if you are interested in sharing your story.*

*admin@resolvenewengland.org  
781.890.2250*

*We are always looking for new ways to provide benefits and services to our members, both household and professional. If you have any suggestions on how we can better provide for our members, or if there is a feature or benefit you'd like to see, please let us know. And as always, thank you for your support of RESOLVE NEW ENGLAND!*



# NEW YEAR NEW BEGINNINGS



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