



## Gestational Surrogacy with Oocyte Donation

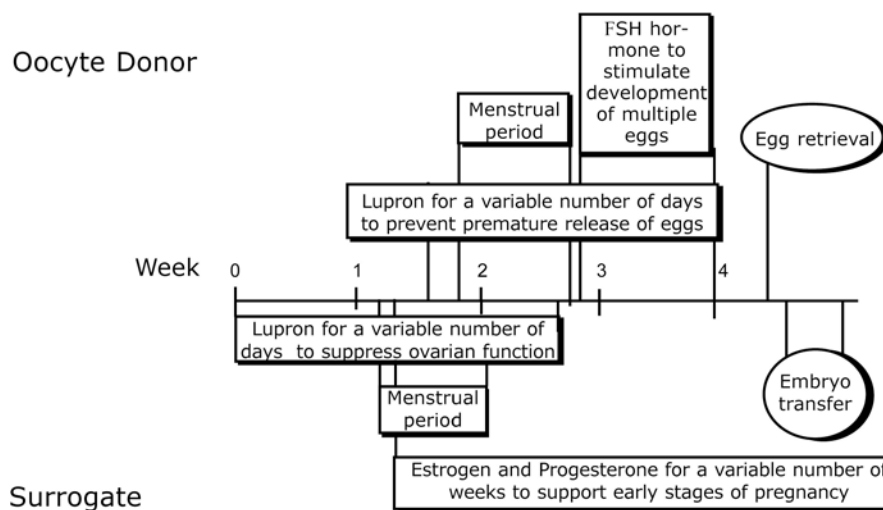
Gestational surrogacy with oocyte donation is one of the most effective treatments available to help infertile couples achieve pregnancy. Typically, there is a 50-80% probability of live birth per cycle of treatment. The procedure is similar to *in vitro* fertilization.

In this treatment, an egg donor provides the eggs, the intended father provides the sperm and *in vitro* fertilization is done to create embryos. The embryos are then transferred into the surrogate's uterus.

Gestational surrogacy with oocyte donation consists of:

1. Ovarian stimulation to induce growth of multiple eggs within the donor's ovaries
2. Ultrasound guided retrieval of the eggs
3. Fertilization of the eggs with the intended father's semen
4. Preparation of surrogate's uterus for embryo transfer
5. Embryo transfer
6. Establishment of pregnancy

This is an example of a gestational surrogacy with oocyte donation treatment sequence. Actual treatment is individualized.



### 1. Ovarian Stimulation

Gestational surrogacy with oocyte donation treatment begins with the onset of the egg donor's menstrual period. Oral contraceptives are started within the first seven days of her menstrual cycle. They prime the ovaries for an optimal response.

One week before the estimated onset of the following menstrual period, Lupron injections begin. Lupron prevents premature release of the eggs from the ovaries prior to the egg retrieval procedure. The Lupron injections are given subcutaneously (just under the skin). These injections are given for approximately three to four weeks.

After one to two weeks of taking Lupron the egg donor will start her menstrual period. Soon after the onset of this period, she will begin taking FSH (Follicle Stimulating Hormone) injections in addition to the Lupron.

FSH stimulates maturation of multiple eggs in the ovaries. The FSH medication is taken for approximately ten days depending on her response. During this time the ovarian stimulation is monitored by ultrasound and estrogen blood levels.

Once the eggs are ready, she will be instructed to stop taking the Lupron and FSH and to take a single injection of HCG hormone. This medication triggers the final stages of egg maturation. Thirty-six hours after the HCG injection, the eggs are nonsurgically retrieved from the ovaries.

## 2. Ultrasound Guided Transvaginal Egg Retrieval

The egg retrieval is an office procedure at Nova IVF. Using ultrasound guidance, a tip of a thin needle is passed through the top of the vagina and into the cul-de-sac (a space behind the uterus). The ovaries are located near the bottom of the cul-de-sac allowing the tip of the aspirating needle to enter the ovarian follicles and aspirate the follicular fluid from them. The fluid is examined under a microscope to identify the eggs.

The egg retrieval takes approximately five to ten minutes. Medications are used for analgesia. There may be a mild cramping sensation when the needle passes through the vaginal wall. The actual follicle aspiration is typically not felt by the patient. The egg retrieval is a very safe procedure. The egg retrieval procedure is the last step in the egg donor's participation in the treatment. She will get her normal menstrual period within two weeks of the egg retrieval.

## 3. Laboratory

On average, eight to fourteen eggs are aspirated. The eggs are identified under the microscope and are placed into petri dishes that have been filled with culture medium. These petri dishes are pre-labeled with the patient's name and an identifying code. The culture medium is prepared in advance of the treatment. The composition of the medium resembles the fluid secreted by the Fallopian tubes. This allows the embryos to develop in either environment at the same rate.

The intended father collects a semen specimen on the day of the egg retrieval. The semen can be collected outside of the office if the specimen can be delivered within thirty minutes of collection; otherwise it should be collected at Nova IVF. The sperm and the eggs are combined after the egg retrieval. The very act of fertilization takes place over a period of several hours during the night. If the infertility history suggests a possibility of a male factor significant enough to keep the eggs from being fertilized by this method, we will perform the ICSI (Intracytoplasmic Sperm Injection) procedure in which a single sperm is inserted into an egg. This can significantly increase the fertilization rate for selected couples.

## 4. Preparation of the Surrogate's Uterus

The lining of the surrogate's uterus must be prepared to receive the embryos. The development of the uterine lining must be synchronized with the development of the embryos. This is achieved by taking estrogen and progesterone.

If the surrogate has monthly menstrual periods, her treatment will typically start with taking oral contraceptives. They are used to suppress her ovarian function and to begin the process of synchronization. Oral contraceptives are started within the first seven days of the menstrual cycle.

A week before the estimated onset of the following menstrual period, Lupron injections begin. Lupron "puts the surrogate's ovaries to sleep" and temporarily stops their production of estrogen and progesterone. This endogenous estrogen and progesterone secretion would interfere with the development of the endometrial lining.

After one to two weeks of taking Lupron, the surrogate will have a menstrual period. Within one to three weeks of the onset of her period, she will begin taking estrogen by way of medicated skin patches. The development of her uterine lining will be monitored with ultrasound examinations and by the estrogen blood levels. Once the egg donor is ready for the oocyte retrieval, the surrogate will begin adding progesterone to the estrogen. The addition of progesterone opens the "window of receptivity" for her uterus and synchronizes development of the lining with the development of the embryos. Progesterone is given as a daily intramuscular injection for the first four days and then progesterone vaginal capsules are given twice daily.

## 5. Embryo Transfer

The embryo transfer is done one to five days after the egg retrieval. The embryos are "loaded" into the tip of a very thin transfer catheter in a very small volume of transfer medium, the catheter is then passed through the cervical canal to within 5 mm of the top of the uterus and the embryos are gently released. The transfer usually takes a few seconds to complete. No resting is required afterwards and

the surrogate can immediately resume her normal daily activities. She does not have to change her lifestyle as she goes through the gestational surrogacy with oocyte donation treatment.

The gamete embryologists will assess the embryos prior to the embryo transfer to determine their likelihood of implantation. Most partners will usually select two to four embryos for the transfer. Approximately one-third to one-half of Nova IVF's surrogacy with oocyte donation pregnancies are twins and there are very few triplet pregnancies.

There may be more embryos than the partners and the surrogate may wish to have transferred. It is possible to cryopreserve these "extra" embryos and store them in liquid nitrogen. Approximately one-half to three-quarters of the embryos survive the cryopreservation/thawing process. The implantation rate of the surviving embryos is similar to the "fresh" embryos.

## 6. Establishment of Pregnancy

After the embryo transfer, the front and back walls of the uterus gently hold the embryos keeping them within the uterus. There is no need to restrict surrogate's physical activity. She will continue taking the estrogen patches and progesterone vaginal capsules.

Approximately two weeks after the embryo transfer, she will return to Nova IVF for a blood pregnancy test. The result will be out the same day. If the pregnancy test is positive, an ultrasound examination is scheduled two weeks later to visualize the implantation site and to look for a heartbeat.

Once a heartbeat is seen, there is a 95% probability that the pregnancy will continue to a live birth and only about a 5% chance that it could still end in a miscarriage.

The surrogate will continue coming to Nova IVF every 1 to 2 weeks to have her estrogen and progesterone blood levels monitored. Six to eight weeks into the pregnancy the placenta produces so much of its own estrogen and progesterone that the supplementation can be discontinued. The surrogate's treatment at Nova IVF usually ends at that point and she will be referred for routine obstetrical care. Once she discontinues all medications, her pregnancy becomes indistinguishable from a pregnancy conceived spontaneously.