Dr. Dorette Noorhasan (00:04)
It's a process and no two journeys are the same. And I encourage patients to talk to other fertility patients, but at the same time, your journey is going to look different from another person's journey.

Priya Bathija (00:19)
So you're trying to have a baby, and it turns out it's not as easy as everyone made it sound. You spent your early years being told to be careful. It only takes one time to get pregnant.

But then you're ready. You're trying. You're doing everything you can to get pregnant. And it turns out one time wasn't enough. 24 times wasn't enough.

You see your friends getting pregnant, and it seems so easy. For everyone but you.

Getting pregnant can be really hard. It can be filled with ups and downs, and no matter how hard you try, there are no guarantees.

But understanding your options can help you feel like you have a little more control over what's happening.

Hi, I'm Priya Bathija, and this is the Women's Health Playbook. I've spent over two decades working to help make healthcare in America better for women. I've heard from women all over the country about what they're grappling with when it comes to their health.

According to the CDC, one in eight women under the age of 49 face infertility. In reality, according to our guests today,it's more like one in six. And in 20% of those cases, the infertility goes unexplained.

For many women, getting pregnant is an exhausting, seemingly never-ending treadmill of cycle tracking, intercourse having, waiting around to see if it worked, kind of exercise.

All the while, you're thinking about it constantly. You're trying to spot any little clue from your body that it worked. And you're bracing yourself for the disappointment you know might be coming.

But there are many options out there if you're ready to seek help.

In this episode, we discuss how you can build a collaborative relationship with your doctor and care team. And we cover everything from asking for what you need to ensuring you leave the room with a clear plan of action. Plus, why infertility isn't just a women's health issue. It afflicts men too.

Our coach for today is Dr. Dorette Norhausen.

Dr. Dorette Noorhasan (02:45)
I'm a fertility physician. I currently practice in the Dallas Fort Worth area.

Priya Bathija (02:51)
She grew up in an immigrant family in the US Virgin Islands.

Dr. Dorette Noorhasan (02:56)
I got accepted to Boston University School of Medicine on early admission. I finished my last year of college there and then went straight into medical school there.

Priya Bathija (03:07)
She completed her OBGYN residency in Houston and then did a fellowship in reproductive endocrinology and infertility in New Jersey.

Dr. Dorette Noorhasan (03:16)
I've been in private practice for about 17 years. I really enjoy taking care of patients.

Priya Bathija (03:23)
But, Dr. Norhausen said, while she's always loved her work, she came to understand it even better as a patient.

Dr. Dorette Noorhasan (03:31)
Because I came from an immigrant family, I put my career first. And I did not meet my husband until a month before my 38th birthday. It was much later in life. And my husband at that time was in his early to mid-40s. Neither of us had kids. And so essentially I've done five rounds of IVF, five egg retrievals, and surrogacy eventually to have my only child.

And so this is a topic that I know personally as a patient, as well as a physician.

Priya Bathija (04:06)
After sharing her story with her own patients, she was encouraged to start sharing her infertility struggles more publicly to raise awareness.

Dr. Dorette Noorhasan (04:16)
If a fertility doctor can go through this, it would be so much more helpful for other patients to learn about this.

Priya Bathija (04:23)
Since then, she's written two books: Miracle Baby and the Fertility Manual.

Dr. Dorette Noorhasan (04:28)
As physicians, we talk the medical lingo and sometimes we forget to break it down into simpler terms. And so the fertility manual teaches patients basic infertility knowledge so that they're equipped to go and ask their doctors the right questions about their care.

Priya Bathija (04:45)
And now she's raising awareness with her new podcast, Modern Parenthood.

Dr. Dorette Noorhasan (04:51)
I deliberately chose the name modern parenthood, a bit broader than just infertility, because it's not just having a biological child. Some patients do IUI and IVF, which we'll talk about later on, but other patients will do third-party reproduction, donor egg, donor sperm, surrogacy. Others may adopt, others may foster and then adopt. And so what parenthood looks like today is very different than what it looked like decades ago and sometimes it looks different today than what we thought or parenthood should have looked like, what we had dreamt as a child, what being a parent should be. But it really is that love and showing up for a child is what really makes you a parent.

Priya Bathija (05:39)
In this conversation, Dr. Noorhasan talks about the prevalence and changing landscape of infertility. Why comprehensive fertility testing for both partners is so important, and she gets real about the emotional and financial realities of the fertility process.

I think one of the misconceptions we have is that infertility is uncommon, but it actually is more common than most people think. Can you share some of the data around that?

Dr. Dorette Noorhasan (06:12)
Absolutely. When I first started doing this, we used to say one in eight couples needed fertility treatment to have a child. Today it's one in six couples that need treatment.

When I first started doing this, I used to say one percent of children worldwide were born via some form of what we call artificial reproductive technology. Today I say three percent of children born worldwide are from artificial reproductive technology. So it's more and more prevalent today.

It's there's probably two components to this. There's probably more awareness today than they were decades ago. Decades ago, we did not know why Aunt Susie never had a child. We just assumed perhaps she just didn't want children. And we didn't know that perhaps maybe she struggled in silence. So today there's more awareness. But also today there are other things that influence why infertility is more prevalent.

Age is a big one. We're waiting later in life to have children. Sometimes we're in second marriages. We have a first set of family and have a vasectomy or tubal ligation and then have a second set of family in our late 30s and early 40s.

Our environment plays a big role. Today we have pollution, we have microplastics, our diet is not as clean as it was decades ago. So our environment and our lifestyle, the stress and quick,

easy fixes, stopping for quick meals instead of eating whole grains and good lifestyle changes also affects our fertility.

So it's very different today than it was decades ago. In the nineteen twenties it was different when you lived off the farm and everyone started having children at eighteen or twenty two. A very different world than it is today.

Priya Bathija (08:06)
We often think as a society when we consider infertility, we think about it, we talk about it as a female issue. But it's not. Can you talk a little bit about male infertility?

Dr. Dorette Noorhasan (08:20)
Absolutely. And that's why I say 40% of my listeners are men. Male infertility.

So when a patient presents to us, we do the testing. And when we find a source of infertility, it's about 50-50. So 50% of the time it's female, 50% of the time it's male. And that's when we find a source of infertility. About 20% of patients will have what we call unexplained infertility. And all that means is the testing looks good. We're not sure why you're not getting pregnant.

But when we do find a source in that 80% of patients, it's about 50-50. So men do play a major role in this process. Sperm is important. And I've seen where very abnormal sperm can have a negative impact on embryo quality. And so sperm is important, and men do play a large role. It's not just a female problem.

It is a couple problem because they want children together. They're presenting as a couple as them. It's not your problem or my problem. It's our problem. And so having the men there as well as having them do testing and participate in a treatment is very important.

Priya Bathija (09:37)
Yeah, I never realized that until recently because I have not gone through the process. So I had no idea that it could be 50-50. It's just always presented as a woman's challenge or problem.

So if a couple is trying to get pregnant but they're unsuccessful, when is the right time to seek out a fertility specialist? Like what have they done already? Or tried before they need to come to you.

Dr. Dorette Noorhasan (10:08)
Great question. There's no perfect time to come and see me. So you could decide you want to see me from the very beginning.

I have patients that will come and see me and not even trying to get pregnant. They just want to do some testing. They want to know what they have to work with. They think they're going to start trying maybe in three to six months. So I have couples that come and see me from the very beginning.

Now, the way we define infertility, we say if you're a female and you're 34 years of age or younger, and you've been trying for a year or longer, you're diagnosed with infertility, and you should see a fertility doctor. We say if you're a female 35 years of age and older, and you've been trying for six months or longer, you should go and see a fertility doctor.

Now, there, like I mentioned, there are other people who should see me from the very beginning. If you have irregular cycles, if you've had a tubal ligation, if you've had a vasectomy. Members of the LGBTQ plus population will want to see me from the very beginning. So there are many people that have a medical diagnosis and will want to see me from the very beginning.

And like I mentioned, there are people who will come and see me, they haven't even been trying. They just want to know what they have to work with. And this is where education and awareness is so important because when those couples come in and see me, I'm like, wow, that's awesome.

You're starting this process and you want to do some testing. Most of times everything looks great, but sometimes we find a problem and it's great that they didn't try and waited a whole year just to see a fertility doctor and they found out, hey, there's some things we need to address today before you even start trying.

Priya Bathija (11:55)
You mentioned testing, that when patients come to you they can get testing. What does a comprehensive fertility work up look like for both partners, male and female?

Dr. Dorette Noorhasan (12:06)
Absolutely. I divide the testing into four big categories.

So the first category is eggs. We want to look at egg quantity and quality. And typically that involves blood testing, typically on the second, third, or fourth day for your cycle. So that's called like your baseline labs. FSH, follicular stimulating hormone, LH Luteinizing hormone, estradiol level, as well as AMH antimularin hormone. So we're looking at those numbers.

Ideally you would want your FSH to be less than 10. And with and that is with an estrogen level or estradiol level of under, I say under 80, under 80 because I'm a little bit more lenient, but super strict physicians may say actually you want your estradiol level to be under 68 when you look at that FSH level. An AMH level, I like an AMH level of 1.5 or higher. So those are some of the blood testing we look at.

We will look at an ultrasound where we do what's called an antral follicle count. And the follicles, ideally, you want to see about eight to ten follicles total between both ovaries. And let me backtrack. So a follicle is a sack of fluid in the ovaries that contain eggs. And so counting the follicle, we cannot count actual eggs. You can only see eggs under the microscope, but

counting the follicles, a nice number would be eight to ten. So in terms of egg quantity, quality, we're looking at those numbers.

Also, ovulation. Ideally, if a woman tells you I have very predictable cycles on average, it comes every month when I expect it to come, plus or minus a couple days on either side, but it's pretty predictable. If a woman gives you that history, just based on that history, most likely that woman is ovulating.

Sometimes we'll check a progesterone level. So progesterone rises after ovulation. Typically, we will check that about seven days after ovulation. So we're typically looking in a woman with perfect 20 to 30 day cycles, we'll check that progesterone level somewhere between day 19 to 23. So that's eggs.

The next thing we look at is sperm and sperm quantity, quality, same thing. So semen analysis, we'll have him create an appointment. Plan to be about two to five days of abstinence is about the right range. And then give us a sample. We're looking at volume. We want it to be about 1.5 milliliters or higher. We're looking at concentration. We want about 16 million per milliliter or higher.

We're looking at motility. Motility is how fast the sperm swims. We want about 42% of the sperm to have good motility. And then morphology, morphology shape of the sperm. Morphology helps us predict how well sperm will be able to fertilize an egg on its own. And we're looking for about 4% or higher on a Kruger-strict morphology. So that's sperm.

And then the third category is anatomy, so female reproductive tract. There's about three different tests we'll do. One is called an HSG, hysterosalpingogram.

It's a dye test where we inject dye and see the fallopian tubes fill and then spill the dye. And that's when we know that the tubes are open. A saline infusion sonogram, I do that with a three-dimensional ultrasound where I can look at details within the cavity, looking for things like fibroids, polyps, anything that may obstruct an embryo from implanting or growing. Hysteroscopy, sometimes that can be done in the office as a diagnostic tool. Or in the operating room as a treatment where we go in and remove polyps or fibroids. So those are three different tools we use in terms of evaluating the anatomy.

And then the fourth category is my other category. So that includes things like the thyroid. The thyroid is what we call a homeostatic hormone. It influences multiple systems in our body, including our reproductive system. And can affect our ability to get pregnant or result in miscarriage. So the thyroid is definitely important.

I look at vitamin D levels. Vitamin D needs to be optimized. And a large percentage of us in the world are vitamin D deficient. And that can influence our reproduction as well. I also look in women with irregular cycles, we'll look for a hormone called prolactin. It's very rare that that's elevated, but there is a gland that sits at the base of the brain called a pituitary gland. If there

are certain parts of it that enlarges, it can release a hormone called prolactin, which can make women's cycles irregular.

We also look at polyendocrine metabolic ovarian syndrome. It is a multi endocrine syndrome that often women struggle with weight. They have insulin resistance, they can have irregular cycles. They can have mildly elevated levels of testosterone. So we will check a testosterone level as well in women with irregular cycles, as well as genetic testing.

So earlier on in this conversation, I mentioned sometimes couples will see me before they even try to get pregnant. So genetic testing. One is genetic carrier screening. Genetic carrier screening is in the entire world, many of us carry genes for silent or recessive disorders. A silent or recessive disorder means you only carry the gene, but do not have the disease. And so you don't know that you carry the gene because you don't have symptoms of the disease, and nor will you ever get this disease.

It only becomes a problem when a child gets one copy of the gene from the egg and one copy from the sperm. And then with two copies, then you can have the full bloating disease. So things like cystic fibrosis, SME, fragile X, Thalassemia, sickle cell, these are very prevalent in our population. So genetic carrier screening is also part of that testing, as well as carrier type or chromosomes. Women should, well, actually, all of us, we have 46 chromosomes. Women are 46xx, the last pair is XX. Men are 46XY, the last pair of chromosomes are X and Y.

A small percentage of the population have translocations, meaning they have all the chromosomes they need for normal day-to-day function. But those chromosomes are arranged in the wrong pattern. And so when those people go to get pregnant, they can have infertility or miscarriages. Those are all part of the quote unquote other testing that we do when patients present to us.

Priya Bathija (19:06)
So that's a lot, right? We're looking at eggs, we're looking at sperm, we're looking at the anatomy of the woman, we're looking at all these other factors that are happening in her body on a day to day basis. How do you sit down and have a conversation with patients to help them understand what all this data means for what they are trying to accomplish with their family building timeline?

Dr. Dorette Noorhasan (19:34)
Yes, absolutely. Patients can be very overwhelmed when you give them this slew of testing and they have to do all of this. But all the testing matters. Doing all the testing and roughly around the same time for both partners is very important. And all of those tests give me different information where I need all of that to get the big picture.

And so what I would like to share with our listeners is, it is a process. So you will see your fertility physician and they'll send you for a test. And some of those blood testing, particularly the genetic testing, can take a good four to six weeks sometimes before we get the results back. So

you don't have answers at your new patient visit. Your new patient visit is just getting comfortable, learning about your testing. And then at your second visit, then you'll have the results of your testing and have answers and a potential treatment option at your second visit.

So your new patient visit, I know one of the things is people come into their new patient visit expecting answers. And it's it's you don't get any answers in many instances, unless you brought 800 pages of old records with you. Most of the time we're just setting you up for testing. And then your second visit after the testing, we're reviewing results and then potentially presenting with treatment options. And then the treatment options take time and

It can be frustrating, particularly when people wanted to be pregnant yesterday. And allowing people to give themselves grace and understand this is a process. And for most people, it'll be a few months, but occasionally we have difficult cases. It may take a year or two before we can finally help them get pregnant.

Priya Bathija (21:21)
Yeah. So are there any questions that patients should be asking at those first or second visits to help them get better information from their fertility specialist?

Dr. Dorette Noorhasan (21:34)
I think at your first visit is seeing if it's a right fit, making sure you're comfortable with the process, filling out your paperwork initially before you get to the doctor's office, the feeling you get when you walk in the front door. Do you and your physician,is that a good match?

Um and then at your second visit, hey, what do these results mean? How can I use these results to either try to get pregnant naturally or should I move on to treatments and which treatment is right for me? Um, and many times patients focus on success rates of the clinic. Success rates of the clinic matter, and success rates in the IVF lab matters, but also there's your individual prognosis as a patient. If I have if I see two patients on the same day,

The twenty-one year old who's married to a fifty year old and they have male factor, but she has amazing twenty-one year old eggs. And then a 45 year old married to another 45 year old, those two people are gonna have very different success rates in terms of what in terms of their IVF and same doctor, same lab. And so asking what my individual success rate is very important.

Priya Bathija (22:56)
So you mentioned that there are many options to consider when it comes to fertility. And I want to talk about each of those and when they might be the right course of action for an individual, but sort of in a rapid fire way, because for each of these, we could do a whole episode or more to talk about them. But I just want to give our listeners sort of a lay of the land of what's out there and available to them.

So the first of course is timed intercourse. Can you tell us more about that?

Dr. Dorette Noorhasan (23:28)
Timed intercourse cycles, you can combine that naturally with your natural cycles and watching your ovulation predictor kit and doing timed intercourse. You can combine it with pills like Clomid or Letrozole and then doing timed intercourse. Success rate, again, depends on the person. It's probably about three to five percent, I would say, on average.

Priya Bathija (23:50)
And then what about medicated cycles? Is that the same thing or different?

Dr. Dorette Noorhasan (23:55)
So medication, if you did pills like Clomid or Letrozol. Now, if you did it with intrauterine insemination, of course, I'd say about five percent. If you combine the Clomid or Electrazole with intrauterine semination, success rate's about 10%. If you combine Clomid or Letrazole with IUI, but in a lesbian couple using donor sperm in their 20s, that success rate's 20%. So again, it boils down to who the person is that's sitting in front of me.

Priya Bathija (24:25)
You just mentioned intrauterine insemination or IUI. What is that?

Dr. Dorette Noorhasan (24:31)
Mm-hmm. Intrauterine dissemination or IUI. That's where we get the sperm sample. And it's really like a pap smear. That's what I tell patients. You don't need anesthesia. It really is a pap smear. It's a speculum exam. And we just put a catheter into the uterus, inject the sperm, you're done. It's like a pap smear. You don't need to take any special medicines ahead of time. You don't need to do anything different. You're in for a few minutes in the office and you're out.

Priya Bathija (24:56)
Who might that be a good option for?

Dr. Dorette Noorhasan (24:59)
That's a great option for young couples, young with good testing results, with great sperm, great eggs, both fallopian tubes are open. That's who that would be a good option for.

Priya Bathija (25:11)
Okay, and then I think the one that we hear the most about is IVF or in vitro fertilization. Can you explain that one?

Dr. Dorette Noorhasan (25:19)
So in vitro fertilization, fertilization occurs outside the body. So in vitro, in the lab, fertilization occurs outside the body. In vivo fertilization, fertilization occurs within the body. So that's what time in a course or IUI. So all in vitro fertilization means is that the fertilization occurs outside the body. But that also means we need the eggs and sperm in our hands to make that fertilization happen.

So for men, it's very easy for them to give us sperm. They can give us sperm the old-fashioned way in a cup.

For women, though, they have to take injections to make their ovaries produce the eggs, and then we have to retrieve them. The retrieval is done vaginally with a vaginal ultrasound, and you get anesthesia for this process. So you will not feel or remember it, and there are no incisions on your belly. And then we have the eggs and sperm uh in our hands, and we can do the fertilization.

Now, most people today will we do fertilization with ICSI. So you'll hear that term thrown out quite a bit too as well. ICSE's ICSI, intracytoplasmic sperm injection. That's where we pick up the sperm and inject it into the egg to create an embryo. ICSI was initially developed for severe male factor, where we've seen improved fertilization.

Back in the old days, men with pore sperm, well, their wives moved on to donor sperm or they never had children. But once Ixy was developed, then we were able to help men with core semen parameters to help them have biological children. Since then, we've been utilizing ICSI more and more frequently in the unexplained infertility category. ICSE is very beneficial because several of those patients with unexplained infertility on a cellar level, the eggs and sperm don't know how to get together correctly. And so helping them fertilize is helpful.

Priya Bathija (27:17)
Hey, it's Priya. I just wanted to pop in here and encourage you to send this episode to a friend. The information we're sharing here is so valuable, and it's how we help each other get the best care possible as women in America. So hit the share button on whatever app you're listening on. Send it to your daughter, sister, aunt, mother, a coworker, or honestly, send it to every girl dad you know. Because the more we all know, the better healthcare will be for everyone.

Okay. Back to the play.

Yeah, and then you had mentioned third party involvement in this process. Is that third party assisted reproductive technology or is that something else?

Dr. Dorette Noorhasan (28:02)
So third party reproduction is where essentially you're borrowing an egg, you're borrowing a sperm or a uterus. So donor egg, donor sperm, or surrogacy.

So donor egg, typically for women with lower egg quantity quality, where the egg is past that time frame where that per we could use that egg to create a live birth. Donor sperm for a there are some instances in heterosexual couples where we have to move on to donor sperm.

Many times we're using it for LGBTQ population. And then surrogacy, surrogacy or gestational carrier. That can be utilized for women. There are some women who are born without a uterus,

believe it or not. Some women who've had a hysterectomy, women with severe medical disease where being pregnant would put either the child and or the mother at risk.

Then there are some women where we keep putting in good embryos into the uterus and this person's still not getting pregnant. All of those would be considered for a gestational carrier or surrogacy.

Priya Bathija (29:11)
Okay. So that is a lot of different options. Did I miss anything or did we miss anything in this conversation?

Dr. Dorette Noorhasan (29:17)
And then of course there's adoption. There is foster to adopt and then adopting um straight outright. There are multiple ways to be a parent today.

Priya Bathija (29:30)
How do you guide patients through these options without them feeling rushed or simultaneously behind. I can imagine there's couples that feel both ways in these conversations.

Dr. Dorette Noorhasan (29:44)
I think it's all about education and awareness. You give people the options and you allow them to make a choice that's right for them. And some couples may make a decision that other couples will choose a completely different option. And I think for each one of us it's just giving the options and allowing people to make an informed decision.

Priya Bathija (30:08)
And you mentioned some of the efficiency rates as you were going through these different options and how much of it depends on who the woman is, who the man is, what we're dealing with in terms of egg and sperm. But what are some of the most common surprises that your patients encounter regarding fertility rates and their efforts?

And the second thing is no two journeys are the same. I encourage patients to talk to other fertility patients. I encourage them to join groups because you do need the support. But at the same time, your journey is going to look different from another person's journey. So comparing is not a good thing because that only provokes anxiety. Um, and what one protocol may work well for one person, may not work well for another person. And this is where individualized care and the prognosis of one person is very different than the prognosis of the other person. So understanding those things is very important, so that there are no surprises.

Priya Bathija (31:39)
You know, the physical, emotional, and financial weight of fertility treatment can really consume a person or a couple's lives. What suggestions do you have for balancing realistic success rates with the emotional need for hope? And I think I'll say on your behalf, straight out the gate, don't compare yourself to others, but what other tips do you have for our listeners?

Dr. Dorette Noorhasan (32:09)
So eating a healthy lifestyle is important. That's one thing you have control over. So lifestyle factors. Joining support groups, important. There are national groups like Resolve. That helps as well with getting you connected with other couples. There are groups on Facebook that they get together and talk about their uh cycles. So having a support group is important. Family and friends, important as well.

Seeing a therapist in some severe cases can be beneficial. There are people, just like you said, struggling with the emotional as well as the financial stresses and everything else. So seeing a therapist is very beneficial for many couples. And a few couples may also need to be put on treatments like an SSRI, like a Lexapro or some type of antidepressant, anti anxiety medication, but those are very few. Most people do well with just therapy and joining groups. So having that village, that group of people that you can rely on and bounce things off of is very important.

Priya Bathija (33:24)
Yeah. And you mentioned financial costs and the stress that can come with that. What are some of the financial costs that are associated with fertility treatments?

Dr. Dorette Noorhasan (33:35)
You know, when I first started doing this, there was very little coverage from insurance carriers for fertility. Today, I'd say probably about sixty-five percent of the patients I see have fertility coverage. More and more insurance companies are now covering fertility treatments as well as things as egg freezing. And so people now have options in terms of coverage for their fertility treatments.

Priya Bathija (34:04)
Yeah, and how can they work with their fertility specialists to advocate for coverage, appeal insurance denials, or find more accessible care models?

Dr. Dorette Noorhasan (34:17)
In terms of advocating for yourself, call your insurance directly and get an explanation of benefits directly from your insurance. Because sometimes what the insurance company tells your doctor's office may be very different than what they tell you. So you being an advocate for yourself and getting it directly from the insurance is so important.

Your physician's office, they will also contact your insurance. Many times the insurance companies will not even talk to us or give us a pre-authorization until you've done all of your testing, and then they want to see the results within the last three to six months before they would even give us a pre-authorization code. So that's that again, that's where the testing phase is so important. We will not be able to get a preauthorization in many instances where there's insurance coverage if there's not recent testing done. And then that pre-authorization, once we submit all the paperwork can take up to three weeks before we can get a yay or nay from the

insurance company. So I definitely encourage patients to be an advocate for yourself because you're in charge of your care.

Priya Bathija (35:25)
So this has been a fantastic conversation. I have learned so much. And I really appreciate how you set forth all of the options and the data and the lab tests in such a clear fashion. Is there anything that we missed in the conversation or anything you'd like to add on this topic?

Dr. Dorette Noorhasan (35:47)
I think I encourage all of our listeners to go get testing. If you think you want a child at some point, start with some testing and figure out if you need to do treatment or do you need to freeze eggs, freeze sperm? What do you need to do? But just start with testing. Just know what your options are.

When you're going through fertility treatments, it's scary and you go through your first cycle and you may get a negative result. And we don't have a hundred percent pregnancy success rate.

And how do you scrape yourself off the ground and find the courage to go on to that second cycle? I will tell you, I did five rounds of IVF, and this is coming from a fertility doctor who practices fertility, but you put your own life on pause when you go through fertility treatments. So for me, I was training to run a half marathon, and every time I go through a fertility treatment, I have to stop training.

And then when I go back, I'm like three months behind of where I left off. And so you put your whole life on hold for something of a chance, not a hundred percent guarantee that it's going to work.

And sometimes you get lucky and you get a child, and sometimes you don't. And we did our journey over several years because I need lots of pauses in between. My husband as well had to go through a surgery on his end to have things work for him. And he also took medications as well. So men are involved, and we had both. We had both male and female factor as well as uterine factor and needed surrogacy. And I will tell you, now being on the other side of it, my only regret is that I did not do another five rounds of IVF to give my son a sibling.

But it's hard when you're going through it to not see the light at the end of the tunnel. And I wished I did more cycles. I wished I had a bigger family.

And so for that person out there that's struggling that thinks fertility treatment is just something so far reached that I want to tell you, we've been doing IVF since the first, well, the first IVF baby was born in 1978. We've been doing it even before then. That was when we first finally got successful.

We've been doing it for over 40 years. And it's a safe procedure. Um, chances of anything going bad is very, very low, less than one percent. And so it's a safe procedure. I will encourage

anyone out there who is struggling or not sure if fertility treatments are right for them. I will tell you as someone now who's on the other side of the fence, I wish I did more cycles to give my son as a sibling.

Priya Bathija (38:35)
Yeah. None of this is easy, right? It's so complex and it's a lot to navigate. So I really appreciate you being with us, Doctor Norhasen, and talking to us about fertility options and treatment. I really enjoyed our conversation this morning.

Dr. Dorette Noorhasan (38:53)
Thank you so much, Priya.

Priya Bathija (38:59)
Thank you for listening to the Women's Health Playbook. While our experts can't provide you with direct patient care and medical advice, we hope that you have been armed with the resources you need and the questions you can ask your healthcare providers. We ask that you review these recommendations and reach out to your care team to discuss which approach is right for you. If you want to dive deeper into the tactics and resources we discussed today,

You can find those in the show notes for this episode. The Women's Health Playbook is a media company focused on ensuring you have the resources, tools, and skills you need to navigate healthcare. For more plays and picks you can use to take control of your health and healthcare journey, visit us at women's healthplaybook.com. And to join our community and get more women's health resources sent directly to your inbox.

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Our producer is Avery Moore Kloss. You can find her at averymoorekloss.com.

I'm Priya Bathija. Catch the next episode of the Women's Health Playbook right now in your favorite podcasting app. We hope you will share this podcast with a friend, because the more we all know, the better healthcare will be for everyone.