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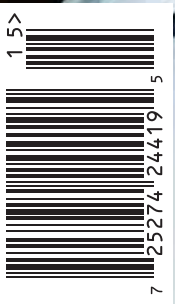
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Our **Fall 2011** issue
publishes August 12,
full of fashion, design,
health and wellness,
and locals you'll want
to know.



Josie Lepe

Of babies, weddings and fresh starts

It's an unthinkable situation: Lynette Leighton was 37, divorced and childless when she was diagnosed with invasive breast cancer. The treatment that could save her life – chemotherapy – would also leave her infertile. She had to act quickly. Under the guidance of Dr. Mitchell Rosen, head of UC San Francisco's Fertility Preservation Center, she chose a sperm donor, fertilized her eggs, harvested and froze her embryos, then began chemo – all the while not knowing if she'd live long enough to be a mother.

"Lynette's Story" (Page 45) ends on an upbeat note, as Leighton has been cancer-free for two years. It underscores the lengths to which many will go to bear a child. "Everybody takes it for granted that if they want to, they will be able to have children, and they spend much of their lives trying to not get pregnant," Rosen says. "Then when they want a child and can't have one, it is heart-breaking."

Our larger story on cutting-edge fertility treatments (Page 39), by Melinda Sacks, broadened my understanding of how science and technology, and professionals like Rosen, are making it easier to conceive, and to ensure that babies will be healthy and normal. These innovations allow women and men to get past common infertility issues, such as endometriosis, low sperm count and age – and also more complicated problems such as Leighton's. It's a provocative read.

The rest of this issue? We have weddings on the brain, what with William and Kate's spectacle coming later this month, and the annual nuptial season gearing up. I invite you to join in: Check out our spellbinding bridal fashions layout on Page 90, styled by Hasti Kashfia, then debate Erika Kittler Brown's picks of the best local spots to tie the knot (Page 109), and peek at some creative wedding favors and florals (Pages 116 and 122, respectively).

And don't miss Donna Lynn Rhodes' look at "Second Acts" (Page 83), where a few locals well acquainted with life's curveballs talk about turning unwanted changes in career and life into inspiring, positive transitions.

Getting married, being able to choose from more fertility options, moving on to a new chapter – they are but a few paths of many. In the spirit of weddings and babies and fresh starts, I wish you rich and joyous life-affirming experiences, whatever path you are on.

Katharine Fong
Editor & Publisher

oh, baby!

New options for conceiving –
now, or later

By **Melinda Sacks**

When it comes to infertility and fertility, myths – and startling facts – abound.

Among the myths: After age 40, you can kiss your chances of conceiving goodbye. If you're fertile at 20, you'll be fertile till you hit menopause, at least.

Among the facts: At 70, Omkari Panwar gave birth to twins in India in 2008, the same year Rajo Devi Lohan, 70, delivered a son, all the result of in vitro fertilization (IVF). Hollywood stars such as Celine Dion, Marcia Cross and Halle Berry have made giving birth after 40 look doable and downright glamorous.

Age, of course, is not the only reason women – and men – may be infertile; sexually transmitted diseases, endometriosis, hormone imbalance, anorexia or a partner's low sperm count all can contribute. Statistics from the Centers for Disease Control show infertility rates for women ages 15 to 44 (considered childbearing years) have remained about the same over the past few years, at 11.8 percent. What has changed is that infertility treatment has improved significantly, with decreased risks and increased safety, and options have expanded as clinics and specialists have grown more skilled. Preg-



nancy success rates nearly doubled at fertility clinics in the past decade, according to UCLA's School of Medicine.

Better early evaluation and treatment increase chances of success, as do a combination of traditional and cutting-edge approaches.

Worries of becoming the next Octomom through assisted reproductive technology (artificial or partially artificial methods used to achieve pregnancy) are lessening every year, experts say. At the same time, options for older women are expanding, but still with a few caveats.

"There are so many misperceptions," says Dr. Mary Abusief, reproductive endocrinologist and infertility specialist at Fertility Physicians of Northern California, which has offices in Palo Alto and San Jose. "The Hollywood fantasy we see is movie stars who had a baby at 59 or say they got pregnant at 60, and that can cause a lot of disappointment. If more of these people would say what they really went through, that would help."

"No one is going to get pregnant on their own at age 60," agrees Dr. Mitchell P. Rosen, director of the UC San Francisco Reproductive Laboratories and Fertility Preservation Program. "Every physicians group has its own cut-off age at which they will treat infertility based

on ethics and risk. Our cut-off is 50. ... We know that as we age, our organ function is not what it was. Getting pregnant is an incredible stress on the body, and studies show as you age there are complications that increase."

Escalating treatments

The first step when a woman is having trouble conceiving should always be evaluation, experts say. Most insurance companies cover this step, which runs about \$350 for those paying out of pocket.

From there arise a series of escalating treatments and associated costs, which are customized depending on the situation:

- **Clomid** (generic is clomiphene), a prescribed medication that stimulates egg production. Can be combined with timed intercourse or insemination to increase the chances of conception. Side effects: mood swings, bloating, weight gain, headaches. Risks: increased chance of twins (6.9 percent) or triplets (0.5 percent). Success rate: about 10 percent per month (vs. 20 percent of couples with no fertility issues who get pregnant every month). Cost: about \$1,000 per cycle.



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In vitro fertilization has a success rate of 25 to 55 percent on the first try; a decade ago, it was 10 percent.

- **Injections** of stronger medication (gonadotropins) are often used if Clomid doesn't produce ovulation or causes ovulation but not pregnancy. This regimen induces "super-ovulation," and when combined with insemination, results in about a 20 percent success rate, says Dr. Mary Ramie Hinckley of Reproductive Science Center, with offices in San Ramon, Orinda and San Jose. Risks, side effects: 20 percent chance of twins, 5 percent chance of triplets; more bloating than with oral medication. Cost: about \$3,000 for a one-month cycle.

- **IVF** surgically removes a woman's eggs from her ovaries, and combines them with sperm. Once fertilization occurs, the embryo is put back into the uterus. Success rates: depends on age, Hinckley notes, but today range from 25 to 55 percent on the first try. (Ten years ago, IVF rates were at 10 percent.) Cost: about \$15,000 "in and out the door" at her clinic, Hinckley says.

- **Egg donation** involves retrieving eggs from a donor and implanting them in the uterus of the woman who wants to become pregnant. A good option for women over 40 who are having trouble conceiving, Hinckley says. Success rate, when combined with IVF: 75 percent. Cost: about \$23,000 per try. "A lot of couples have extra embryos, and those are frozen for future tries," Hinckley says, in which case the cost is \$3,000 for each additional implantation at her clinic. The upside is the children will all be related.

- **Freezing embryos** (Cryopreservation) has improved to the point that the success rate for pregnancy with a frozen embryo is almost the same rate as when a "fresh" embryo is used.

- **Oocyte cryopreservation** freezes eggs using

cryoprotectants, or antifreeze solutions, in place of the water contained in the egg (in earlier freezing procedures, the water would turn to ice crystals and disrupt the egg's DNA and membrane structure). Critics consider it experimental, and success rates are low (some say 2 to 4 percent per egg in women under 35). Cost: \$10,000-\$14,000 if it includes testing, monitoring and storing the eggs over a period of years. Thawing and fertilizing the egg, then transferring the embryo, is about \$5,000-\$7,000.

"An important misconception a lot of women have [is] they think eggs can be frozen and used any time," Abusief warns. "Eggs can be frozen if women go through an IVF cycle, but freezing is not as optimal as we'd like. Frozen embryos are much more likely to be successful."

The cutting edge

Perhaps the most hotly discussed new fertility treatment today is preimplantation genetics screening and preimplantation genetics diagnosis, which involve testing the chromosomes in embryos in a laboratory to screen for genetic conditions before fertilization or placement in the uterus. The test allows the doctor to implant healthy embryos, and to better avoid implanting those with chromosomal defects, an increasing worry for older parents. Preimplantation genetics screening also may be used for those who have suffered numerous miscarriages or failed IVF cycles.

"The most exciting breakthrough in the field is whole chromosome analysis," says Hinckley of Reproductive Science Center. "We can biopsy an embryo and run a test on all 23 sets of chromosomes to find out if the embryo is healthy. This still puts stress on the embryo, and it takes two days to get the results. It is not 100 percent

accurate, but it is the biggest breakthrough.”

The procedure is new enough, however, that there is only limited information on whether it actually improves success rates of a healthy pregnancy, and not every genetic abnormality can be found. The costs for preimplantation genetics screening are around \$5,000 in addition to IVF, which runs anywhere from \$7,000 to almost \$20,000, depending on the clinic and number of cycles. In addition, this new ability to screen chromosomes raises ethical questions, such as whether it will lead to pressure on doctors to create “designer” babies.

Explains Hinckley: “A large cause of infertility is bad eggs. Bad eggs make unhealthy babies – they won’t implant, or you’ll miscarry, or there will be a genetic disorder. Sometimes we will biopsy an embryo to try to understand whether a patient can make a good embryo and identify the best one. You might make 10 embryos, but only one is healthy, so you could just put that one back [into the uterus].”

Elective single embryo transfer involves “finding the very best embryo and only putting one back,” Hinckley says. “That will increase pregnancy rates and decrease problems, and that is ultimately what people wanted all along. We just didn’t know how to get there. Now we are able to choose one embryo.”

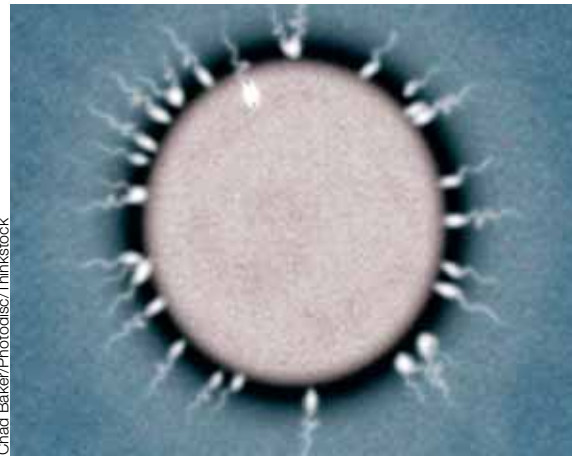
No matter how great the technology is, though, finding the right physician and “making sure they know how to use the technology,” as Hinckley puts it, is paramount.

The mind-body connection

Even in the highly specialized and technology-intensive world of reproductive medicine, treating the whole patient is now recognized as a means to better results. A growing understanding of the mind-body connection and its possible role in fertility has resulted in an increasing number of clinics with a psychologist on staff to help patients deal with emotional issues, as well as programs that offer acupuncture, yoga and Chinese alternative medicine.

“We use hormones (in treatments for infertility), and they alter the way people feel,” says Abusief of Fertility Physicians of Northern California, who figures that 40 percent of her patients already are suffering from anxiety and depression when they walk in the door.

“The medications can make you tired, irritable, bloated. They contribute to making women feel as if they are on an emotional roller coaster. We offer group counseling, stress reduction classes, meditation. I cannot tell you how many patients have said this is very helpful.”



resources

The American Society for Reproductive Medicine offers the latest research developments and a network of reproductive specialists by geographic region. asrm.org

Society for Assisted Reproductive Technology helps patients find infertility clinics where they live and review success rates. sart.org

RESOLVE: The National Infertility Association provides an overview of issues, resource directories to help find doctors, online support groups and a newsletter. resolve.org

“**Taking Charge of Your Fertility**,” the popular book by Toni Weschler, now in its 10th edition, has its own practical website with everything from charts that help you track your own fertility to FAQs and online support resources. tcoyf.com

Fertility Physicians of Northern California has offices in San Jose and Palo Alto. Their website offers information on treatment options, donor programs, articles and events for those dealing with fertility issues. fpnc.com

Reproductive Science Center is a 25-year-old full-service fertility clinic with offices in San Ramon, San Jose, Orinda and Modesto. RSC’s site includes information on treatments and services, along with podcasts and videos. rscbayarea.com

UC San Francisco’s Center for Reproductive Health offers a multidisciplinary approach to fertility issues at a world-class teaching hospital, with a specialized Fertility Preservation program for those recently diagnosed with cancer or other conditions that will impact fertility. <http://coe.ucsf.edu/ivf>

Lynette's story



At 37, I was diagnosed with cancer. What could I do to preserve my fertility?

By **Melinda Sacks**

Lynette Leighton was taking her morning shower when she discovered a hard, immovable lump that she immediately knew was cause for concern. As a Bay Area doctor in residency who had spent time in a breast clinic, she suspected what she might be facing, as she writes in a letter about her experience:

"I waited through my next period, just as I had instructed others to do, hoping the lump would declare itself as a cyst, or magically resolve, but it continued to grow. The lump was 'worrisome' by mammogram and more so on biopsy. I was 37 years old, and I had invasive breast cancer.

"Ironically, I had spent the previous month working with cancer patients in a breast care clinic, so I was familiar with my options. My surgeon discussed local surgery, mastectomy, chemotherapy and hormone therapy.

"When she suggested I meet with a fertility specialist, though, I was caught off-guard. Most of my patients at the breast care clinic had been in their fifties, sixties or seventies. Most had already had children, so the subject of their fertility never came up. But it made sense: Chemotherapy drugs target fast-growing cells, whether they be cancer cells, hair follicles or ovaries. Even if my ovaries survived, I would be on Tamoxifen, a drug that can cause birth defects, for several years.

"I had not yet had children. My husband had children from a previous marriage, and by the time I was sure I wanted one of my own, he resisted. After several years of discussion, he agreed to have children. [But] he changed his mind in the end, and decided he no longer wanted to be in a committed relationship. I was diagnosed with can-

cer one month after my divorce was finalized. No partner. No children.

"One of the loneliest times during my cancer treatments was sitting in the fertility doctor's waiting room the first day. I had a lot in common with the other women there, but there was one noticeable difference: Each of the other women had a partner, someone to hold her hand in the waiting room, reassure her at night and help parent her children. I wondered if I would dare to have a child on my own. I also wondered if I would be alive long enough to be a mother.

"My doctor recommended I have embryos made and frozen for future uterine transfer, a process with greater chance of resulting in live births than freezing my eggs alone. I charged ahead, not wanting to one day regret having missed my chance to become a mother. We agreed we would try to stimulate two cycles of eggs and harvest them before I began chemotherapy, so we needed to hurry."

Leighton was guided by Dr. Mitchell Rosen, a reproductive endocrinologist at UC San Francisco. After choosing a sperm donor, she had breast surgery, underwent her fertility treatments and the harvest of her own eggs, and then six months of chemo followed by two months of radiation.

Today at 40, Leighton has been cancer-free for two years. If her doctor gives her the go-ahead, she can soon stop taking Tamoxifen and get pregnant, she says happily.

"I think one of the most liberating decisions I made, especially after my divorce and cancer, was that I wanted children, and I would do it alone, without a partner. It took so much pressure off me. It gave me hope."

LYNETTE'S STORY Continues on Page 148



"I can't imagine my children anywhere but Saint Andrew's! Beyond just teaching facts, they create so many opportunities for my children to try to new things and experience learning for themselves."

Katrina L. alumna '86 and mom to Jack '17 and Charlie '20



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LYNETTE'S STORY

Continued from Page 45

What lies ahead is not entirely clear for Leighton, who has been dating, and completing a yearlong women's health fellowship in New York. She hopes to have up to three children, and that may include adoption.

"I now believe that when I first see the face of my child, he or she will become real to me, a being of their own, and their genetic origin will fade to the background," she writes. "It has been a difficult two years, but ... I am grateful to be alive and am several steps closer to meeting my future child." 

preserving fertility when illnesses strike

If you contract a disease that requires systemic chemotherapy, such as cancer, hemochromatosis, sickle cell disease or lupus, you are at risk of losing your fertility. And often you have only hours or days after diagnosis to figure out what to do.

Reproductive endocrinologist Mitchell Rosen, director of UC San Francisco's Fertility Preservation Program, acts fast to give patients the most options. He starts by guaranteeing they can get in to see him within 24 hours of their call.

"A patient gets slammed with facing death, and then all of a sudden are told they may also be infertile after the treatment that saves their life. It is overwhelming for women to also have to think about their future and having a child at the moment of diagnosis," Rosen says.

Rosen walks patients through the options, which include:

Harvesting and freezing eggs or embryos (success rate for the latter is higher and involves fertilization from a partner or donor's sperm). When it is time to implant the embryo in the recovered patient, preimplantation genetic screening can help reduce the chances that the embryo is carrying a disease-related gene. The test isn't perfect, but Rosen notes

that most cancers, for example, are not inheritable and that the process can be helpful for patients.

Ovarian tissue cryopreservation

allows the patient to preserve her ovarian tissue for transplant back into the body after the cancer treatment has been completed. The risk is that cancer could have already infected the tissue and transplant could reintroduce diseased cells into the patient.

Growing ovarian tissue in vitro

to create an egg capable of being fertilized. This procedure is in development; it may eventually allow a woman the ability to use her own ovary and eggs to preserve her fertility without the risks of transplanting possibly diseased tissue back into the body.

WEDDING VENUES

Continued from Page 113



Kimberly White

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