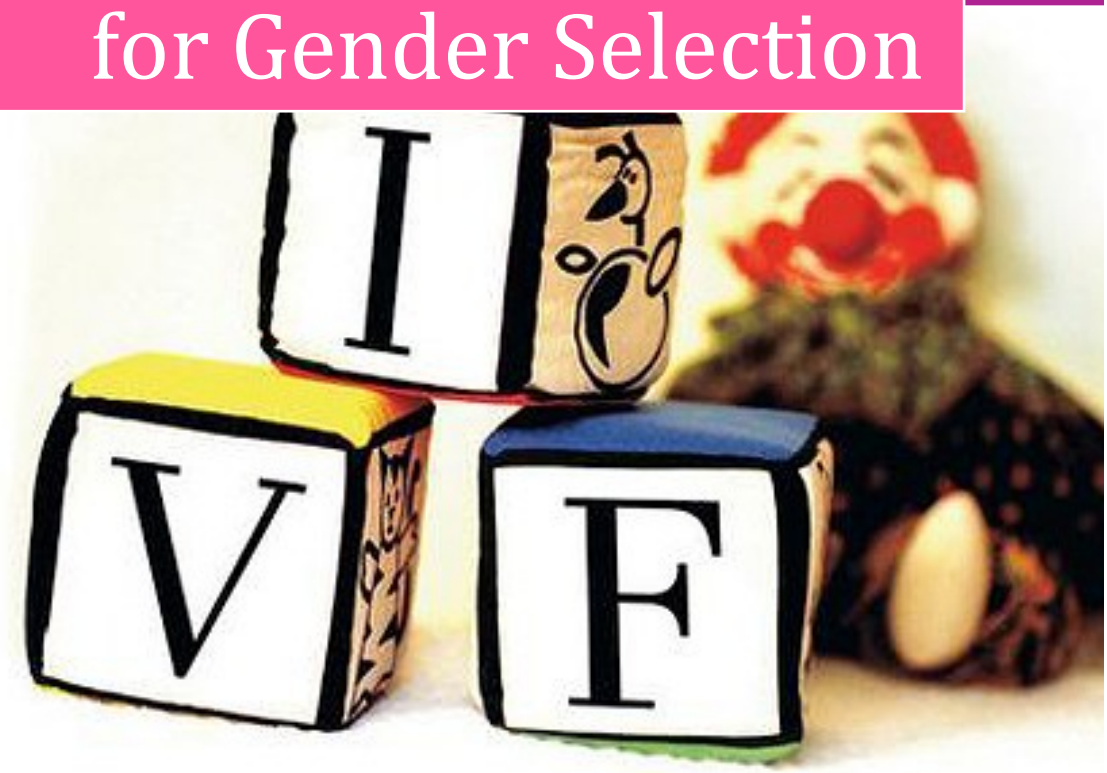
Guide to Understanding IVF/PGD for Gender Selection



GenderDreaming.com

2015 Guide

What is HT, IVF with PGD?

High Tech gender selection(IVF with PGD) is elective IVF. There are some sperm spinning options out there too but they are largely unproven so they will not be the focus of this guide.

Q. What is the actual procedure?

A. You go through an IVF cycle, taking injectable medications to force your ovaries to produce multiple follicles(eggs) and then go through an Egg Retrieval(ER) procedure where under moderate sedation (much like the dentist's office for wisdom teeth extraction type sedation), the Reproductive Endocrinologist(RE) extracts the eggs using a long needle inserted through your vagina to aspirate each egg from both ovaries.

After ER, fertilization happens whereby your partner's sperm are either injected via ICSI into each egg or allowed to fertilized naturally in a dish. Day 1(the day AFTER ER, you receive the fertilization report)

3 or 5 days after ER, a biopsy is performed on your embryos and one cell is removed from each. This cell is then analyzed FISH on Day 3 or up to all 24 chromosomes via Natera or aCGH on Day 5 after ER.

EGG RETRIEVAL DAY

Q. What happens with Egg Retrieval(ER)?

When should I get to the office?

A. In most cases, you will need to get to our facility about 90 minutes before your procedure. Someone will greet you and bring you to the back to the recovery area. Your partner will be asked to wait in the reception area.

FRESH SPERM COLLECTION

Q. When should my partner collect the sperm?

A. If appropriate, your partner will need to collect and give his specimen at the facility about the time of your egg retrieval. The sperm from this specimen will be used to attempt to fertilize your eggs.

Q. Can the sperm be collected at home?

A. Discuss this option with your doctor. Your partner would be given a home collection kit and instructions before you take your hCG medications. You will need to make arrangements as to specific time to bring the specimen to our facility to be processed.

EGG COLLECTION

Q. What will happen once I get there?

A. You will need to empty your bladder.
You will change into a hospital gown.
A nurse will talk to you to review your medical history.

You will have many people (the nurse, anesthesia personnel, etc.) asking you the same questions. This is to make sure that any information we need is accurate so to the procedure will be as safe as it can be.

The nurse will talk to you about what you can expect and answer any questions. A hair cover will be put on your head. An IV will be started by the anesthesiologist or nurse. The doctor who is doing your retrieval will meet with you and answer questions.

Q. What happens after I go to the procedure room?

A. You might be wheeled to the procedure room on the stretcher or you may walk there on your own and be asked to get up onto the table. A medication will be given through the IV to make you feel sleepy. You will be put on the procedure table in a position similar to that used for a pap smear. You will be covered with sterile drapes.

A sterile saline solution will be used to clean your vagina and cervix before the egg retrieval to decrease the risk of infection.

Q. How is the actual egg retrieval done and how long does it take?

A. The egg retrieval procedure takes about 15 minutes. The same transvaginal ultrasound is used to see your ovaries. A needle is guided by the ultrasound probe through the vaginal wall into the ovarian follicles (egg compartments) and as many eggs as possible are retrieved. When the procedure is done, all of the instruments and drapes are removed and you are brought by stretcher to the recovery area.

Q. What happens in the recovery room?

A. A sensor on your thumb will monitor your blood oxygen level, patches on your chest will monitor your heart rate and rhythm, and a cuff will take your blood pressure at set times. Once your monitoring is done, all of the equipment will be removed.

A nurse will take out your IV once you start to take fluids by mouth. You will be ready to go home about one to two hours after your procedure.

Q. Will anything else be done before I can go home?

A. A nurse should go over your post-operative discharge instructions with you and will give you a written copy of it will to take home.

Q. Do I need someone to stay with me after I go home?

A. You cannot drive yourself home. You may be groggy and slightly crampy afterwards and it is a good idea to have someone with you or nearby the rest of the day.

Q. What is done in the lab the day the eggs are retrieved?

A. During your retrieval, the fluid from your follicles (the compartments within the ovaries) is given to the embryologist who will look under the microscope to find out about how many eggs there are.

When the retrieval is done, an egg count is given. This count may be changed some after the granulosa cells are stripped away and the eggs are looked at more closely the morning after retrieval.

The eggs are then inseminated with the prepared sperm sample and placed in the incubator.

DAY AFTER ER

Q. What happens the day after the retrieval?

A. This is the day when the first fertilization results are known.

EMBRYO DEVELOPMENT

Q. What does the lab look for in the eggs?

A. Embryo cleavage:
This is the amount of cell division or growth that has occurred in the fertilized egg (embryo). It also is how the embryo looks.

The overall appearance of the embryos:

This is called embryo morphology. The cells of an embryo should be of similar shape and size.

Evidence of fragments:
If there are a lot (more than 50% of the embryo), it can lower the chance of implantation. In most cases, the more cells that are present, the "healthier" the embryo and greater chance of pregnancy. The more equal and regular the cell development the better the chance. Many couples with lower cell numbers or development get pregnant while a couple with high cells numbers in their embryos may not get pregnant in any given cycle.

Q. How does the embryo develop?

A. As the egg matures, the embryo develops many cells and goes through the stages of blastocyst development.

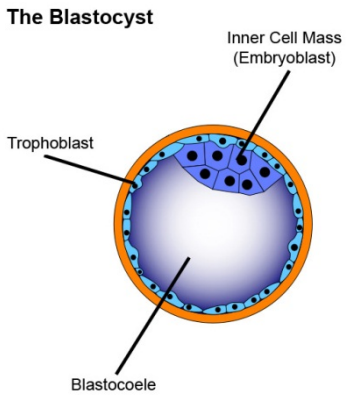
Q. What are the three stages?

A. During the following stages, of the embryo maturing, the cell number is no longer used to describe development.

The morula stage:
This is before the blastocoel(an early metazoan embryo typically having the form of a hollow fluid-filled rounded cavity bounded by a single layer of cells) is formed.

The pre-blastocyst stage:
As secretions build up in the embryo, a cavity develops called a blastocoel. This is an opening in the blastocyst.

The blastocyst stage
When the blastocoel occupies about 50-75% of the embryo. When the blastocoel occupies more than 75% of the embryo, the embryo is called an expanded blastocyst.

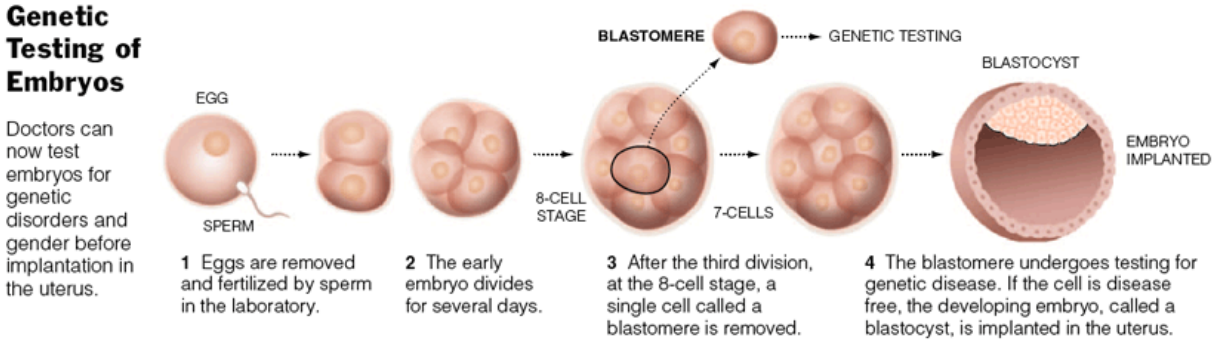


Q. Can you tell which embryo will have the best chance of developing?

A. Each embryo is unique. The ability to predict their growth and potential is limited. The development of your embryos in the IVF laboratory may not show their ability to continue to develop once they are transferred back into your uterus. It is not possible to tell which embryos will be healthy nor their gender just by looking at them. That is why we use PGD testing to both identify gender and tell us about the health of the embryos.

PGD BIOPSY AND TESTING OPTIONS:

The original biopsy day was day 3. Day 3 biopsy involves taking a single cell on day 3 of life of the embryo:

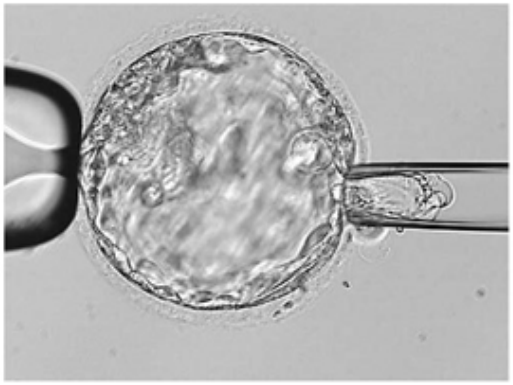


Day 5 biopsy is the newer PGD method and multiple cells are taken from the outer layer of the embryo (trophectoderm biopsy) that will eventually become the placenta.

Day 3 Biopsy

One cell removed from a day 3 embryo for genetic testing

Day 5 Biopsy



Outer cells of blastocyst are biopsied and genetically tested

Recently, trophectoderm biopsy is gaining popularity and becoming the standard embryo biopsy. Since trophectoderm cells are extra-embryonic tissue, they do not become part of the fetus but do become part of supporting structures, such as the placenta and membranes. Trophectoderm biopsy takes place at the blastocyst (day 5 or 6) stage of development, as the trophectoderm is beginning to herniate through the zona pellucida. Instead of removing an individual blastomere or cell, several trophectoderm cells are removed.

With a Day 3 biopsy, 5 days after ER, you get the report of how many available embryos you have remaining(attrition is normal) and you decide how many to put back via Egg Transfer(ET). Transferring 1-2 embryos at ET is typical and any more than that, you risk a higher order multiple pregnancy which is not a desired outcome for IVF ever.

An alternative to the day 3 biopsy is waiting until day 5, removing multiple cells from the remaining embryos(those that survive until day 5 and make it to a blastocyst stage) and those cells are analyzed using Natera or aCGH. All 24 chromosomes are evaluated at that time. This is a newer procedure and many clinics are using this. Results are available Day 6 when using aCGH for a fresh transfer and if using Natera, a planned FET is necessary.

Q. Day 3 biopsy or Day 5 biopsy? Which is better/preferred?

A. Since Natera no longer offers a day 3 option, FISH is the only day 3 option left. Typically, up to 5 probes(the number of chromosomes analyzed) are used. It checks for the existence- not the integrity- of X,Y,13,18 and 21.

The only fresh transfer option available now with Day 5 biopsy is with using aCGH. Natera requires freezing everything and a return trip for a frozen embryo transfer.

Day 3 Pros-

- Most embryos will make it to day 3 and be able to be biopsied. You do not have to wait for an embryo to become a blastocyst in order to biopsy it.
- You are able to do a fresh transfer no matter what stage the embryo is on day 5.
- False positives are possible with day 3 biopsy and only a re-biopsy on day 5 can confirm if the embryo is in fact abnormal.

Day 3 Cons-

- Most embryos will make it to day 3 and be able to be biopsied. You do not have to wait for an embryo to become a blastocyst in order to biopsy it.
- You are able to do a fresh transfer no matter what stage the embryo is on day 5.
- False positives are possible with day 3 biopsy and only a re-biopsy on day 5 can confirm if the embryo is in fact abnormal.
- Only one cell is analyzed. There can be an issue with the single cell that is not representative of the entire embryo's health and produce a false-positive result.
- Mosaics can happen which means the single cell selected can have a chromosome abnormality but the embryo can actually be healthy.
- There is a chance that the cell will be damaged during the process and a "No DNA detected result" can happen.
- You cannot know if all chromosomes are present and healthy.

Day 5 Pros-

- Since the embryo is further along in development, mosacism should be lessened at this point
- Using Natera or aCGH, all chromosomes can be reviewed hopefully increasing the pregnancy rate.
- Cells are removed from what will become the placenta and not one of only 6-8 cells like on day 3 which may be easier on the embryo.

Day 5 Cons-

- An embryo must become a blastocyst and have the trophoderm layer that becomes the placenta from which the cells are taken on day 5.
- If the embryo does NOT reach blastocyst stage on day 5 and takes until day 6, the embryo must be frozen and a later Frozen Embryo Transfer(FET) must be performed.
- Because of the high rate of abnormals with IVF, a risk of a no-transfer is higher with a day 5 biopsy due to reduced numbers. Natera's website states that a transfer is likely with minimum of 8 embryos biopsied- this does NOT take the gender selection into consideration though which means our chances at transfer are reduce beyond their quoted rates.
- Confined placental mosaicism (CPM) represents a discrepancy between the chromosomal makeup of the cells in the placenta and the cells in the baby. It is estimated to occur in 1-2% of pregnancies where the placenta contains abnormal cells but the embryo is normal.

Q. What are the various types of PGD Testing?

A. CCS is a term that refers to 23-chromosome testing. It isn't a test. You have to ask what these they use- CGH, PCR, Natera.

FISH, PCR, CGH and SNP are all methods of genetic analysis used for PGD, PGS and CCS.

FISH, Fluorescent In Situ Hybridization
Fluorescent In Situ Hybridization (FISH) is used for the determination of sex for X-linked diseases, chromosomal abnormalities and aneuploidy screening. However, this method of analysis does have its limitations. A human cell contains 23 pairs of chromosomes, but FISH analysis allows accurate assessment of only 5 to 8 chromosomes in each biopsied cell.

"The problem is, you're still only screening part of the chromosomes," Dr. Dunn says. "And so you're not screening for translocations and inversions, so it's not as effective a tool."

PCR, Polymerase Chain Reaction
PCR, sometimes called DNA amplification, is most often used for the diagnosis of single gene defects, including dominant and recessive disorders.

CGH, Comparative Genomic Hybridization
CGH allows genetic specialists to examine all 23 chromosomes and provides a more detailed picture of the entire length of the chromosome, which may detect imbalance of chromosomal segments. A newer advanced technique offered in some labs is called array CGH or microarray CGH (mCGH). This is an accelerated CGH protocol providing results in 24 hours for all chromosomes.

SNP, Single Nucleotide Polymorphism Analysis
SNP is another newer technique that can examine all 23 chromosome pairs. "Most genetics labs have gone to the technology of SNP analysis because of the fact that it can do both copy number changes and inversions and translocations," says Dr. Dunn. This is Natera. It tests all 24-chromosome but requires a FET but can test for more than aCGH.

Q. What is Embryo Transfer(ET) like?

A. Usually, you must drink a bottled water like you would for a 20-week ultrasound and you go in to the RE's office the morning of day 5. You may or may not know if you will have a transfer before you arrive. At some point, you will find out and if you do have a transfer, you will be taken to a procedure room with a table like in your OB's office. At my clinic, there was a screen where they displayed the images of my embryos that were available for transfer. We discussed the grade of each embryo and the likelihood of pregnancy. You should know before you go in if you are willing to transfer more than one.

Your legs go up in stirrups and the embryologist loads the embryos in a catheter and the RE inserts it into your vagina, through the cervix and into your uterus. The embryo(s) are injected into your uterus, the catheter is checked to make sure the embryos made it out(they can stick to the sides) and once confirmed, you may be asked to lay still for 5-30 minutes on the table.

After that time, you will be allowed to get up and use the restroom and free to go.

Q. What happens after ET?

A. Bedrest may be recommended but there is really no research showing that it makes a difference either way. It is generally recommended that you do not lift anything heavy for a couple of days after ET. No swimming and general rest is advised- nothing that would cause uterine contractions is recommended(no sex).

Q. What are potential complications with IVF?

A. OHSS- Ovarian hyperstimulation syndrome (OHSS) is a complication occasionally seen in women who take certain fertility medicines that stimulate egg production, usually with IVF although it is possible to get OHSS with IUI as well.

Normally, a woman produces one egg per month. Some women who have trouble getting pregnant may be given medicines to help them make more eggs.

If these medicines stimulate the ovaries too much, the ovaries can suddenly become very swollen. Fluid can leak into the belly and chest area. This is called ovarian hyperstimulation syndrome (OHSS). OHSS occurs only after the eggs are released from the ovary (ovulation). 1

in 10 IVF patients will get OHSS so you need to be aware of the symptoms and call your doctor immediately if you suspect OHSS because it is a life-threatening condition if left untreated.

Symptoms

The symptoms of OHSS can range from mild to severe. Most women with the condition have mild symptoms such as:

•Abdominal bloating

•Mild pain in the abdomen

•Weight gain

In rare cases, women can have more serious symptoms, including:

•Significant weight gain (more than 10 pounds in 3 - 5 days)

•Severe pain or swelling in the belly area

•Decreased urination

•Shortness of breath

A. Retrieval Complications- Follicle retrieval is a relatively simple, straight forward procedure. Nevertheless, in some patients, the anatomy is such that it can be difficult to easily reach the ovaries. In these cases, there is always a slightly higher chance of damage to internal organs such as the bowel, bladder or blood vessels. Even in the simplest of cases, internal damage is possible – albeit very rare. Bleeding from the inadvertent puncture of a small blood vessel is probably the most common minor complication of retrievals. This usually results in annoying pelvic pain and cramps over the next few days, but rarely requires anything other than mild pain medications.

Q. When can I POAS and see a positive?

A. 5dp5dt(5 days post 5 day transfer), it is totally possible to see a BFP either on a digital or double line pregnancy test. Some people do not see a positive until closer to 7dp5dt and in rare cases sticks remain negative even though beta is positive.

Q. How is pregnancy confirmed?

A. A blood “Beta” test is ordered usually around 10-12 days past transfer. A level around 100 is a good indication of a healthy pregnancy but levels can vary greatly.

Q. How much does it cost?

A. Costs vary. In the USA, costs will range between $10,000 - $20,000 for the IVF and PGD portion. The average IVF Base Cost in the US is $11,709. The average PGD cost in the US is $3,500. Medication costs can range between $2,000- $5,000+. There are some multi-cycle

packages and some refund packages out there. Anesthesia and freezing extra embryos are additional costs.

There are Pretesting costs as well to assess your ovarian reserve before you cycle. Below are the typical pretesting tests that will be required by your clinic-

Sonohysterogram - An in-office ultrasound procedure in which saline in instilled into the uterus to detect possible abnormalities inside the lining which may adversely affect pregnancy.

Trial Transfer - This procedure typically consists of an ultrasound and placement of a tiny catheter inside the uterus to determine the direction and length of the uterine cavity prior to the IVF cycle. This procedure ensures that the least traumatic transfer can be accomplished during the actual IVF treatment cycle.

Semen Analysis - This laboratory analysis measures volume, sperm concentration, sperm motility, and morphology to determine if more advanced techniques such as ICSI should be used for successful fertilization.

FSH Levels - This test measures the baseline Follicle Stimulating Hormone present in a woman's body. The test is done by blood draw, typically on the second or third day of the menstrual cycle. It provides an indirect indicator of egg quality.

Initial Visit or Consult Fee- The initial visit or consultation at an IVF clinic typically includes meeting with a physician to review your case history, perform a physical examination and possibly an ultrasound. With an ultrasound, they will assess your ovarian size and antral follicle count(AFC). You first visit may include a consultation with a financial coordinator to review treatment costs, financing options, and insurance coverage.

E2 Level - This blood test measures the estradiol level in a woman's body. The estradiol level helps validate the accuracy of the timing of the FSH to assure it is being done at the proper time.

TSH and Free T4 - This blood test checks thyroid function.

Prolactin - This blood test checks the level of prolactin, the hormone that helps the body produce breast milk at the proper time. High levels of prolactin can interfere with conceiving no matter what the method of treatment.

Infectious disease screening for BOTH you and DH

Q. Where is Elective IVF for Gender Selection available?

A. Throughout the USA in around 150 clinics. It is available internationally at SART in Thailand, Genesis in Cyprus and Farrah Hospital and CUBE and Reprofit in the Czech Republic. It is illegal in Western Europe, Canada and Australia although some people have received approval for genetic reasons in Australia to have it done locally.

Q. How do I begin the process?

A. After reading up, you need to schedule a consult or two with a prospective RE. Some are free and some can cost over $300 depending on the RE/Clinic. HRC consults with Dr Potter and Dr Braverman of Braverman IVF in NYC are free to Dream Members and can be requested through the site. After your consult, you will have orders from the doctor for your pretesting which will help gauge your chance of success.

To schedule a FREE CONSULT with either Dr Potter in California or Dr Braverman in New York, use these links to access the contact forms-

Dr Potter with HRC- http://genderdreaming.com/forum/announcements/46689-link-contact-form-gender-selection-australia.html

Dr Braverman in New York- http://genderdreaming.com/forum/announcements/46689-link-contact-form-gender-selection-australia.html

Q. What is Pretesting/Ovarian Reserve Testing? I'm a fertile woman, why do I need that?

A. Everybody does pretesting. It's a rite of passage for the IVF world. Even DH gets to get involved on this one! DH has to do an infectious disease panel as does DW. Some DH will get a semen analysis(SA) done but that is not required for IVF.

The typical pretests for the woman are-

Day 3 FSH- (Can be cycle day 2, 3 or 4) They are looking for your day 3 level to be under 10. Day 10 should be under 10 as well if you do a clomid challenge test.

Follicle stimulating hormone (FSH) is one of the most important hormones involved in the natural menstrual cycle as well as in pharmacological (drug-induced) stimulation of the ovaries. It is the main hormone involved in producing mature eggs in the ovaries.

FSH is the same hormone that is contained in the injectable gonadotropins which are used to produce multiple eggs for infertility treatment.

Think of it like stepping on the gas pedal in the car to get going. The FSH is the gas, and the pituitary gland releases FSH to get a follicle "going" at the beginning of every menstrual cycle. If there are few follicles left (and perhaps lower quality follicles) the amount of "gas" has to be increased to get a follicle developing.

In a menopausal woman, the gas pedal is on the floor for the rest of her life - even though there are no follicles (or eggs) left. The woman's body never gives up trying - FSH levels are permanently elevated. 40+ means you are in menopause.

Day 3 Estradiol- Always done with a day 3 FSH test because if your day 3 estradiol level is too high, it will make your FSH level appear FALSELY low.

Clomiphene challenge test
A clomiphene challenge test is a dynamic type of test that can discover some cases of poor ovarian reserve that are still showing a normal day 3 FSH.

This test is done by:
1.Obtaining a day 3 FSH and estradiol
2.Take 2 tablets of clomiphene (100 mg) on days 5-9 of the cycle
3.Repeat an FSH level on day 10 of the cycle
The normal Clomid challenge test result is a low FSH on day 3, a low estradiol on day 3 and a low FSH on day 10.

Anti-Mullerian Hormone
This blood test can be completed on any day of your cycle. AMH is secreted by the granulosa cells in ovarian follicles. It is first made in primary follicles that advance from the primordial follicle stage. At these stages follicles are microscopic and can not be seen by ultrasound. The ranges of what a good AMH level are vary but the USA uses this scale-

High (often PCOS)- Over 3.0 ng/ml
Normal- Over 1.0 ng/ml
Low Normal Range- 0.7 - 0.9 ng/ml
Low- 0.3 - 0.6 ng/ml
Very Low- Less than 0.3 ng/ml

International labs use a different scale.

European and Australian levels

Ovarian Fertility Potential pmol/L
Optimal Fertility 28.6 - 48.5
Satisfactory Fertility 15.7 - 28.6
Low Fertility 2.2 - 15.7
Very Low / undetectable 0.0 - 2.2
High Level > 48.5

More information on Pretesting numbers and what they mean-

We get a lot of questions about what our pretesting means. I recently came upon this chart from CHR that I find helpful for a quick glance that also takes age into account-
http://www.antimullerianhormone.net/amh-levels/

Interpreting FSH Levels Should Be Age-Specific
A few years ago, CHR's research established age-specific levels of FSH and AMH. Any FSH level means different things if found at different ages. For example, a normal FSH level for a woman at 42 suggests premature ovarian aging (POA) if found in a 32-year old. To really assess a woman's ovarian reserve, and her IVF pregnancy chances, one really needs to look at age-specific AMH and FSH levels. The table below demonstrates age-specific AMH and FSH levels for CHR's patients.

And 0.16 is the lowest detectable amount.
MH 0.16: What does it mean if the AMH is 0.16 or less?

Have you had fertility testing with AMH 0.16? AMH or Anti Mullerian Hormone is produced by the ovarian follicles. AMH levels correlate with ovarian reserve. It has been documented that

women with lower Anti-Mullerian Hormone / AMH have smaller ovaries and produce less eggs compared to women with higher levels.

A level of AMH of 0.16 is at the lowest level of the measure scale. This means that AMH is either extremely low or even undetectable. Does having an Anti mullerian hormone of 0.16 or less than 0.16 mean that you are menopausal? Absolutely not. Pregnancy can still occur with very low AMH lvels. IVF can still work with low AMH levels and IUI can still work with low AMH levels. But is certainly is a red flag on the fact that you probably have a very diminished ovarian reserve.

Having a low AMH level should not mean that you have do immediately consider egg donation.

Q. What are my chances of success?

A. That is the $1,000,000 question!
Your age and your pretesting results along with your clinic's stats will give you an idea of likely a successful outcome may be.

Here are the possible outcomes- BFP, BFN, Chemical, No Transfer(NT), miscarriage. www.SART.org is a great website for checking up on your potential clinic's statistics for your live birth chance. When viewing them, the three numbers I analyze when choosing a clinic are the 1. The live birth rate for the youngest age bracket, 2. The number of embryos transferred on average to arrive at that live birth rate and 3. The FET rate. Those 3 things tell you how good a clinic is at getting people pregnant with the fewest embryos transferred to make it happen. If a clinic averages over 3 embryos transferred for the youngest age group that is not a positive attribute.

Now, those numbers are largely based on infertile women but in some ways we cut our chances going in because we potentially eliminate half of the available embryos on transfer day due to wrong gender. I don't care how old(young) you are, how great your pretesting is, etc., there is never a sure thing when it comes to IVF. The younger you are, the better your chances.

According to Sart.org, the National percentages of cycles resulting in live births are as follows-

Age	Live Birth Rate
<35	40.1%
35-37	31.8%
38-40	21.5%
41-42	12.2%
>42	4.2%

Keep in mind when look at statistics that these are stats for infertile people that are using IVF to have a child and not select gender. Using PGD to test all chromosomes can greatly improve your chances of success. That being said, age is the biggest issue people face when using IVF and unfortunately, as you can see by the stats above, the older you are, the harder it is to find success with IVF.

Important Factors Affecting Outcome-

Clinic Factors

The clinic's Live Birth Rate Per Transfer for women in your age group can be one of the most important factors in determining actual total cost for IVF. The Live Birth Rate indicates your chances of taking a baby home.

Two IVF cycles will always be more expensive than one cycle. If your clinic does not have at least a 51% live birth rate then odds are that you will need more than one cycle of IVF before you bring home a baby.

All clinics are required by law to submit their success rate data the CDC. You can look up that information by clicking here. The verification process required by the CDC means that this success rate data is at least 3-4 years old. If a clinic does not report its results we would recommend you not consider using that clinic.

Patient Factors

Patient age affects cost of IVF treatment because typically older patients receive higher doses of stimulation medications for longer periods of time.

The type of IVF cycle greatly affects the cost of IVF. Using donor eggs typically requires agency fees, donor fees, and other lab and screening fees which add significant cost to the IVF cycle. Cycles utilizing a surrogate to carry the baby include the cost of recruiting and screening the surrogate as well as legal fees and the surrogate's fee for her services.

If you are under 38, I like to think we have a better than 50/50 chance which if you take some time to look at SART's site, you'll find out that 50% chance of success is pretty good odds for IVF! Your clinic choice and age directly affect those odds though. We call success the first time

you cycle a One Hit Wonder(OHW). It is difficult to be a member of that club. The younger you are, the higher your chances, in theory, but most of us are in our 30's and until you start approaching later 30's, I think we are all on a level playing field for the most part.

They tell infertile people that you are likely to find success with IVF within 3 cycles. After 3 cycles, your odds do not increase and you reach the point where you have to decide when it is enough. Sometimes, you may fail with the fresh cycle and find success with a FET from the same batch of embryos. Some women do better with FET cycles because you do not have all of the stimulation meds in your system. So, it's hard to say until you try what your actual chance of success is. Pretesting will help gauge where you may fall with your chances but proven fertility can trump poor pretesting so not even that is a sure thing.

So what now? Well, if you would like help finding a clinic either in the USA or Internationally that offers IVF with PGD for Gender Selection, we can help. If you register(registration is free) in our Discussion Forum www.genderdreaming.com/forum/register.php, you may then use our IVF/PGD Clinic Location Service. You will need to become a Dream Member($12 annual fee) to use this service. We have people available to assist you via email and provide you with all of the information you need to get started down this path.

If you are NEW to forums, it is simply a community of supportive people interested in the same cause. There are various topics within the forums and there is a “High Tech” forum that discusses using IVF with PGD for GS and there are women from all over the world chatting with one another! We love to help so please join us today and ask any questions you may have about the process.