Short Communication

iMedPub Journals
http://wwwimedpub.com

Journal of Reproductive Endocrinology & Infertility
ISSN 2476-2008

2019
Vol.4 No.1:10

DOI: 10.21767/2476-2008.100035

Treatment of Infertility: As Simple as a Piece of Cake

Wu Y*

35 Tina ST Beaudesert Queensland, Australia

Received: November 14, 2018; **Accepted:** Janaury 07, 2019; **Published:** Janaury 14, 2019

***Corresponding author:** Wu Y

35 Tina ST Beaudesert Queensland, Australia

younas.soc@gmail.com

Tel: +61 410088845

Citation: Wu Y (2019) Treatment of Infertility: As Simple as A Piece of Cake. J Rep Endo Infert. Vol.4 No.1:10

When a patient phoned me for an appointment, and wanted my help to become pregnant, I first asked her "when was your last period?" The first day she started her menstrual period was then called Day 1. We asked her to come to see the doctor on Day 12. On the 12th day, we did routine exams and blood ELISA tests: Follicular Stimulating Hormone (FSH), Luteinizing Hormone (LH), Estrogen, Progesterone Prolactin (PRL), Testosterone and A Transvaginal Ultrasound (TVU). When you do a TVU on Day 12 to 14, if you find one oocyte close to 20mm and a routine check of Cervix Mucous Score (CMS) close to 12 and the patient is over her 40th year, she can never be pregnant. The reason is that the oocyte can't come out from the membrane of the ovary to meet the sperm. In ordinary women's menstrual cycle, there is a natural peak of the hormone Progesterone occurring on Day 14. With the help of a Human Chorionic Gonadotropin (HCG 10,000IU) by Intramuscular injection on day 14, there will be an artificial peak of Progesterone, to stimulate the oocyte to come out of ovarian membrane (artificial ovulation). On the day of HCG injection, we told tell her to have coitis or sexual intercourse for three continual days. We then tell her husband to refrain from having sex and to wait until after the next ovulation treatment plan, A lot of women however became pregnant without having the next treatment plan. Too much and frequent sex may decrease the number and quality of the sperm. I told couples to have sex 3 days per month on Day 13, 14 and 15th and invariably they succeeded in getting pregnant. This is usually called 'natural contraception', when they only use a condom on Days 12 to 16. We saw hundreds of women with Polycystic Ovarian Syndrome (PCOS), who had typical clinical symptoms as hirsutism. PCOS is easily detected under TVU (about 10 oocytes less than 10 mm) and LH/FSH >3/1.

Hyperprolactinemia is easily diagnosed through routine Blood Hormone assays, which find the PRL is high. Bromocriptine is a very effective medicine for it. We prescribed Bromocriptine as soon as we got the blood result indicating a high PRL. When I prescribed a Medicine like Bromocriptine which may cause vomiting, I asked the patient to put the medicine into the anus or rectum before going to bed. When I found patients with a dry vagina, blood estrogen and CMS both very low on day 12 to 14 and these patients had PCOS and Hyperprolactinemia; their fertility was invariably impaired **(Table 1).** To treat this infertility I prescribed 0.125 mg Estrogen Estradiol (EE) in **Table 2,** per day to increase CMS. When is the best time to give it? We all know

Table 1 Chart of treatment for infertility.

Time/Date	Medicine	Notes
Day 1		
Day 2		
Day 3	CC / EE	
Day 4	CC / EE	
Day 5	CC / EE	
Day 6	CC / EE	
Day 7	CC / EE	
Day 8	CC / EE	
Day 9	CC / EE	
Day 10	CC/ EE/HMG	
Day 11	CC/ EE/HMG	
Day 12	CC/ EE/HMG	
Day 13	CC/ EE/HMG	
Day 14	HCG + sex	
Day 15	Sex	
Day 16	Sex	

a small oocyte starts to develop on day 3. A lot PCOS patients and patients getting old and patients with hyperprolactinemia and other unknown conditions are unable to naturally grow to reach a 20 mm Oocyte; so on day 3 we give them Clomiphene Citrate (CC) 50 mg daily to help growth of the oocyte and EE 0.25 mg daily to reach a higher CMS. We all know the medicine Human Menopausal Gonadotropin (HMG) helps the growth of the oocyte, thus we add HMG 75IU by intramuscular injection daily starting from day 10 [1-4]. When we start HMG on day 10, multiple pregnancies, of more than twins cannot happen and we do not disturb the natural menstrual cycle. On day 14, we

Table 2 Demonstrating medicine dosage from day 1 to day 16.

Medicine	Dosage
CC (Clomiphene Citrate)	1@ 50 mg
EE (Estrogen Estradiol)	2@ 0.125 mg
HMG (Human Menopausal Gonadotropin)	75 IU
HCG (Human Chorionic Gonadotropin)	10,000 IU

stop CC and EE and HMG and prescribe HCG and tell them to have sexual intercourse for 3 continuance days. For patients with simple hyperprolactinemia, we prescribed bromocriptine 2.5 mg daily as soon as we found blood PRL to be high. For patients with amenorrhea any day we start CC and EE is determined to be menstrual period day 3. On day 10 we prescribed HMG and on day 14 we prescribed HCG, prescribing the same for patients with PCOS and for other infertile women. On day 14 we stopped all medicine (CC and EE and HMG and bromocriptine) and as stated above, we prescribed HCG and ordered them to restart sexual intercourse for three continual days **(Table 2)**. This regimen is simple and easily understood and most importantly it does not disturb women's natural menstrual cycle or develop any side effects like ovarian hyper stimulation syndrome etc. It is cheap, does no harm and results in a high pregnancy rate. The patients love to try it. Patients with no luck from IVF (*in vitro* Fertilization), can get pregnant using this regimen, and often succeeded in one cycle of treatment. (Should we try this regimen for one or two cycles before attempting IVF?). One patient who was pregnant after this regimen, who failed after spending a fortune on IVF, brought her friend to see me. An ovarian tumor was found by TVU in this patient. She got pregnant after one cycle of this regimen. I told her to have a caesarean to get the infant out together with the ovarian tumor. Another patient who lived far away and was 35 years old with the history of artificial abortion wanted to get pregnant. Her relative had given me her blood serum for ELISA tests. The relative bought the above regimen from me and the patient became pregnant, without even seeing me and before the blood hormone results had come out. It is important to ask the husband to cooperate. The sperm's quality and quantity obviously improved after weeks or months of refraining from sexual activity [5]. Even patients suffering endometriosis for 10 years and who had tried everything and failed; became pregnant after my telling them the exact time to have sexual intercourse, to coincide with the time of ovulation i.e. three days continual sex from day 13 to day 15. One patient who is very tall and who had previously suffered a miscarriage, after using the above regimen, became pregnant again. After 5 months pregnancy however a miscarriage happened again, which I suspect was not related to any fertility problem. My experience with the hysteroscope: In one of my patient who previously had an artificial abortion, under hysteroscopy I found a tiny bone inside the uterus. After taking out the tiny bone, she became pregnant, which caused me to suspect that the tiny bone was the cause of her infertility. Could a tiny bone be a better Intrauterine Contraceptive Device (IUD) than the usual IUDs available? It is unlike other IUDs, which are made of metal, copper or plastics and which often cause allergic reaction and quite often cause purulent leukorrhea. I have also seen jewellery made of bone [6]. Why not we create different types of IUD made of bone or cartilage from chicken or whatever? A hysteroscopic examination can break intrauterine adhesions. For this reason hysteroscopic hydrotubation with great intrauterine pressure, monitored by abdominal Ultrasound during the surgery is very effective. The results of Hysteroscopy done conjointly with hydrotubation can be seen on a video screen. This is very safe and widely approved as it does not cause patients discomfort or requires anesthesia. A TV guided laparoscopy, however does require anesthesia. After making the fallopian tube patent by hysteroscopic hydrotubation, we start the regimen [7]. The happiest thing in the world is to share success of pregnancy with the patients. If you are interested in taking my research further or if you have used my regimen and found it produced a successful outcome, please contact me at: Doctor PO Box 183 Beaudesert, QLD 4285 Australia.

References

1 Anwar S, Ayesha A (2016) Infertility: A Review on Causes, Treatment and Management. J Womens Health 2: 1-5

2 Allen CM, Lopes F, Mitchell R, Spears N (2018) How does chemotherapy treatment damage the prepubertal testis?

3 Quaas A, Dokras A (2008) Diagnosis and Treatment of Unexplained Infertility. Rev Obstet Gynecol 1: 69-76.

4 Deshpande NA, Nour NM (2013) sex Trafficking of Women and Girls. Rev Obstet Gynecol 6: e22-e27

5 Leyendecker G, Wildt L, Hansmann M (1980) A New Approach to the Treatment of Infertility in Hypothalamic Amenorrhea. J Clin Endocrinol Metab 51: 1214-1216.

6 Jill J (2015) Treatments for Infertility. JAMA Patient Page 313: 320-321.

7 Xianbin Li, Tang Y, Wang C (2013) Adjunctive Aripiprazole Versus Placebo for Antipsychotic-Induced Hyperprolactinemia: Meta-Analysis of Randomized Controlled Trials 8: e70179.