

AMERICAN MORNING

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Two Doctors Face Off on IVF Treatments
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ROBERTS: All over the world, just-released numbers show that first-time mothers are getting older in America. But every year over age 30, a woman's chance of getting pregnant declines. More than 7 million American women now are dealing with some sort of infertility. And many are turning to the laboratory to assisted reproduction commonly called IVF.

That's how Nadya Sulaman became the now-infamous octomom. And many critics got all over her for doing it. Now in a controversial new book, "Making Babies: Proven Three-Month Program for Maximum Fertility," Dr. Sami David said too many women are getting pushed toward IVF.

On the other side of this debate, Dr. Jamie Grifo, a reproductive endocrinologist and program director at New York University Fertility Center. Doctors, good to see you both this morning. Let's go to you first Dr. David. You claim in your book that 50 percent of IVF procedures are unnecessary. Where's the evidence for that?

DR. SAMI DAVID: Well, the evidence - first off the book is written with my co-author Jill Blakeway, a wonderful acupuncturist. 40 percent of infertility is male related. So I ask myself why is it that IVF doctors are pushing the drugs on the women when in fact the man is the one that should be evaluated.

So many couples are being herded in to IVF when perhaps there are much easier cause - much more treatable causes for their infertility instead of giving them high dose of drugs with the risk of drugs, with the risks of preterm delivery, with the risk to the baby. There are easier ways, better ways, and in this economy, a lot cheaper ways of having a baby other than having to resort to in vitro.

ROBERTS: And Dr. Grifo, you heard what Dr. David said, there are too many people being pushed toward infertility and are women being given drugs when it is actually the man who should be being treated here?

DR. JAMIE GRIFO, PROGRAM DIRECTOR, NYU FERTILITY CENTER: Well, we're not pushing patients in to in vitro fertilization. That's the last resort treatment, not the first resort treatment. And we do diagnose patients. We do treat specific problems that we find.

And it is true, 40 percent is male factor. And those men are worked up and treatable problems are corrected and then the appropriate treatment is given, and it's based on data, and it's based on evidence. And when simple things fail, then IVF becomes the last resort and it's also the most effective treatment.

ROBERTS: OK. Let's break this down into a few categories here. First of all, a starting line - if a 35-year-old woman walked into your respective offices having trouble getting pregnant,

how would they be treated? And how would they be treated differently? Dr. David, you want to start?

DAVID: It all depends on whether they've seen other doctors before me. All right. The important thing is to go over a complete - totally complete history. Find out about the woman's habits, her hobbies. The husband - does he take tub baths? Does he put a laptop computer on his lap? A lot of these little questions are not raised at the time of interview with the IVF doctors.

A good history should take at least one hour. You need to know everything about the woman and the man. Then you run the appropriate tests. Cultures on the cervix, hormone tests on the woman. Examining a man very critically. Let's look at his sperm shapes, not just counts. Is there an infection in the man. Are the tubes OK? Are the uterus OK? You really must be absolutely complete. This is where a doctor is meant to be.

ROBERTS: Is that different from what you do?

GRIFO: No, it's exactly what most of us do. And that's how you treat patients - you make a diagnosis and then you give specific treatment. The problem is most of the infertility that we treat is age related decline in fertility. And our treatments are aimed at increasing the odds of getting someone pregnant. And it turns out that IVF for many patients is the most effective treatment. And that's why we often resort to IVF when simpler, less invasive, less expensive treatments don't succeed.

ROBERTS: So what Dr. Grifo is doing is the same as what you're doing yet there is IVF as a next procedure. Are you really, I mean, that much at odds with each other?

DAVID: We're not at odds with each other at all. I do send patients in vitro but only after everything has been tried and tested. On the reverse, though, what I'm finding in my own practice, I find as many IVF failures coming to me or to Jill Blakeway who become pregnant, especially these women who are deemed hopeless. (INAUDIBLE)

ROBERTS: OK. A lot more issues related to this that I want to talk about. We got to take a quick break. We'll be back again with Dr. Sami David and Dr. Jamie Grifo right after this. Stay with us. Thirty-seven minutes now after the hour.

(COMMERCIAL BREAK)

ROBERTS: We're back with our two doctors and two different views in making babies in the laboratory. The IVF debate, Dr. Sami David and Dr. Jamie Grifo return with us now.

So let's talk about this idea is this still in some ways a big experiment? You talk about the effects of drugs use in IVF, Dr. David, in your book. And you say, some studies show an increase in cancer risks from fertility drugs, however a Danish study, over the course of decades followed 54,000 women found no increase in incidents of ovarian cancer because of use of fertility drugs?

DAVID: There is another study, John, I think '08. When 19,000 people were evaluated. And there was a slight increase. This is not to scare people away from IVF, a slight increase in ovarian cancer, but more importantly, an increase in other types of ovarian tumors that are

not cancerous or perhaps pre cancerous called borderline tumors of the ovary. This is not to scare people away from IVF at all but if there is an easier, less expensive way, a more natural way to achieving a pregnancy in this economy and with our concerns, why are we doing aggressive therapy.

ROBERTS: One of our producers here at AMERICAN MORNING had breast cancer, and also had IVF. When she read Dr. David's book she got concerned that whew, would she be at higher risk because for recurrence of breast cancer because of all these drugs that she took?

GRIFO: Well, there's not one study that has documented that. And the problem with all the studies looking at ovarian cancer is it's always been known before fertility treatments that the group of infertile women had a higher risk of ovarian cancer to begin with. So when you compare that population to the normal average population, these population studies are fraught with problems in terms of analysis.

So studies that are only good are the ones that will follow the patient in time and two big studies have done that and found no difference in these patients. So the worry about these drugs is really limited and if there are risks, they're very small if at all.

ROBERTS: Another big issue too is how old is too old? And Dr. David, you are talking in your book about discrimination against women who are older. Because, you know, you look at the hormonal panel when a person comes in for IVF and if certain hormones are above a certain level, they're not particularly a good candidate for it. Yet at the same time, you say that predominantly, it's older women who are pushed to IVF. So it's kind of like you're trying to argue it both ways here?

DAVID: Well, I think what I'm seeing in my practice and Jill Blakeway as well is patients have been given a hopeless chance. You're 45 years old, you're 43 years old, even a 32-year-old if FSH is high is being turned away by IVF doctors saying your eggs are too old. You have to give that person a chance to achieve a pregnancy. I'm just, you know, I'm sorry for these patients.

GRIFO: That may be your experience. But that's not how we practice. We tell the patients what their chances are based on some of these parameters. A 32-year-old with high FSH doesn't have a...

ROBERTS: FSH being follicle-stimulating hormone.

GRIFO: Follicle-stimulating hormone, which is a marker for ovarian reserve and good egg quality. If that value is elevated, your chances are lower. And if we don't tell patients these facts, then we're not being good doctors either. We don't discard them and tell them their case is hopeless. I've never told a patient that her case is hopeless. There's always hope.

What we have to do is help them navigate the complex series of choices that they must make in treatments. And that's what our job is and our goal is as practitioners, educate patients and help them make good decisions. And when you do that, they make good decisions.

ROBERTS: The other big issue here is science versus luck. How much is luck? How much is science? You write in your book, "I have helped many patients become pregnant who have

failed in vitro attempts. There's a huge population of women who have failed in vitro and may still be able to conceive without in vitro or fertility drugs." What do you know, Dr. David, that IVF specialists like Dr. Grifo have missed.

DAVID: For example, a lot of the doctors gave the importance of infections in the husband's semen, for example. And in all the cases...

GRIFO: We check. We have semen analysis. We do a culture.

DAVID: Virtually every case I've seen that come to me failed IVF. There maybe a mild bacteria in the semen. And this is not what they're looking for. Week after week, Jill Blakeway and I will see patients who have not succeeded with IVF who succeeded in easier, less expensive ways.

ROBERTS: Sometimes you refer to IVF and sometimes IVF doctors will refer back to you. It's a little circle. How much of this, Dr. Grifo, is luck versus science?

GRIFO: Well, everyone has a baseline pregnancy rate. When you look at a couple, there's a chance that they'll get pregnant. Some patients it's a very low chance. And sometimes there are treatment independent pregnancies that occur. After failing IVF, there have been patients who get pregnant. It's just a fact. But it's not the most likely event that you see as a doctor. So we're trying to help patients get their best chance. As they get lower, their chances get lower. And if you ignore them and you don't treat them, then you really ruin your chances of being successful.

ROBERTS: Great discussion this morning. Gentlemen, it's great to be with you, Dr. Sami David, Dr. Jamie Grifo. Appreciate you coming in.

GRIFO: Thanks for having us.