

Fertility meds in a nutshell: Part 1 The Oral Meds

Actually, fertility meds don’t come in a nutshell. They come in the form of a pill or injections, depending on the type of medication. The oral medications are addressed here as they are usually the first step for those proceeding with fertility treatments.

There are two different oral medications prescribed for fertility treatment in the U.S.: clomiphene citrate (Clomid) and letrozole (Femara). Although they work in different ways, the end result of both is that the brain perceives low estrogen levels and makes more of a hormone called FSH, which can produce a follicle (egg) in those who don’t ovulate on their own, and many follicles in those who ovulate but need help achieving a pregnancy. Both are good at their jobs, as most women who take them make follicles and ovulate, but they can come with a price and that is the way that the low estrogen levels can make you feel, especially on clomiphine. Estrogen is necessary to build a uterine lining, to make cervical mucus that is easy for sperm to penetrate, and contributes to a sense of well-being. Low estrogen, then, can be the cause of a thin uterine lining, unfavorable cervical mucus, hot flashes, mood swings, and an overall sense of not well-being. The good news is that <10% of woman experience these side effects and that these feelings go away after the course of the medications. The bad news is that you can feel like a raging PMS monster. Don’t worry, though, we have a Plan B and we can give you a medical clearance note if you want to punch someone.

Plan B is letrozole. It is also good at it’s job, and it has a short half-life. That means that it leaves the body a short amount of time (about 48 hours) after taking it, so the body doesn’t have time to experience the anti-estrogen effects. So, why not just use letrozole first? Well, clomiphene is older and we know a lot about it, feel comfortable using it, it’s cheap and most insurances cover it. It’s also FDA approved for making follicles (ovulation induction) and letrozole is not. Don’t let that scare you, though, we use a few medications in fertility treatments that are not FDA approved for fertility treatments, but are safe and standards of care.

As mentioned before, the planned outcome for these is to make 1-2 follicles if you don’t normally ovulate and 2-4 follicles if you ovulate. The dose might be increased or decreased depending on your response, and many practices will ask you to have ‘relations’ (time intercourse appropriately) every day or every other day for a few days after stopping the medications. If you are going to a fertility practice, they might administer a medication called a hCG or a trigger shot, that causes ovulation to occur in 36 hours, so we can precisely time intercourse or, a more proactive option, intrauterine insemination (IUI).

If you are on clomiphene and having any of the mood disturbances, make sure to tell your provider this. Continuing on clomiphene might not be the best choice for you as you are susceptible to it’s anti-estrogenic effects. If you are have an ultrasound after taking clomiphene and your uterine lining stays thin, you might be prescribed some estrogen during your cycle (after the clomiphene stops so as not to interfere with the brain’s perception of low estrogen), but you shouldn’t use clomiphene for subsequent cycles, as this effect will most likely continue.

Some women take progesterone (and sometimes estrogen) after ovulation until the pregnancy test. This is because your provider thinks (either due to blood levels or a shortened time from ovulation to menstrual cycle) that you have an insufficient luteal phase. The function of the corpus luteum, the cyst that is left after the egg ovulates out of the follicle, is to produce hormones, mostly progesterone, that make the uterine lining ready for the implantation of an embryo and, should pregnancy take place, support it until the placenta starts to work in a few weeks. Low progesterone levels or a short (<14 days) period of time between ovulation and the next menstrual period, might be signs of an inadequate corpus luteum, so the concern is that an early implantation is not being supported. By giving you progesterone (and sometimes estrogen) we can, in fact, act as your body’s corpus luteum and support the uterine lining, and make it cozy for an embryo to implant there. Estrogen is given as an oral pill. Progesterone is usually given as a vaginal suppository because oral progesterone doesn’t work so well for lining support.

Usually a pregnancy test is done about 2 weeks after ovulation. If you are taking estrogen or progesterone, it can prevent a period from happening, so a blood test is necessary (since low levels of estrogen and progesterone generate a menstrual cycle, high levels can delay the start of one). If you are pregnant, expect to stay on the hormones for a few weeks. If not pregnant, you will stop them.

Most fertility treatments, if they are going to work, will work in 3-6 months. If you don’t achieve a pregnancy after 3 months of therapy, it might be worthwhile to see your provider to talk about next steps (we have many options if oral therapy doesn’t work). If you are not ovulating or making follicles on oral therapy, you should talk to your provider sooner than 3-6 months as you are not really getting a chance to achieve pregnancy those months and your time might be better spent trying a different medication regimen. The chance of achieving a pregnancy per cycle is anywhere from 5-20% (depending on age, sperm count, and if you are doing an insemination or not). This is actually the chance that those who are not subfertile have each month of getting pregnant (I know that you know people who get pregnant “looking at their husband” but for most people the percent chance each month is lower than you think).

Ultimately, these meds work very well for people and many get pregnant easily and quickly. For those of you who don’t, it’s important to know that there are other options, even though it’s disappointing. Also, now that you know what to expect, be sure to tell your healthcare provider if you experience uncomfortable side effects, don’t think you are ovulating or think your period is coming quicker than it should. Finally, no discussion on fertility treatment would be complete without mentioning the need to find and explore self-care methods. For some, it’s exercise. For others, reading a good book or journaling. Everyone, though, should feel free to limit contact with toxic people during this time (unless you can’t, like a family member or weird co-worker, then just work on peacefully detaching when you are around them). We, as women, are always taking care of those around us and it’s ok (and necessary) to give yourself permission to take care of you during your fertility journey. For other self-care ideas, see my blog on this and other subjects at [www.fertilehealthexpert.com](http://www.fertilehealthexpert.com).