

Infertility: The Family Physician's Role in the Age of Reduced Access to OB/GYNs and Specialist Care

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Disclosures

- We do not have a current financial relationship with any entities that may have a direct commercial interest in the subject matter of the CME program
- For the purposes of this talk, female and male refer to the sex assigned at birth based on reproductive organs uterus/ovaries and testes, respectively

Objectives

- Define infertility with respect to causes and recommended timeline to initiate evaluation.
- Discuss initial evaluation for infertility as part of a primary care practice without access to specialists, including recommendations and interpretation of investigations.
- Review evidence-based management strategies, including lifestyle counseling and potential mental health impact of infertility.
- Discuss cost, accessibility, and ethical considerations in infertility management, including when it goes beyond a family physician scope.

The Equity of it All

- Average cost of a single IVF cycle in the United States is between \$12,000 and \$20,000
 - Multi-cycle packages range from \$30,000 - \$50,000.
 - 70% of women who undergo IVF go into debt.
- Commercial insurance
 - Pay for initial evaluation, but not the labs, imaging, and any additional treatment
- Medicaid
 - Varies widely by state
- Self-pay

PCP role

- To promote equity amongst all patients, it is the PCP's role to inquire about fertility desires and develop a management plan that will promote success.
 - **One Key Question:** "Would you like to become pregnant in the next year?"
- Primary care is responsible for mandatory discussions about fertility as part of a broader aspect regarding reproductive health issues.
- Diagnostic testing and treatment for infertility should be available to everyone in need of these services. The disparities in rates of infertility and the barriers to accessing assisted reproductive technology services should be understood through and addressed within a reproductive justice framework. Obstetrician-gynecologists and other health care professionals should identify specific populations at risk and their accompanying barriers to access to help improve infertility care across populations.
 - ACOG Committee Statement Number 14, January 2025

Additional Statistics

ACOG Committee Statement 14 Infertility: Disparities and Access to Services

- The Centers for Disease Control and Prevention estimates that **19% of married women aged 15–49 years** with no prior births **have infertility** (they are not surgically sterile and are unable to achieve pregnancy after 1 year of trying).
- Approximately **16%** of currently married women aged 15–49 years **have difficulty achieving pregnancy or carrying a pregnancy to term** (impaired fecundity).
- A cross-sectional analysis of women aged 33–44 years found that Black women had **twofold increased odds of infertility** (95% CI, 1.3–3.1) when compared with White women after adjustment for socioeconomic status, pregnancy intent, and risk factors for infertility.
- For Black, Indigenous, and people of color, the **prevalence of infertility often is high**; even when it is comparable with the prevalence in White women, the **utilization of infertility services is lower**.
- Several studies have found that women undergoing infertility treatment had depression and anxiety with reported rates up to **30–40%**.
- Other studies have noted that women with infertility experience **shame, grief, a perceived lack of femininity, and self-blame**.

Table 1. Populations at Risk for Inequities in Infertility Care	
Population	Risks
Minoritized racial and ethnic groups	Black, Asian-American, Hispanic, and Indigenous communities experience differences in seeking and receiving care, diagnoses, and pregnancy rates.
LGBTQ+ individuals	Denial of treatment based on same-sex partnership, single parent status
Single women	Denial of treatment based on same-sex partnership, single parent status
Individuals with HIV (or other infectious diseases)	Denial of treatment based on disease; limited laboratory resources for cryopreservation of gametes or embryos
Individuals with cancer	Limited access for fertility preservation and fertility treatment based on lack of referrals from oncologists; limited financial ability to pay for services on short notice
Active-duty and reserve uniformed service members and veterans	Limited access for treatment; limited coverage by military benefits
Religious and cultural aspects	Prohibitions on the use donor gametes and embryos; stigma associated with infertility; language barriers; immigration status
Individuals with disabilities	Denial of treatment based on disability
Oocyte donors, gestational carriers, transnational surrogacy	Risks of coercion
Patients without 3 rd -party payment support	Unable to proceed with treatment
Individuals with limited access based on geography (eg, rural, legal restrictions)	Inability to access treatment based on lack of proximity to health care professionals or legal restrictions to access
HIV, human immunodeficiency virus; LGBTQ+, lesbian, gay, bisexual, transgender, queer+.	



Depression, anxiety, quality of life, and infertility: a global lens on the last decade of research

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- Essential Points:
 - Independent of culture and country, studies globally show an impact on quality of life ranging from depressive and anxiety symptoms to sexual dysfunction.
 - Male infertility is associated with self-blame, social isolation, diminished self-esteem, and psychiatric conditions.

And the opposite...

- 25-60% of infertile individuals report psychiatric symptoms
- Does treating the psychiatric symptoms increase pregnancy rates?

Maybe

- Research studies are mixed, some showing benefit and other not
 - Quality of studies poor
- What is true?
 - Infertility patients (both men and women) experience distress, depression anxiety, and decreased quality of life.
 - Infertility providers and counselors should offer psychological interventions and emotional support
 - Can lead to longer retention in ART treatment and higher pregnancy rates

Comfort with Infertility

Article 

PanAfrican
Medical
Journal

Research



Management of infertility among primary health care physicians in Morocco: a cross-sectional study

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Keywords: General physicians, infertility, management, primary health care

- Infertility management in PHCS influenced by gender, age, post-graduate period, and years of experience
- 44.3% thought infertility management is not an activity for PHCSs
- 70.2% did not investigate among infertile couples
- 13.8% never gave advice about improving fertility

Review

- Infertility:
 - Impairment of a person's capacity to reproduce as an individual or with their partner
 - Medical diagnosis and not a "social condition"
 - World Health Organization and AMA designated infertility as a disease in 2009
 - Inability to achieve pregnancy after 12 months of regular, unprotected sexual intercourse
 - Or if ≥ 35 years of age, 6 months of regular, unprotected sexual intercourse
- Worldwide affects 17% of people regardless of income



Etiology

FEMALE FACTOR

- 35-50% of causes
- Uterine Factor
 - Submucosal fibroids
 - Mullerian anomalies
- Tubal Factor
- Ovarian Reserve
- **Ovulatory Dysfunction**
- **Other**

MALE FACTOR

- 40-50% of causes
- Up to 15% men worldwide struggle with infertility
- **Semen abnormality**
- Anatomic abnormality
- Genetic abnormality

UNEXPLAINED

- Up to 30% of causes
- Absence of identifiable cause

Timing of Evaluation

- Based on female partner's age
 - < 35 yo: after 12 months of regular, unprotected intercourse
 - 35-40 yo: after 6 months
- Immediately:
 - > 40 yo
 - High risk condition for infertility
 - Endometriosis
 - Condition that affects ovarian reserve
 - Menstrual irregularities
 - Known or suspected male infertility
 - Known or suspected uterine, tubal, peritoneal disease
 - Sexual dysfunction
 - Non-heterosexual partnership

Evaluation of Female Infertility

Table 1. Anamnesis.

Infertility	<ul style="list-style-type: none">– Time of infertility– Intercourse frequency– Previous treatment
Life habits	<ul style="list-style-type: none">– Alcohol consumptions– Smoking– Diet– Physical activities– Use of drugs– Occupational risks
Gynecological history	<ul style="list-style-type: none">– age at menarche– cycle length and regularity– menstrual flow– dysmenorrhea– dyspareunia– previous use of contraceptive methods,– previous gynecological infections and pelvic pain
Obstetric history	<ul style="list-style-type: none">– etiology of infertility (primary or secondary)– obstetric and perinatal outcomes– recurrent miscarriages

- Comprehensive medical history
 - Goal: identify conditions that impact pregnancy
 - Neurologic, thyroid, nutritional deficiencies
 - Duration and types of previous infertility treatment
 - Obstetric, menstrual, contraceptive, surgical, sexual histories
 - PMH: DM, obesity
 - ROS
 - Medications and other teratogenic exposures
 - Family History
- Physical exam:
 - Key areas: thyroid, breast, GU
 - Signs of hyperandrogenism

Evaluation of Female Infertility

LABS

- TSH, prolactin if clinically indicated
- CMP, A1c to r/o DM, renal/liver disease
- Ovarian function:
 - Midluteal serum progesterone (~CD 21)
 - LH via urinary ovulation kit
- Ovarian reserve:
 - Antimullerian hormone
 - Stop combined OCP for 8 weeks before testing
 - FSH on cycle days 2-5, with estradiol
- Cervical mucous evaluation is no longer standard

INDICATORS OF DIMINISHED OVARIAN RESERVE

Indicator	Value
Anti-mullerian hormone	< 1.0 ng per mL
Antral follicle count	< 5-7
FSH	> 10 mIU per mL (10IU per L)

Preserved ovarian reserve ≠ preserved ovarian quality

Evaluation

IMAGING

- Hysterosalpingography
- TV Ultrasound
 - If using to evaluate antral follicle count:
 - Days 2-5 cycle
 - $\geq 10-12$ follicles of 2-10 mm
- Sonohysterography
- Hysteroscopy
- Hysterosalpingo-contrast sonography
- MRI
- 3D ultrasound

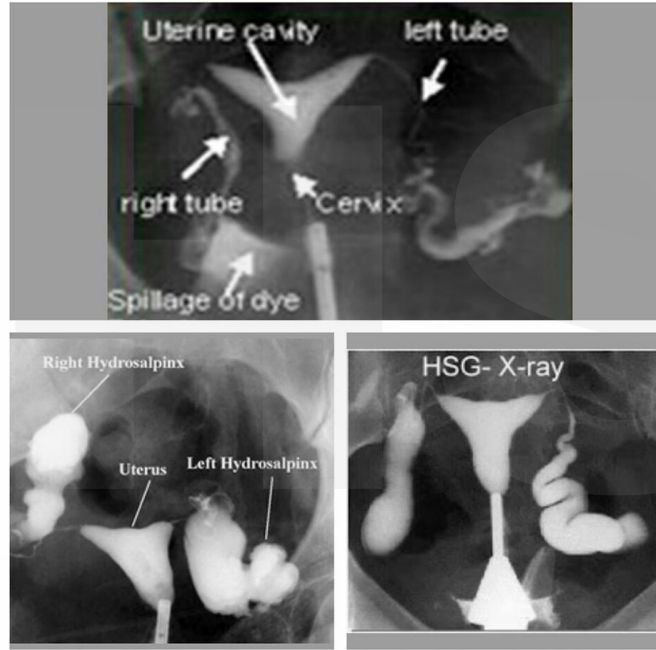


TABLE 3

Imaging Options for the Diagnosis of Infertility

Imaging	Technique	Cost*	Evaluation
Ultrasonography (transvaginal)†	Evaluation of uterus, cervix, adnexa with ultrasound probe via vagina	\$145	Ovulation Uterine factor
Hysterosalpingo-contrast sonography	Evaluation of uterus, adnexa, and infusion of fluid via cervical catheter; contrast agent with bubbles used to evaluate for tubal patency	NA	Ovulation Tubal factor Uterine factor
Hysterosalpingography†	Radiopaque dye injected into uterine cavity via cervix and followed with fluoroscopy through fallopian tubes	\$220	Tubal factor Uterine factor
Hysteroscopy	Evaluation of uterine cavity with transcervical fluid	\$3,990	Uterine factor
Laparoscopy with chromopertubation	Indigo carmine introduced via transcervical catheter during laparoscopy	\$6,680	Tubal factor Uterine factor
Magnetic resonance imaging	Evaluation of entire pelvis; option for contrast use	\$640 \$945 (with contrast)	Uterine factor (müllerian)
Sonohysterography	Evaluation of uterus, adnexa with fluid infusion via cervical catheter	NA	Ovulation Tubal factor Uterine factor

NA = not available.

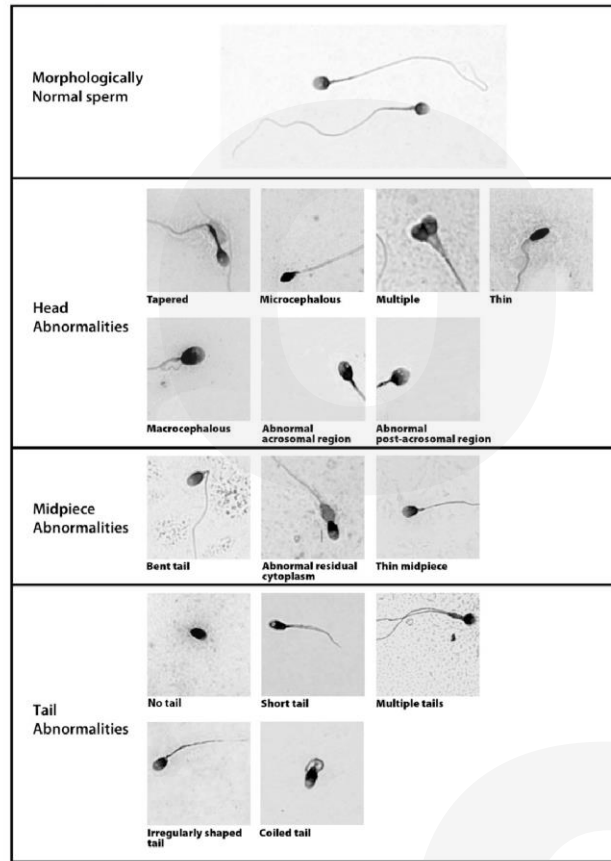
*—The fair price represents reasonable out-of-pocket costs based on price comparisons. Actual cost will vary with insurance and by region. Information obtained at <https://healthcarebluebook.com> (accessed February 21, 2023; zip code: 66211).

†—First-line imaging in the primary care setting.

Information from references 9 and 10.

What about the male partner?

- Remember: 50% of infertility cases relate to the male partner
- Canadian Urological Association and American Urological Association guidelines both state that with a thorough history, physical examination, and initial diagnostic tests, some advice can be offered to all men dealing with infertility



Evaluation of Male Infertility

- History
 - Reproductive history: prior fertility, sexual dysfunction, ED
 - Developmental history
 - PMH: DM, obesity, HTN or CVD, ED, history of STIs
 - childhood illness (mumps, cryptorchidism)
 - Genital trauma
 - Surgical history of reproductive tract
 - Exposures: environmental, toxin, substance exposure (tobacco, narcotics and cannabis)
 - Medications
- Physical
 - BMI, gynecomastia, GU exam
- Semen analysis
 - Collect and submit within one hour of production
 - Need 2 samples over 2-4 weeks

Modifiable Risk Factors for Male Infertility

Alcohol use

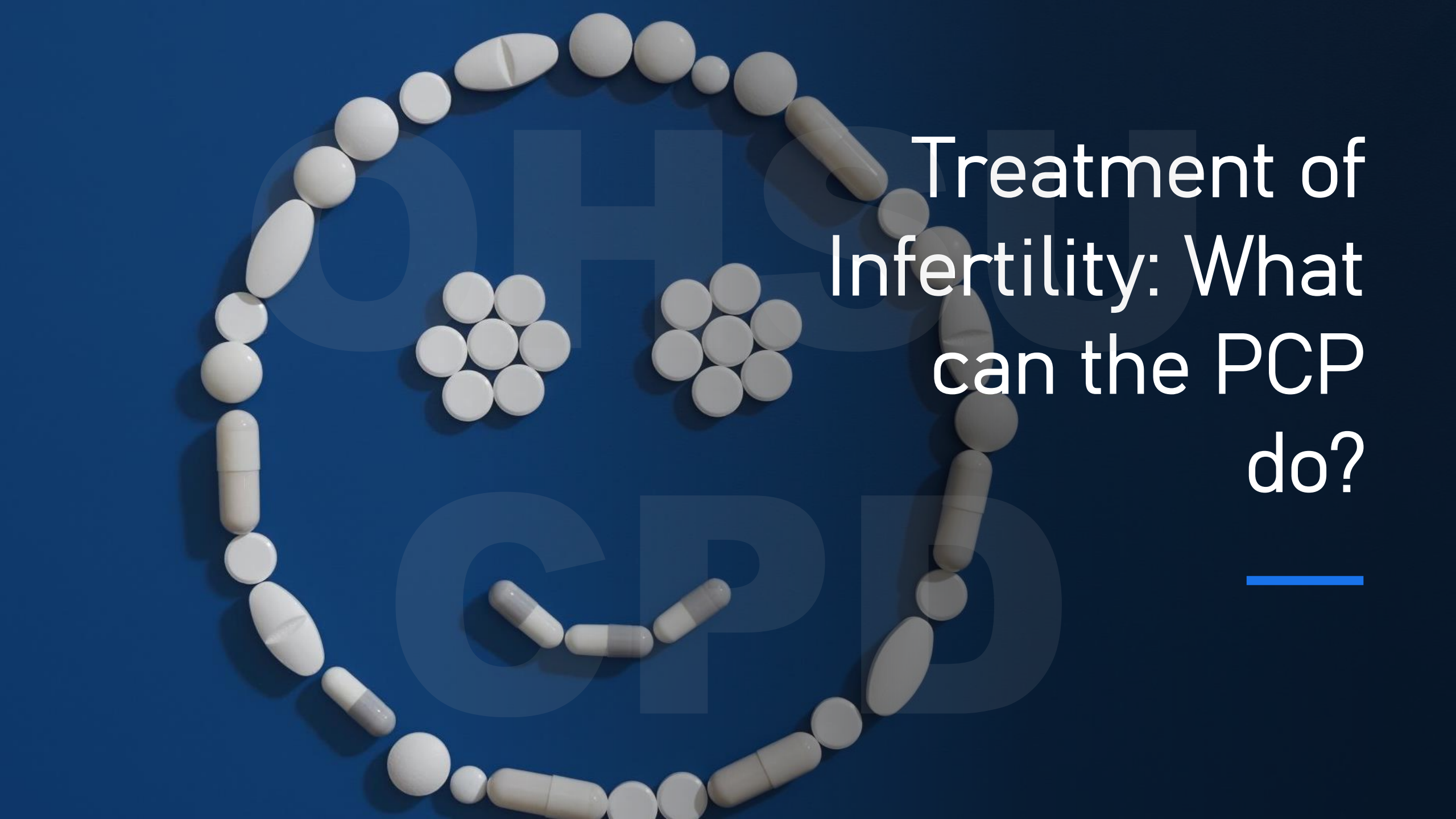
Environmental or occupational exposure to toxic chemicals

Illicit drug use

Obesity

Smoking

Varicocele



Treatment of
Infertility: What
can the PCP
do?

General principle of management of infertile couples

Involve both partners in the evaluation and management of infertility

Recommend lifestyle modifications to enhance fertility

Couple:

Smoking cessation

Reduce exposure to potential environmental toxins

Women:

Abstinence from alcohol

Reduce excess caffeine intake

Weight modulation with target BMI 20-25 kg/m²

Perform infertility evaluation according to established guidelines

Identify cause of infertility

Reversible causes:

Implement medical or surgical therapy to correct etiology of infertility

Irreversible causes:

Assisted reproductive technology

Gamete donation

Gestational carrier

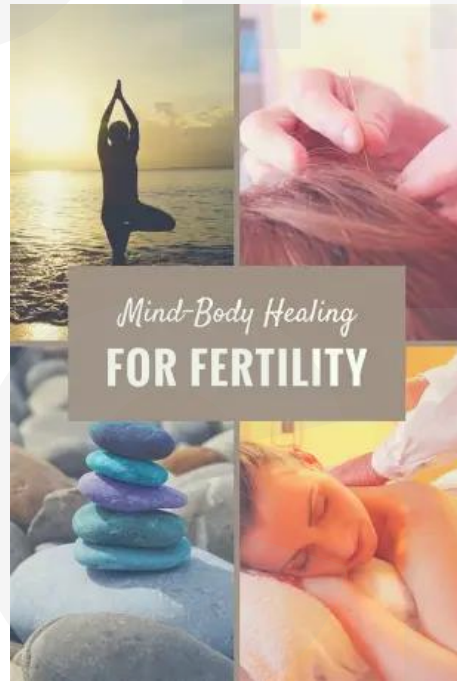
Adoption

Lifestyle Modifications: The PCPs domain!

- Weight modulation
 - Target BMI 18.5–25 kg/m²
 - Encourage weight gain if BMI < 17
 - Referral for cognitive behavior therapy if altered attitudes toward weight/eating
 - 2003 RCT showed higher rate of ovarian activity (87%) compared to observation (25%)
 - Weight loss for BMI > 25
 - 5–10% weight loss can improve spontaneous ovulation rates
 - Consider GLP1s to assist, but avoid pregnancy while taking
- Avoidance of toxins:
 - Women: meds, nicotine, narcotics or any kind, excess caffeine (>200 mg daily), environmental
 - Men: spermatotoxic lubricants, nicotine, wet heat (saunas and hot tubs), anabolic steroids/exogenous testosterone

Optimize control of chronic medical conditions

- Couples:
 - Diabetes
 - HTN
 - Obesity
 - Mood Disorders
- Women:
 - PCOS



THE MIND/BODY PROGRAM FOR INFERTILITY

- Combines psychoeducation and mind-body skills to support women and their partners in their journey to parenthood.
- Developed by Dr. Alice Domar
- Based on research from Harvard Medical School
- Shown to significantly reduce symptoms of stress, depression, and anxiety => increased pregnancy rates

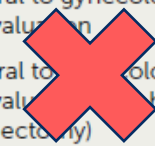
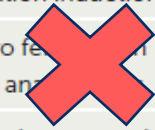
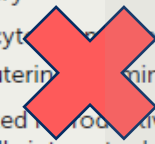
Fecundability Diet?

- Mediterranean-style dietary pattern has the best evidence
 - Whole grains, omega-3 fatty acids, fish, vegetables, fruits, plant-based proteins (soy)
 - Caveat: mercury rich fish
 - Reduce trans fats, red meat, ultra-processed food
- Anti-inflammatory diet
 - Reduced red and processed meat, high-glycemic carbs, sugar-sweetened beverages, ultra-processed foods
- Supplementation
 - Folic Acid: at least 400 μg daily (if BMI > 30, would suggest 800 μg)
 - Consider if deficient:
 - Vitamin D
 - Vitamin B12 (think vegetarian or vegan diet)
 - Iron

Beyond Lifestyle: Based on Etiology

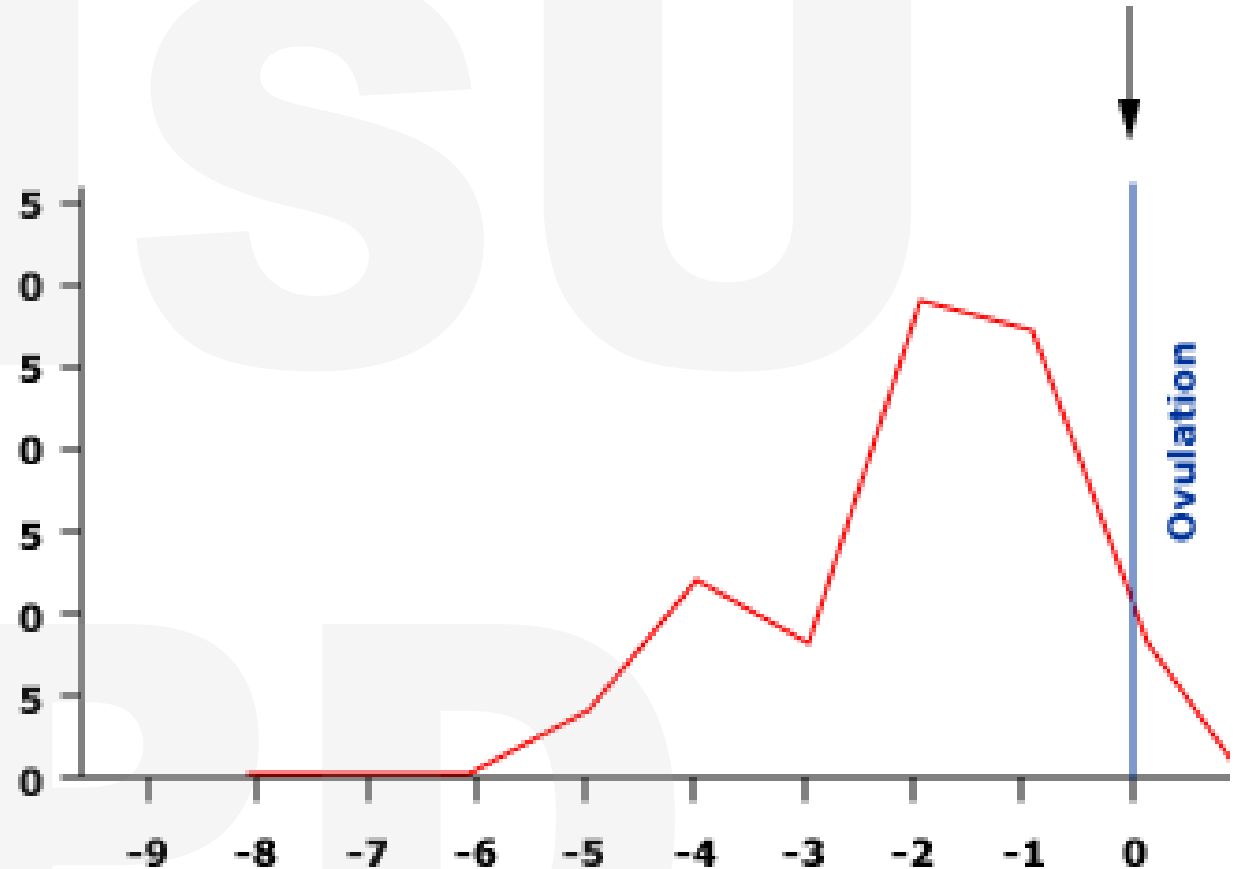
- Ovulatory
- Nongynecologic
- Tubal
- Uterine
- Male factor
- Unexplained/Idiopathic

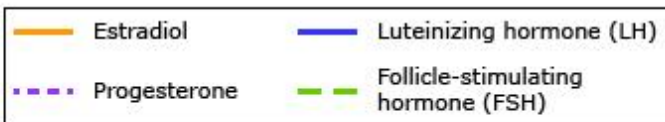
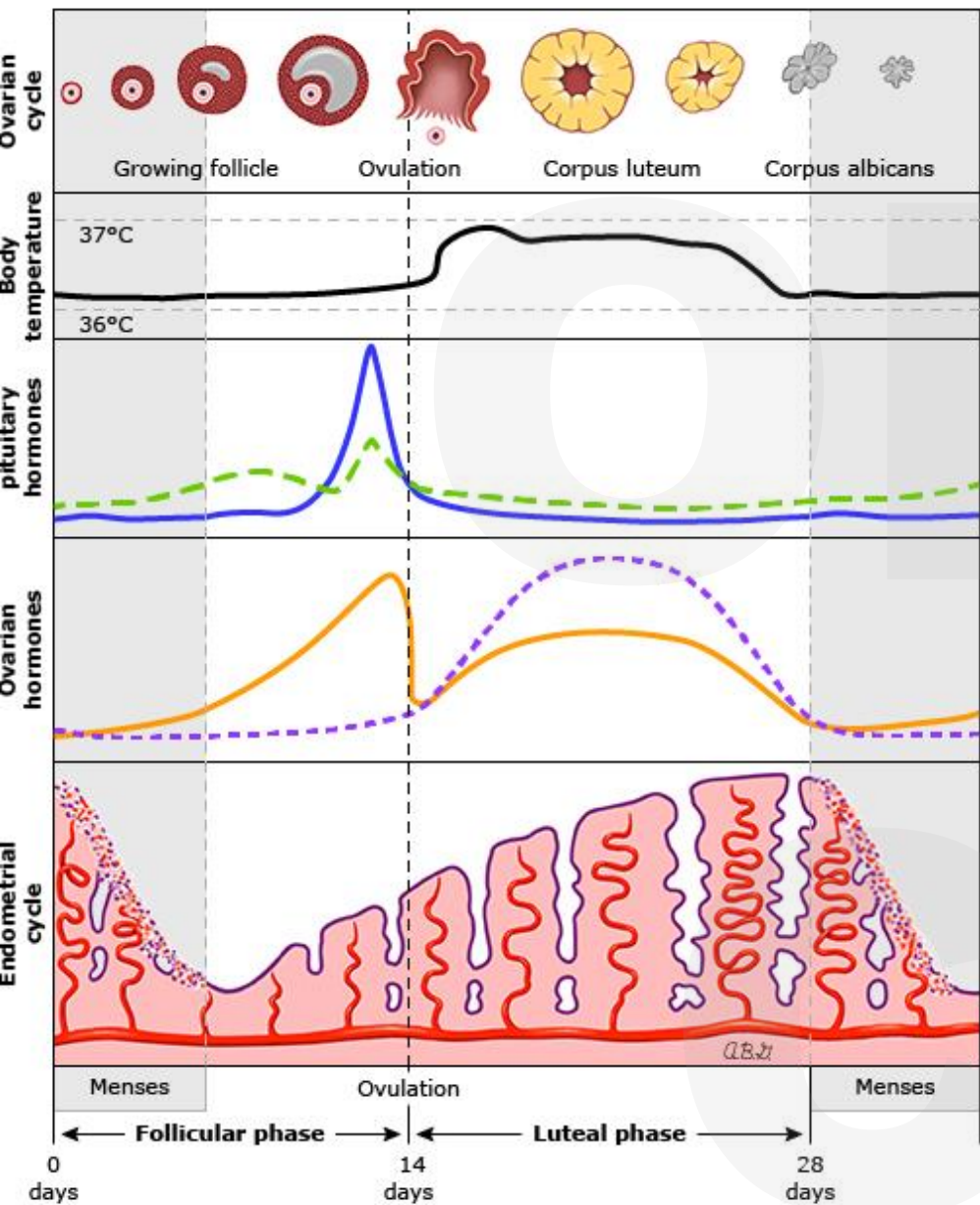
Management of Infertility		
Factors causing infertility	Diagnosis	Treatment
Male infertility	Abnormal semen volume	Intrauterine insemination
	Abnormal sperm count	Intracytoplasmic sperm injection Surgery*
	Abnormal sperm motility/morphology	Intracytoplasmic sperm injection Intrauterine insemination
	Unexplained	Assisted reproductive technology (usually intracytoplasmic sperm injection) Intrauterine insemination
Nongynecologic medical conditions	Hyperprolactinemia	Dopamine agonists
	Hypothyroidism	Thyroxine
Ovarian factors	Hypothalamic dysfunction	Donor eggs Gonadotropin therapy
	Polycystic ovary syndrome	Lifestyle modifications Metformin Ovulation induction agents
	Diminished ovarian reserve	Donor eggs Ovulation induction agents
Tubal factors	Tubal obstruction	In vitro fertilization Tubal anastomosis
Uterine factors	Leiomyomata	Referral to gynecologist for surgical evaluation
	Endometrial polyp	Referral to gynecologist for surgical evaluation (hysteroscopic polypectomy)
Unexplained	—	Assisted reproductive technology (ovulation enhancement plus intrauterine insemination) Expectant management In vitro fertilization



Optimizing conception

- Timed intercourse:
 - 6 days prior to ovulation to 1 day after ovulation
- Frequency of intercourse:
 - 2-3 times per week upon cessation of menses
 - Semen quality is optimized when there are 2-3 days of ejaculatory abstinence
- Non-factors:
 - Lubricants
 - Coital positioning
 - Presence of orgasm





Determining optimal timing

- Low resource interventions
 - Menstrual calendar
 - Tracking cervical mucous
 - Basal body temperature measurements
- Commercially available methods
 - LH kits
 - Best for irregular cycles or infrequent intercourse
 - For most women, do not increase fecundability, but may decrease time to conception

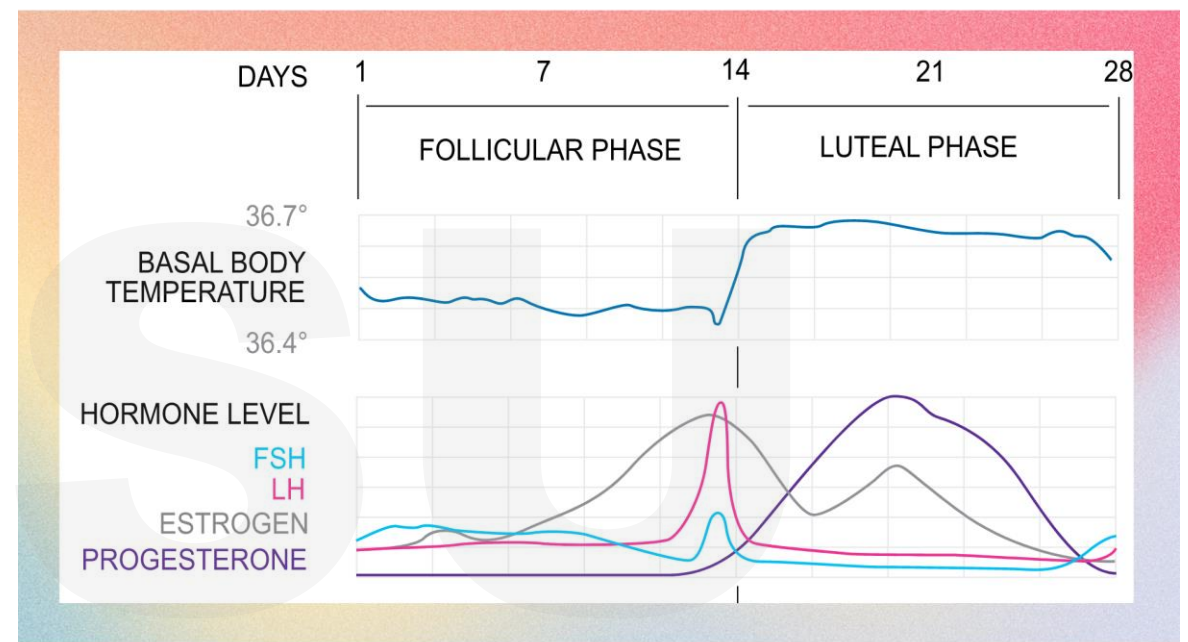
Test	Description	Brands	Accuracy in detecting ovulation
Urinary LH	Detection of high LH in urine	Many	97%
Urinary LH and estrone-3-glucuronide	Detects rising estrogen and high LH in urine	Clearblue easy fertility monitor and Clearblue digital	95-95% for fertile days
Underarm temperature measurement	Constant body temperature measurement	DuoFertility	100% sensitive to detect ovulation
Vaginal temperature measurement	Vaginal temperature measurement	OvuSense	99% for ovulation, 89% for ovulation prediction
Salivary ferning	Microscope to look for salivary ferning	KNOWHEN ovulation monitoring system, Geratherm	42-53%



Counseling on method

BASAL BODY TEMPERATURE

- Looking for rise in body temperature of 0.5-1° C
- Occurs after ovulation: due to increase in serum progesterone
- Method:
 - Measure as patient wake, before standing-up
 - Wearable devices can be helpful for constant tracking



LH SURGE TESTING

- Urine sample: endogenous LH surge
- ~36 hrs before ovulation
- Method:
 - Start on 10th day of cycle
 - Collect urine in middle or end of the day

Ovulation Disorders

Feature	WHO Classification	FIGO 2024 HyPO-P Classification
Origin	WHO, ~1973	FIGO, 2024
Primary Basis	Hormone patterns (FSH/LH/E2)	Etiology + site of dysfunction (hypothalamus, pituitary, ovary, PCOS)
Number of Groups	3 groups	4 pillars with multiple subcategories
Group I	Hypogonadotropic hypogonadism (low FSH/LH/E2)	Hy : Hypothalamic disorders (functional HA, tumors, infiltrative disease, genetic causes)
Group II	Normogonadotropic normoestrogenic (mostly PCOS)	P : Pituitary disorders (hyperprolactinemia, adenomas, Sheehan, infiltrative disease)
Group III	Hypergonadotropic hypogonadism (ovarian failure)	O : Ovarian disorders (POI, gonadal dysgenesis, iatrogenic, autoimmune)
PCOS	Included within Group II	PCOS : Separate pillar with sub-phenotypes and etiologic categories
Granularity	Low	High — dozens of etiologic subgroups
Clinical Utility	Good for broad teaching; limited for management	Designed for diagnostic pathways, research, and treatment planning
Modern Relevance	Outdated; does not reflect genetic, metabolic, or imaging advances	Current consensus standard endorsed by FIGO committees
Strengths	Simple, memorable	Etiology-based, comprehensive, aligns with modern reproductive endocrinology
Limitations	Over-simplifies PCOS; lumps diverse etiologies together	More complex; requires detailed workup

PCOS

Multistep approach to treatment of anovulatory infertility associated with PCOS

	Treatment	Cost	Multiple pregnancy risk
First line	Weight loss for high BMI	Low	Not increased
First line	Letrozole (alternate: clomiphene)	Low	Low
Second line	FSH injections	High	High, includes high-order multiples
Second line	Ovarian drilling	High	Not increased
Third line	IVF	Very high	High but reducible with single embryo transfer

- Metformin
 - Corrects hyperinsulin state
 - Can lead to increased menstrual cyclicity and enhance spontaneous ovulation.
 - Live birth rate not as high as with ovulation induction medications
 - Only recommended if patient has glucose intolerance
 - May facilitate weight loss and ovulation
 - Provides other metabolic effects beneficial for pregnancy
 - No current harm

Ovulation Induction: You can do this!

CLOMIPHENE

- Selective estrogen receptor modulator
 - Mimics hypoestrogen state → ↑ FSH → development of multiple dominant follicles
 - Ineffective for hypothalamic amenorrhea and primary ovarian insufficiency
- Dose:
 - 50 mg QD x 5 days
 - Days 2-5 of menstrual cycle
 - Can increase to 100 mg QD

















LETROZOLE

- Aromatase inhibitor
 - Advantages:
 - Produce fewer follicle and lower E2 levels
 - Decreased risk of multiples
 - Shorter half-life
 - Reduced antiestrogen effects on endometrium and cervical mucous
 - Choice for women with PCOS
 - Shorter time to pregnancy
 - Higher live birth rates compared to clomiphene
 - Dose:
 - 2.5-7.5 mg QD x 5 days on days 3-7 of menstrual cycle

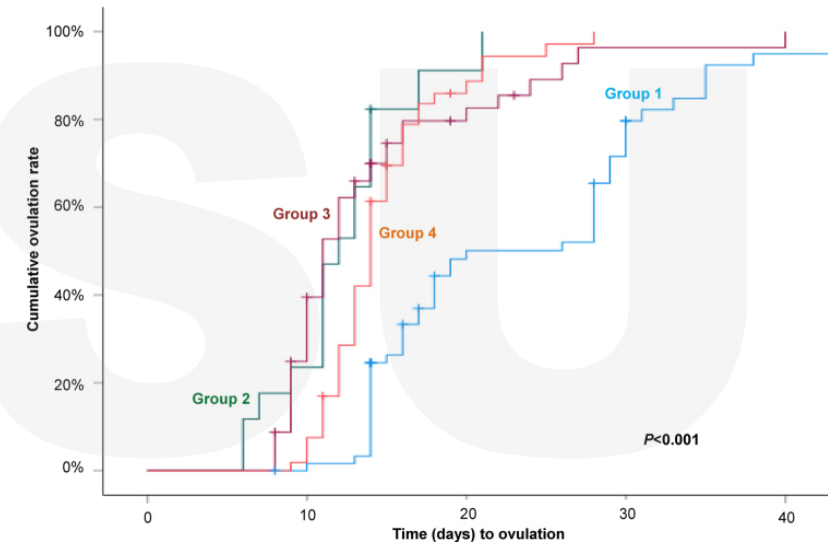


Ovulation Induction Calendar

1 	2 	3  	4  	5  	6 	7 
8	9	10 OPS →	11	12 	13	14 
15	16 	17	18	19	20	21 serum progesterone
22	23	24	25	26	27	28
1 	2	3	4	5	6	7

Best Protocol

- Small study, only 52 patients with PCOS
 - Total of 189 ovulation induction cycles
 - Mean age 30.9 yrs, BMI 32.1 kg/m²
 - 4 groups
 - Group 1: 2.5 mg x 5 days
 - Group 2: 2.5 mg x 10 days
 - Group 3: 5 mg x 5 days
 - Group 4: 5 mg x 10 days
- Ovulation rates improved starting with 5 mg and/or a 10 days extended course vs usual recommended 2.5 mg x 5 days.



A comparison of letrozole regimens for ovulation induction in women with polycystic ovary syndrome

Rachel S Mandelbaum¹, Ravi Agarwal¹, Samuel Melville¹, Caroline J Violette¹, Sharon Winer¹, Donna Shoupe¹, Koji Matsuo², Richard J Paulson¹, Molly M Quinn¹

Affiliations + expand

PMID: 38983726 PMCID: PMC11228783 DOI: 10.1016/j.xfre.2024.03.004

What about irregular periods?

Pre-treatment with medroxyprogesterone (Provera) to induce a withdrawal bleed

5-10 mg once a day x 10 days
Bleeding should start 3-7 days after finishing MPA
First day of withdrawal bleeding = CD 1

Then begin typical letrozole protocol

2.5 – 5 mg daily on CD 3-7

Ovulation Induction Medications

- Risks:
 - Ovarian hyperstimulation syndrome (1.4%) and multifetal gestation
 - Abdominal pain & distention, ascites, GI problems, respiratory compromise, oliguria, hemoconcentration, hypovolemic shock, and thromboembolism
 - Most common when both ovulation induction medication AND gonadotropins used together
 - Multiple gestation
 - Greater with clomiphene compared to gonadotropin therapy
- Common side effects of medications
 - Clomiphene: vasomotor symptoms, abdominal bloating, n/v, HA, breast pain
 - Letrozole: edema, sweating hypercholesterolemia, menopausal flushing, GI, arthralgia/myalgia, dizziness, HA, insomnia, somnolence
- Increased cancer risk? **NO**
- Cost (from GoodRx)
 - Clomiphene 50 mg: 30 tablets ranges from \$101-\$400
 - Letrozole 2.5 mg: 30 tablets ranges from \$16.50-\$50

Non-gynecologic Infertility

HYPERPROLACTINEMIC ANOVULATION

- Dopamine agonists
 - Cabergoline
 - Binds more specifically to dopamine D2 receptors on lactotroph cells
 - Fewer side effects
 - Bromocriptine
 - Fetal safety is better established
 - More nausea
- Stop once pregnancy diagnosed

HYPOTHYROIDISM

- Levothyroxine

When Enough is Enough: Referral timing

- No success with 6 rounds of ovulation induction medications
 - Pregnancy success rates rise with each round until 6, then they plateau and start to go down
- Tubal, Uterine, Idiopathic, or male infertility
 - These would all require surgical or higher supervision medical needs that are beyond the scope of a PCP, especially in a low access area

Further Study: an assortment of resources

- Women's Health Fellowships through AAFP
- American Society for Reproductive Medicine:
 - [Basic Infertility for Healthcare Providers | American Society for Reproductive Medicine | ASRM](#)
- [Family Medicine CME & Clinical Updates | Decera Clinical Education](#)
- American College of Obstetrics and Gynecology:
 - [PROLOG: Reproductive Endocrinology and Infertility, Ninth Edition - Online Assessment | ACOG](#)

Conclusion

- Infertility is a common concern, and PCPs should inquire about it.
 - Use the one key question!
- The PCP is the prime person to assist with initial evaluation and management of infertility
- Lifestyle modification and control of chronic medical conditions is our domain
- Ovulation induction is easy and safe and can be achieved in the PCP office

References

- Phillips K, Olanrewaju RA, Omole F. Infertility: Evaluation and Management. *Am Fam Physician*. 2023 Jun;107(6):623–630. PMID: 37327165.
- Sana El Adlani et al. Management of infertility among primary health care physicians in Morocco: a cross-sectional study. *Pan African Medical Journal*. 2025;50(12). 10.11604/pamj.2025.50.12.45189
- Infertility: Disparities and Access to Services. Committee Statement No. 14. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2025: 145:e51–e57
- Andrea Mechanick Braverman, Teni Davoudian, Isabelle K. Levin, Anne Bocage, Sascha Wodoslawsky, Depression, anxiety, quality of life, and infertility: a global lens on the last decade of research, *Fertility and Sterility*, Volume 121, Issue 3, 2024, Pages 379–383.
- Rooney, K. L., & Domar, A. D. (2018). The relationship between stress and infertility. *Dialogues in Clinical Neuroscience*, 20(1), 41–47. <https://doi-org.offcampus.lib.washington.edu/10.31887/DCNS.2018.20.1/klrooney>
- Souza MDCB, Silva LABD, Sequeira FF, Azevedo Antunes R, Souza MM. The management of infertility for primary care physicians. *Women Health*. 2023 Mar;63(3):194–203. doi: 10.1080/03630242.2023.2165599. Epub 2023 Jan 25. PMID: 36696953.
- Alesi S, Habibi N, Silva TR, Cheung N, Torkel S, Tay CT, Quinteros A, Winter H, Teede H, Mousa A, Grieger JA, Moran LJ. Assessing the influence of preconception diet on female fertility: a systematic scoping review of observational studies. *Hum Reprod Update*. 2023 Nov 2;29(6):811–828. doi: 10.1093/humupd/dmad018. PMID: 37467045; PMCID: PMC10663051.
- Mandelbaum RS, Agarwal R, Melville S, Violette CJ, Winer S, Shoupe D, Matsuo K, Paulson RJ, Quinn MM. A comparison of letrozole regimens for ovulation induction in women with polycystic ovary syndrome. *F S Rep*. 2024 Mar 28;5(2):170–175. doi: 10.1016/j.xfre.2024.03.004. PMID: 38983726; PMCID: PMC11228783.
- Kuohung, W., Hornstein, M. (2025). Female infertility: Treatments. In R.L. Barbieri (Ed.), *UpToDate*. Retrieved January 14, 2025, from <https://www-uptodate-com.offcampus.lib.washington.edu/contents/female-infertility-treatments>.
- Berga SL, Marcus MD, Loucks TL, Hlastala S, Ringham R, Krohn MA. Recovery of ovarian activity in women with functional hypothalamic amenorrhea who were treated with cognitive behavior therapy. *Fertil Steril*. 2003 Oct;80(4):976–81. doi: 10.1016/s0015-0282(03)01124-5. PMID: 14556820.