Introduction to Recurrent Pregnancy Loss

Hi and welcome back to the Beyond Infertility Summit. I'm your co-host, Dr. Carrie Jones. And I am so excited because I get to interview the other co-host, the amazing Dr. Aumatma Simmons.

She is the founder and fertility expert at the Holistic Fertility Institute and co-founder of Madre Fertility. Now, today we're talking about a really important topic that's recurrent pregnancy loss.

And honestly, I just don't think it gets enough research or press or discussion even on social media, because it is something that is near and dear to many women's hearts.

So let's jump in and get all the details with Dr. Aumatma. Welcome to your own Summit. Thank you so much. And it's such an honor to be interviewed by you, honestly, like.

Oh, that's pretty nice. I think it's pretty fun. That one we're co-hosting this. And two, because you're such an expert, I get the opportunity to really pick your brain and bring this topic to everyone who's listening because I remember years ago when I was in full time practice that I would have women come to me and they'd say, Well, I've had I've had a miscarriage, I've had two miscarriages.

And I was just told to wait. We're not going to do anything until you've had one more. And I thought, that's ridiculous. That's heartbreaking, and we're not going to stand for that.

And so when you and I were discussing about topics, it was the immediate first thing you said, this is what we're talking about, because I know you hear it as well with the women that you work with, the moms that you work with. And I really just want to knock this out of the park.

So the listeners have a notebook full of gems, a notebook full of notes that they can help. Hopefully not have to experience this again. Yeah, absolutely.

And I feel like the way that our medical system is set up and just the oh, it's normal, don't worry about it. It's okay. It'll be better next time. Like for someone who I haven't personally been through that.

I have a lot of really close friends, clients that have been through it. And what I remember most about my pregnancy was the first five months I didn't tell a single soul except my husband and like literally every night woke up in Trump like terror that I was going to have a miscarriage.

That's how like innately I had felt it, even though I had never been through it. So that's just to say, I can only imagine what someone is going through when they've had one loss and they've been told to, we do nothing.

We get pregnant again and now they're pregnant again and they're going into that level of fear. If our nervous system isn't ready to handle that level of fear, it's going to be really challenging to sustain that pregnancy.

So regardless of anything else that contributed to that pregnancy loss, just the fear and stress and all of the hormones that are floating through our body.

Testing for Autoimmune, Blood Sugar, and Methylation Issues

When that's happening, I'm I feel lucky because I had a lot of tools to help my nervous system better handle that amount of stress that I was putting on myself.

I don't know why I had this crazy fear. It was I don't know. It just felt like one of the most horrendous things. And

from what women have described, it is a horrendous thing.

So to tell someone like, hey, just go through three of those before we even think about doing any testing is just insane to me. Certainly you haven't been through this before.

If you don't understand. Especially because there's so much you can do. And I have talked about this before. This is a key part of your workup when you're working with women infertility.

And that's you mentioned tools in your toolbox that I really want to examine those today. So women feel heard and can be pretty proactive. So when you are working with somebody maybe for the first time and they tell you that they have a history of recurrent pregnancy loss, what's the first thing you do?

What are you looking at? So much so we have a whole panel of tests that are specific to recurrent pregnancy loss, and I don't want to get into the nitty gritty, but the big categories.

So autoimmune immune markers are really big because if you've had a recurrent loss or if you've had one loss and are like, how do I not ever have that loss again?

Those are good tests to have. Just because the rate of autoimmune and specifically like Hashimoto's is really high in women that have pregnancy loss. So let's just screen you for it and if you have it, let's figure out how to fix it so that you don't end up with another potential loss that I think that's really important.

And then there there are links to blood sugar, blood glucose and insulin and pregnancy loss. So that's something that's already part of our workup, but we want to do it anyway.

And then there are things like epigenetics, snips essentially that correlate to pregnancy loss. So MTHFR is like the most famous one. It's what I say to people because most of them, like most women, come in and they're like, Oh, I've already had a major fire.

Okay, cool. Have we figured out if your methylation cycles are working and that's a different question, then do you have the gene or not? Do you have the snip or not is really a surface level question.

You could have a completely non very gene and still not have great methylation because you don't have enough B vitamins, you don't have the cofactors, all the things, or you have a variant of the gene and it's just not working very well.

Or you don't have MTHFR but you have MTRR, CONT like a whole host of other genes that could be variants that also contribute to methylation so that whole landscape can be complex.

But the starting point for us is a very simple test called homocysteine, and that test is usually homocysteine levels will go up as methylation is not happening very well.

So it's like the byproduct when methylation cycles aren't totally working. So we test that it's like a $15 test versus $500 for genetics. And if that's not working, then let's go back and look at the snips.

But if that's working, then we're good and we don't need to worry about it right now. So those are the mean tests. And then what's really interesting to me is that when I first started this so like 12, 13 years ago and I started seeing a lot of fertility people, I intuitively was just like, the partner is a big component of this.

And these guys would come in and they would be like, No way, sperm are great. My doctor told me my sperm are great. And I'm like, Let me see the results.

And I would look at the results and it'd be like, God, your sperm are actually great. So it didn't make sense to me. And I just started running the same like minus the autoimmune, the same panel on the guys that we were running on the females.

And what I started noticing was almost every single couple that had a pregnancy loss had a guy with awesome sperm that either wasn't methylated well or had blood sugar issues.

And I was like, We got to start, let's just work on this. So then we started working on the guys and all of a sudden the women would have pregnancies that lasted even after three consecutive losses.

They're like, Oh, we had a completely normal, healthy pregnancy. And I was like, Oh, there's something to this. And about three years ago, the research had started coming out about male blood sugar, male insulin and male homocysteine and how it affects pregnancy outcomes in partners.

I just went by the stage like intuition and just being like, Why didn't we address this? You're pre-diabetic. Let's do something about that instead of stopping at your sperm are fine.

Let's move on. It's not you. It's her really looking at it from like, how do we set this couple up for optimal success?

Male Factor and Sperm Quality

And what's interesting, I'm so glad you brought up the male factor part because I have worked with a number of clients over the years, couples, and because the implantation occurred, then even their fertility doctor was saying, well, it's her, not him, because she's able to implant.

And I remember two decades ago, there's a well-known fertility clinic in the city of Portland, Oregon, had a seminar that I went to and the fertility doctor said, the reproductive endocrinologist said, We can't see inside the sperm.

We can count them. Yeah. And we can see if they go forward and we can see if they have a tail or not or they look right, but we can't actually see inside.

So even though implantation is occurring, we don't know the quality of what's inside. Just like we don't we've got to work on a quality for her. And I thought, Wow, you're really ahead of your time.

He didn't understand the blood sugar homicide homocysteine. He was just noting, we can't see inside, so we can't just 100% blame her. So I and of course, I love that you say that.

And I think like now we can see inside, like sperm DNA fragmentation studies are really starting to get more information about the sperm and the DNA of that making up the sperm.

But I was just reading a study yesterday, 50 to 75 mitochondria in one spermatozoa one, and there's millions of that, right. So like the level of mitochondrial function that's necessary to have good, healthy sperm is almost blew my mind to think about like we we really have we're at the tip of the iceberg in terms of being able to fully understand the scope of egg and sperm quality.

And like we have all these models to simplify it. But at the core of it, we have these like the genetic imprint of the next generation that we're creating that is then like magically supposed to merge and like all of the fascinating things of implantation and growth, like all of that is dependent on the DNA that was in the egg and sperm to begin with.

So I think there's a lot for us to still uncover about the vastness of this. The cool thing is you've mentioned very attainable solutions. You mentioned B vitamins, you've mentioned folate, you've mentioned you've mentioned blood sugar, which we can all work.

Right, and we can test pretty inexpensively. You've mentioned the mitochondria and well, somebody listen to this may not fully understand mitochondria, which is fair.

Our mitochondria, where we all learned in school the cellular powerhouses can write us energy or little batteries. And so there there are a lot of nutrients and vitamins and antioxidants and foods eat the rainbow.

And we mentioned stress already. You know, there's a lot of things when listening to this, couples can go, oh, that's that doesn't sound like hardcore medication or big time surgery or very expensive things. It's more attainable then I think medicine lets on.

Absolutely. And like the alternative is, oh, we've had three losses now we're going to go do IVF where they can test the embryos before implantation. And even that doesn't guarantee that you're going to have a healthy pregnancy.

Sure, they can test the embryos, but again, like they're not going into the embryo to look at it. They're looking at it under the microscope and saying, hey, that looks like a healthy, viable embryo and we're going to grade it like a and that's like the best.

So let's implant that one. And then the number of women that do go through that and they're like, it still ended in a loss. So what now? Like, what do I do now?

So I feel like our holistic solutions are just so easy and I'm putting it in quotes a little bit because it is easy.

Inflammation, Gut Health, and Food Sensitivities

It's going to take effort, but it's not challenging like anyone can do it versus is the other option, which is way more expensive and still hasn't stacked the odds fully in your favor because to a certain extent, like, yes, we can test it, but you may need to go through three, four, five retrievals before you get enough embryos that are grade eight quality to actually try implantation.

And still you can have the best embryo and still not have a good outcome. I think definitely like the natural holistic approaches in this way, like it doesn't harm you if you're prediabetic and working on your blood sugar, great.

You're going to have a healthier life with your child. That seems like a big win to me. Absolutely. And we shouldn't even have to call it holistic. We should just call it natural physiology.

The B vitamins are we have them in our body. You need them and our body requires them as an example. It's not even a holistic we were saying not required by the body.

Make the body go round. Yes. Yeah. Now, you mentioned inflammation and I want to I want to touch on the inflammation and I want to touch on actual structural issues.

But I mean, start with inflammation. If you have somebody let's say here's an example I had a patient years ago who had two losses, came to me, turned out she had Hashimoto's didn't know it and she had celiac.

So she was autoimmune allergic to wheat, to gluten and when she gave that up and we worked on our Hashimoto's, all of her GI symptoms that she thought was just irritable bowel syndrome, IBS went away and we we did work on that.

And not only was she able to her next pregnancy very healthy. Carrie, full time term she went on to have more babies and everything was just fine. And it really made me think of when you mentioned inflammation, the intestinal area and the uterine area lay on top of it. Yes.

And if one is mad or inflamed, it may not make a hospitable area in the other. So if you're trying to implant, but yet there is a lot of inflammation swirling about because of the let's say the intestines.

Do you find that to be the case where you go like. Yes, they are. The gut is right on top of the uterus. There isn't really a separation between the two.

And there was only one study that I cannot find. Like I read it years ago, I imprinted on me because it's so freezing and then I never received it and can't find it.

So please don't ask me for the study. But the study basically said that got uterine gut inflammation causes uterine inflammation, which leads to struggled implantation and recurrent pregnancy loss.

And to me, I was like, of course that makes total sense. Like from our brain, yeah, they're right next to each other. They have the uterus has a very similar membrane structure to the stomach, the intestines.

So the things that cause inflammation there are also likely to inflame the uterus. We just don't have a way to measure it. Right. No one's doing studies on like how do we measure uterine inflammation?

But if there was a way to study, if there was a way to test it, then we'd be like, Oh yeah, like the same thing that happened in the gut happened in the uterus.

So absolutely. I think that we too often recurrent pregnancy loss has a degree of inflammation attached to it. And and then the autoimmune connection as as well to food underlying food sensitivities or food allergies.

In the case of celiac, like all of that kind of mixes into whether or not someone is going to have a healthy pregnancy outcome. Absolutely. Like 100, almost hundred percent of the time.

I would say at the very I don't want to make sure everyone gets tested for food sensitivities, but usually we can pick it up on a basal body temperature chart.

We can look at it and say, oh, you might have got inflammation. We need to test your food and make sure that the food that you're putting in, as healthy as it may be, is aligned to your body.

Yeah. So if I tried not to have everyone's been hundreds of thousands of dollars on tests, but like we have tools that are really almost free that we can say, hey, I look at this, I look at this report and I'm like, Oh, I see the pattern that is usually present in inflammation.

Let's test your gut. And almost all of the times it's present, right? Then we can say, Okay, well that's a really easy fix. Let's remove the foods, heal your gut, and simultaneously assume that you have what has been loosely thrown around as a leaky uterus.

It's the same idea like leaky gut, like uterus and address the uterine lining as well to make sure that when you are pregnant again, that implantation is nice and strong and sticks.

Out of curiosity, can you give an example with the basal body temperature, what you might see? Yeah. For example, if somebody is allergic to dairy and they continue to be dairy because they're obsessed with cheese and what would they be looking for?

Yeah. Almost it would we wouldn't be able to differentiate what the food is, but what we'll usually see in basal body temperature charts is in the luteal phase.

There's going to be a high amount of flux in the temperatures and it looks like it's tricky to differentiate from, oh, you don't have enough progesterone, which is what a lot of practitioners decide. Oh, you're not you don't have enough progesterone.

So I'm going to give you progesterone. But the inflammation pattern is like slight dips and spikes in temperature. So it looks like a little wave pattern instead of what low progesterone looks like, which is like a decline and it just doesn't sustain.

Does that make sense? Yes. Yes. Yeah. So it's really fun and I love it like over and over again. All always around between Thanksgiving and the New Year, people fall off their food plans.

They start eating. The stuff that we took them off of that was getting their repeat is amazing. And then we they send in their liberty chart for review and to be like, you fell off of your diet.

What the heck? They're like, Why you're in my house? How did you know that? And I'm like, No, this study, every reteach are there. You really like the reflection of the body is almost instantaneous.

So you pull the foods out, it goes away, you put the foods back in it goes back in. And it's fascinating to me, like the feedback loop that the body has to our cycle and to our charts, our BBC charts is amazing.

So they say, oh, that we call it the fifth vital sign, right, is it's our menstrual cycle. And I will obviously want to touch on progesterone. How often do you see missed low progesterone as a cause for recurrent pregnancy loss?

I, I have a very tricky relationship with progesterone, and that is if we have low progesterone and it happens like there are women who have low progesterone that weren't tested, right?

So they went to their OB. And a lot of times it's you got to test before you're actually having you're in the middle of a loss and then you're like, give me the progesterone now.

And it's like the panic mode isn't helpful, right? It's at that point, it's often too late. So there are going to be the bucket of women that the pregnancy could have potentially been saved had they had progesterone in time.

Then we have the other camp of practitioners that's like, Oh, it's your progesterone. I'm going to just throw progesterone at you. And those women, those couples women are going to unfortunately miss all of the underlying stuff.

Progesterone, Egg Quality, and Early Monitoring

So when you give progesterone, your chart is going to look amazing. So now you think, Oh, we fixed the gut problem because we have enough progesterone, but it's exogenous progesterone.

It's not what your body produced. So even if it's bioidentical, it's still having the cover up effect. So it's going to cover up the gut inflammation.

It's going to cover up. We haven't gotten to it yet. But there the other leading cause of pregnancy losses has to do with the microbiome. So certain type of vaginal and cervical microbiome have been shown, shown to increase the rate of pregnancy loss.

And if you have that but you were given progesterone as the way to fix it thoroughly, fixing the problem. And then the third is just the basic like egg quality issue, right?

So the assumption is, oh, you have low progesterone. The assumption is not that you have low egg quality and giving you progesterone doesn't fix your egg quality to a certain extent.

It'll help a little bit because it's helping to stabilize some hormones, but it's not actually addressing the deeper issue, which is if you have an egg quality issue, if you have a mitochondrial DNA issue, then you really need to address those.

And often what I see is the women that started out with low progesterone, when you fix those underlying things, the progesterone improves. So very rarely do I agree to giving anyone progesterone.

And I will say like the big caveat is most of the women that have had recurrent pregnancy loss, if we've addressed everything, their temperatures look amazing, their hormones look amazing.

Like we've done all the checkpoints and we say, okay, you have the green light, go get pregnant, which often will happen very quickly for them and they get pregnant and then they're monitoring through that entire first trimester.

So there are a couple of things that we're monitoring for. One is the baby tears will start declining about 2 to 3 days before a drop in actual progesterone levels.

So if they continue doing their baby t charts in the first trimester, we're usually catching it before their need gets to that urgency level. So we see that temperature declining.

We're like, Oh crap, we need to happen with the progesterone. And then we'll actually have them do a progesterone test, which we we ideally like to do every 2 to 4 weeks.

So we have a baseline. We do the test when we see that drop before giving them the progesterone so we can say, oh, it went from 50 to 25. Yeah, that's concerning.

Let's make sure you have enough progesterone to sustain. But we have enough time. Like we're not in the urgency of, Oh, my God, it's happening right now.

Can you give me the progress from that? Would it's just way too stressful. And most of the time, by the time they have symptoms of a loss happening, it's too late.

So we really have these like early indicators in place. BBT As the first line and then actual lab testing as the second line therapy to put in place so that any decline or shift in progesterone is addressed.

And then also realizing that there are these like optimal your progesterone, if you're pregnant, should be right. And I'm like, I've seen healthy pregnancies in women with a progesterone of 20 and they sustain that pregnancy all the way to term without any complications, any issues.

So it to me like the question is how much progesterone is optimal for you? And what I've seen is even in those pregnancies, because early on I used to be like, oh crap, that's really low.

And then what I started seeing was it's not really what your level is, it's that it's starting to suddenly drop. That is the problem. So if you got pregnant at a progesterone of 20 and your body sustained that through the whole first trimester until baby took over, then you're good.

Like we don't have anything to worry about. You're that is normal for your body and you're good and you're good for this pregnancy. So it may not even determine, like, what you need in the next pregnancy, but for now you're okay.

Versus so many practitioners that I see, especially in the natural space that are like give you the progesterone you need to be on 200 milligrams, 400 milligrams suppositories, whatever.

And I'm like, okay, that's fine. You're not doing them harm necessarily. But it's always it's like the difference of, do we need this? Is this a value add or is this just something that we're doing to cover our butts.

And then missing the other things you mentioned? Potentially. Yeah, potentially. Yeah. And so many women just used to come, oh, I'm pregnant. I just need the progesterone.

Just write me a script. And I'm like, Yeah, you're at the wrong place. I I'm not going to write you scripts as to write the script, but I've had pregnancy losses before and I'm like, okay.

And, and if they didn't work with us, then yeah. Like sometimes it's just easier to give them the progesterone because at least they're protected. But the ideal is you've had a pregnancy loss, you don't want to have another one, do something, do all the things before you get pregnant again so that those odds are stacked in your favor.

And also your babies favor. Right. We want to optimize the health of that future baby and that's happening through the impact on the DNA. So if we're not able to address those things before conception, then we do what we can do with the progesterone.

But it's like such a Band-Aid. Yeah, that's that's that's a good way to put it. And I love that, you know, obviously, you and I are big sticklers for really trying to get to that that why that root cause like what's really going on, let's have the healthiest DNA possible, ergo the healthiest pregnancy, the baby possible.

And and so I love how you explain that. And I want to round this out with the third thing, which I was mentioning inside the uterus. So let's talk about the things on the inside that can potentially cause issue with her.

Yeah. So inside the uterus, we're really thinking about the lining and the environment. So the lining is relatively easy. There's two or three major things that help with the lining Vitamin E, arginine, CoQ10 circulation.

That's a really relatively easy, relatively simple. What I've seen in that space is people that will take the supplements without really knowing whether or not they have a lining issue and a lot of people that don't have a lining issue and take those a arginine in high doses is not great for fertility.

So if you're taking arginine, you're really taking it as a specific like we need to address this lightning issue and it's temporary. You're not taking this for a long time.

It needs to come with the caveats. But also, if you don't have a lining issue and or you don't have a deficiency of these nutrients, you're not doing anything.

You take all the supplements you want, it's not really helping anything. And then the other piece, which I love, is the microbiome, and that's the environment inside.

Is this really like the microbiome is interfacing with our immune system? And the question that the body is asking is it's safe for this embryo to be here or do we need to rally the troops and attack?

So we want to create an environment that's going to be seeing this embryo as a friendly thing rather than an unfriendly thing. And unfortunately, there are microbes that don't like this embryo.

So the microbes are then like, let's rally the troops and unfortunately leads to it of like a hostile environment in the uterus, which contributes to pregnancy loss. So the big ones are.

Gardner Ella and urea plasma from what I've seen. But like really all we should have in our uterus, cervix, vagina is lactobacillus.

Uterine Lining and Microbiome Health

CHRIS But this specifically. Chris Bodies, there are other types of lactobacillus. I researched them and then I just went to a microbiologist and was like, What's up?

Break this down. What's happening in here? His thought was like, We should only have Chris bodies, we shouldn't have anything else. And I was like, Huh, that's really radical from what I've read.

Like Eyeliners could be common and normal and he's know those studies are done on a lot. Like they'll say I is normal, male and healthy in women of color, specifically black and Hispanic women.

And if you trace those studies, they're done in the environment where women are already predisposed to vaginal dysbiosis. So that answers is not really normal.

It's just common in those populations and it's not a good thing. Oh, my goodness. Like, oh, shit. And the way that I explain it to clients is like eyeliner is, is like the heavies of the microbiome.

I is a transitional microbe, which essentially means they're like, Oh, you come on in. Oh, yeah, you can come in too, and we'll just all be friends, right?

Good, bad, ugly, whatever. We're all friends. So it will welcome all of it versus the correspondence is like the warrior that I have strong boundaries.

You're not allowed in here. Knock on the door. Come in. Visiting hours like we're restricting access. And we want

the warriors at the front line to be that like protective layer.

We don't want the hippie deputies that are like, Yeah, come on in. Everyone's welcome. Let's have a party. And then you have a party in your vagina. But usually not a good thing.

Usually. And this is something somebody could find out, like a vaginal swab, correct? Yeah, exactly. And I generalize. We only do vaginal testing. There are reproductive endocrinologist that are starting to do cervical and uterine testing through biopsy.

There is little data on the the need for all of it. So I think a vaginal swab is really accessible. It's easy. You can do it at home. It's not invasive.

You're not doing a biopsy. Right. There's a lot of advantages. And does that transfer to what's happening in there in the cervix and the uterus is vastly if you have an imbalance in one place, you probably have an imbalance in another place.

How much do we need to like get micro specific on? It is still up for debate because of it. As far as like. Well, what I've seen is a lot of the women that we see that that we've seen in the last like year or two since the microbiome testing became more available, is that we would know that we just started testing everyone because we're like it's do we need to figure out what's normal, what's optimal like we're doing?

So we were paying for everyone's tests and what we found was the recurrent pregnancy loss. Women almost always had some variant of Gardner ELA or urea plasma in their vaginal oh, so and that's not to say they didn't have any of the other factors, it's just that's also present.

So it to me it's like, okay, we, we didn't not do any of the other things, but we also added in this piece of addressing the microbiome and sometimes using antibiotics because is easier, faster than some of the natural alternatives to just address the microbes.

Yeah I was going to say garden rella and your applause and for those listening they're not a forever they are treatable which is. Yeah. Which is nice but you have to test vaginal microbiome test first if you have a. Yes.

And then address it. Yeah. Okay. And then one last question before we wrap this up. This has just been like full of gems. I want to go back to how do you evaluate the lining when you were talking about the vitamin need, the CoQ10 arginine, what is your preferred way to evaluate?

That's usually going to be an Ari thing. Either they're going to are these, I think sometimes an OB-GYN, but it's an ultrasound. So they need to have a specific assessment of how thick is the uterine lining and their I want to say it's tested like in the luteal phase to figure out if it's getting thick enough.

Usually if we're working with someone on the lining, it's because they've already been tested and they come back with, hey, we have this issue. The only other reason that we would supplement those nutrients that I mentioned is because it showed deficient.

So if we tested for nutrients and they were deficient, then giving them those nutrients for a period of time is beneficial in just like making sure that they can have the nutrients that are needed to make good, healthy uterine lining, even if they don't know.

But otherwise we don't usually supplement those. And Arginine specifically has has some negative studies on egg quality. So it's like when you're supplementing you have to be careful about we don't want to go too high, we don't want to do for too long because we don't want to shoot at quality.

In the while, we're trying to support a nutrient. That makes sense. All right, Dr. Aumatma this has been wonderful. I so appreciate it. And this is a really it's a hard topic.

It is a common experience that a lot of women have. And to now be armed with different types of testing, different types of nutrient understanding, things to at least they've written down.

They can look up, they can talk to their doctor about or even there are about evaluate for themselves. I think just having that knowledge puts a lot of that fear at ease.

And so where can people find you? Where can people learn more? Even though you are the co-host of this Summit, I do want to make sure people really understand how they can learn from you.

Yeah, I think the Summit is a great starting point. I feel like it's going to have we're going to have so much content for people to go through and get educated on.

But if you want to specifically connect with me, I'm on Instagram a lot @holisticfertilitydoctor. You're welcome to message us any time.

Where to Find Dr. Aumatma and Closing Remarks

I do check those messages. I also have a person dedicated to answering or in responding in the chat, so she'll usually tell you when it's her and not me.

So yeah, like we're that's the really great place and then holisticfertilityinstitute.com. and very soon MadreFertility.com and we'll I'll keep you guys posted on the Madre thing it is planned to launch in about a month and we are it's going to be really awesome to be able to go through like an algorithm that is like an assessment.

If you are doing it with me, but it's free. Right? I love it. Access Yeah, it's like library. You can have access to it without pulling out all of my energy.

It is. Amazing. And just another amazing free resource for people who, you know, maybe don't location or budget or just for that free starting point. Maybe they're new, they're frustrated.

They're not getting a lot of answers. So what a great area to start here. Yeah. And then can move up to the Holistic Fertility Institute. if they want.

Well, this has been fantastic. I just want to say thank you so much again for talking about our really sensitive topic and giving everybody incredible gems.

So thank you. Thank you for being an awesome interviewer.