



Could you kiss

By Alexis Jetter

PHOTOGRAPHS BY Jennifer Bishop

O

N THE BULLETIN BOARD of the Surrogates' Corner on the Internet, where surrogate mothers swap tips, anecdotes, and medical advice, the recent warning caused quite a stir.

BEWARE OF TOO-GOOD-TO-BE-TRUE

I want to take a moment to warn any women out there who are contacted to be a surrogate by a single male on the East Coast. He seems like the greatest guy. He is not what he seems. . . .

Welcome to the future, where one rather ordinary family finds itself in extraordinary circumstances and the only sure thing is a mother's love. The saga of Baby Ariel* is, depending on your point of view, a love story or a cautionary tale. Either way, it provides a rare window into the world where women carry babies for couples who aren't able to have children themselves.

"Watch out," the Internet message warned in essence: "Do not bear this man's child." But Andy hardly seemed predatory when Rachel Levinson met him a few years ago at an adoption and surrogacy agency. Andy, in fact, looked like he'd make an ideal dad. He was an engaging man, successful in business but, he told Rachel, unlucky in love. At 37, he was anxious to begin parenting on his own, and so he arranged to adopt a little boy.

Rachel, who enjoyed almost all of the agency's clients, particularly liked Andy. Then 32, she had just landed a job as an

*All of the names in this story and the individuals' identifying details have been changed.

When Rachel Levinson decided to have a baby for someone else, she steeled herself for the moment she'd have to give her newborn away. She wasn't prepared for what happened next.

this baby
good-bye?



Rachel thought about her surrogate daughters every day, kept a photo album of each in her family room, and worried about how they'd feel when they grew up. "Maybe these girls will come back and ask me, 'How could you give me up? How could you walk away?'" Rachel says. "I'll be honest: It isn't easy. But I got to know their parents. I listened to their story. And these children will probably be more loved, if that is possible, because their parents went through so much to get them. Besides having my own children, being a surrogate is the best thing I've ever done."

Thirteen years after the famous case of Baby M., in which Mary Beth Whitehead fought to keep the baby she had borne, Americans still know little about the women who bear children for infertile couples. Yet they are all around us, and their numbers are increasing. Since 1979 an estimated 12,000 children have been born to surrogate mothers in the United States, most in the last five or so years.

The prevailing images of surrogates are the financially strapped, remorseful women who are a staple of daytime talk shows. But the few studies of surrogate mothers indicate that the majority are married, moderate-income women with

administrator at the agency after years of staying home with her children and attending night school. Suddenly she was conversing with prospective parents around the globe, and their vulnerability moved her. Andy, even more than most, eagerly shared with Rachel his excitement at the prospect of raising a child.

Andy proved to be an excellent father. After three-year-old Lucas arrived by plane from a South American orphanage, Andy never left his side. He arranged to take his son to work every day and fed the half-starved boy by hand; Lucas grew two inches in a month.

But Andy's experience with the agency had opened his eyes to the possibility of surrogacy, and he longed for a child who shared his genes. Rachel knew that finding a surrogate for a single man would be a problem. "Honestly, surrogate moms want to do it for a more stable family," she says.

The more difficulty Andy encountered, though, the more certain he be-

"I'LL BE HONEST: THIS ISN'T EASY. BUT BESIDES HAVING MY OWN CHILDREN, BEING A SURROGATE MOTHER IS THE BEST THING I'VE EVER DONE."

came that he wanted a child with his bloodline. And what began as a little joke gradually grew serious, until one day Andy asked Rachel in earnest: Would she have a baby for him?

RACHEL HAD TO THINK hard. She knew the emotional costs of surrogacy—of conceiving and carrying a child, laboring through the delivery, then kissing her baby goodbye. For she'd done it twice before, in 1993 and again in 1995.

children at home. More than a third of them choose, after their first contract pregnancy, to bear children for others again. Some use their own eggs; others are "gestational carriers" with no genetic link to the child they carry. But they all share the ability to conceive and bear children, a need for extra income, and compassion for couples who want but cannot have children on their own.

From the outside, Rachel and her family couldn't look more conventional. She and her husband, Brad, live in a new subdivision, drive a minivan, and argue over

ZOMIG™ (zolmitriptan) Tablets

Patient Information about ZOMIG Tablets for migraine headaches

Generic name: zolmitriptan

Please read this summary of information about ZOMIG before you talk to your doctor or start using ZOMIG. No summary can take the place of a careful discussion between you and your doctor. Only your doctor has the medical training and the complete prescribing information necessary to determine if this medicine is right for you. Once you read this summary, you should discuss with your doctor whether ZOMIG is appropriate treatment for you and ask any questions you may have.

WHAT IS ZOMIG?

ZOMIG is the brand name of zolmitriptan, a drug intended to relieve your migraine headaches but not to prevent or reduce the number of migraine headaches you experience. ZOMIG should be used only to treat an actual migraine attack. ZOMIG can be obtained only with a doctor's prescription and should be used by adults only after discussing the choice with your doctor, taking into account your individual preferences and medical circumstances.

HOW DOES ZOMIG WORK?

How ZOMIG works is not completely understood. ZOMIG is a 5-HT₁ agonist that seems to relieve migraine headaches by acting like a brain chemical, called 5-hydroxytryptamine, causing some blood vessels in the head that are swollen during a migraine to constrict (that is, to become smaller), which helps relieve migraine headache.

IMPORTANT SAFETY CONSIDERATIONS

The vast majority of patients who have taken ZOMIG have not experienced any significant side effects. Serious heart problems have been reported in association with the use of ZOMIG Tablets. Some of these heart problems occurred in patients with no known heart disease. However, almost all had risk factors predictive of heart disease and the presence of significant underlying heart disease was established in most cases.

You should not take ZOMIG if the headache you are experiencing is different from your usual migraine attacks. People who suffer from migraines may be at increased risk of certain blood vessel events in the brain (e.g., hemorrhage, stroke, or transient ischemic attack).

Ask your doctor about these and additional safety considerations.

WHO SHOULD NOT TAKE ZOMIG?

Some types of migraine headaches should not be treated with ZOMIG, and some patients should not take ZOMIG because of an increased risk of serious side effects.

- If you have had a heart attack, stroke, transient ischemic attacks, peripheral vascular disease (including ischemic bowel disease or Raynaud's syndrome), or any sort of heart disease or symptoms that are associated with constriction of blood vessels, such as ischemic heart disease, angina, or coronary artery vasospasm, you should not use ZOMIG.
- If you have uncontrolled high blood pressure, you should not use ZOMIG.
- If you are taking certain drugs for depression, talk with your doctor. ZOMIG should not be used if you take or have taken monoamine oxidase inhibitors-A (MAOIs-A) within the last 2 weeks.
- Your doctor will discuss with you the type of migraine headaches you have. If you suffer from cluster headaches, hemiplegic or basilar migraine, you should not take ZOMIG. ZOMIG should be used only in adult patients who have been diagnosed by a physician as having migraine with or without aura.
- Tell your doctor about any other medications you are taking. If you are currently taking any migraine medications that include ergot alkaloids, such as methysergide or dihydroergotamine, or other 5-HT₁ agonists, do not take ZOMIG Tablets within 24 hours of taking these medications.
- Do not take ZOMIG Tablets if you are allergic to zolmitriptan or any of the ingredients in ZOMIG.

WHAT MEDICAL PROBLEMS OR CONDITIONS SHOULD I DISCUSS WITH MY DOCTOR?

- If you have risk factors for heart problems, you should tell your doctor. Your doctor should examine you for heart disease to see whether ZOMIG is appropriate for you. Risk factors include high blood pressure, high cholesterol, obesity, diabetes, and smoking. Other patients with risk factors for heart disease are women who are past menopause (whether natural menopause or menopause resulting from surgery), men over 40 years old, or patients with a family history of heart disease. If you have risk factors and your evaluation for heart disease is satisfactory, your doctor may ask you to take the first dose of ZOMIG in the doctor's office.
- Tell your doctor if you have chest pains, shortness of breath, or irregular heartbeats.
- Tell your doctor if you are taking selective serotonin reuptake inhibitors (SSRIs).
- Tell your doctor if you have a history of epilepsy or seizures.
- Tell your doctor if you have liver or kidney problems.
- Tell your doctor if you have ever had to stop taking any medication because of an allergic reaction or other problems.

USE OF ZOMIG DURING PREGNANCY AND BREAST-FEEDING

Do not take ZOMIG if you are pregnant, think you may be pregnant, are trying to become pregnant, are not using adequate birth control methods, or are breast-feeding, unless you have discussed this with your doctor.

HOW TO USE ZOMIG TABLETS

Tablets: For adults, the usual dose is a 2.5 mg dose or lower with fluids. A second dose may be taken if your symptoms of migraine come back or if you have a partial response to the first dose, but no sooner than 2 hours after taking the first dose. For a given attack, if you have no response to the first dose, do not take a second dose without first consulting with your doctor. Do not take more than a total of 10 mg of ZOMIG Tablets in any 24-hour period.

The safety of treating an average of more than three headaches in a 30-day period has not been established.

WHAT ARE THE POSSIBLE SIDE EFFECTS OF USING ZOMIG?

Do not rely on this summary alone for information about side effects. Your doctor can discuss with you a more complete list of side effects that may be relevant to you.

The most frequently seen side effects with ZOMIG Tablets are tingling, nausea, weakness, pressure, and dizziness.

- Some patients feel pain or tightness in the chest or throat when using ZOMIG. If this happens to you, discuss it with your doctor before using any more ZOMIG Tablets. If the pain is severe or does not go away, call your doctor immediately.
- Shortness of breath; wheeziness; heart throbbing; swelling of the eyelids, face, or lips; or a skin rash, skin hives, or hives happen rarely, but if they happen to you, tell your doctor immediately. Do not take any more ZOMIG Tablets unless your doctor tells you to do so.
- Some patients may have feelings of tingling, heat, flushing, redness of the face lasting a short time; heaviness, or a feeling of pressure after taking ZOMIG Tablets. A few patients may feel drowsy, dizzy, tired, or sick. Tell your doctor immediately if you have symptoms you do not understand.
- If you feel unwell in any other way or have any problem that you do not understand after taking ZOMIG, tell your doctor immediately.

WHAT SHOULD I DO IF I TAKE AN OVERDOSE?

If you have taken more medication than you have been told to take, contact your doctor, a hospital emergency department, or the nearest poison control center immediately. This medicine was prescribed for your particular condition and should not be used by others or for any other condition.

HOW SHOULD I STORE ZOMIG?

Be sure to keep your medicine in a safe place that cannot be reached by children. It may be harmful to children.

ZOMIG Tablets should be stored at room temperature and do not require refrigeration. Store at 20-25°C (68-77°F). Store away from light and moisture. If your medicine has expired (the expiration date is printed on the label), throw it away as instructed. If your doctor decides to stop your treatment with ZOMIG, do not save any leftover medicine unless your doctor tells you to do so. Throw away your medicine as instructed. Be sure that discarded tablets are out of the reach of children.

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SURROGATE MOTHER

who's doing more of the housework.

But while Brad, a shy man with a dry sense of humor, might jokingly pose as Ozzie, Rachel is no Harriet. She's an outgoing, funny woman who doesn't worry about what people think but cares deeply about how they feel. Aside from her family, life has been a series of compromises for Rachel. She would like to have been a doctor but is instead a part-time nursing student and a full-time mother. But nearly ten years ago she made a firm decision: Someday, she would be a surrogate mother. And it wasn't, she says, about the money. "Surrogates do it first from the heart."

In 1990 Rachel was 26 and six months pregnant with her second son. She was working in an OB-GYN clinic when a patient she knew walked in the door sobbing. The woman had just suffered her fifth miscarriage, and though there was no fetus left, the doctor wanted to scrape her uterus to remove the remaining tissue.

Rachel held the woman's hand during the procedure. It was the second time she'd

tried to soothe her after a miscarriage. And this time Rachel found it nearly impossible. For she had undergone an abortion a year earlier, when she and Brad were unemployed, uninsured, and in debt. Rachel still feels the abortion was the right decision at the time. But it left her with great sadness and a sense of being trapped by her fertility. The contrast with the grieving woman on the table proved too much. "I went out in the hallway and sat down on the floor and cried," she says. "I felt that I needed to give something back that I had taken for granted."

A few months later she spotted an ad in the local paper seeking surrogate mothers. It had been placed by an infertility center in New York. Manhattan seemed a million miles away, but Rachel cut out the ad and tucked it in her wallet.

Two years later she pulled it out and showed it to her husband. Rachel wanted to go to nursing school, but with Brad in technical school, they couldn't afford it. As he read the clipping, Brad remembers thinking, If this is legitimate, would it really be an ad in a newspaper?

It was sandwiched between get-rich-quick schemes.

But he agreed to consider the idea. Surrogates see only a fraction of the \$50,000 that parents usually pay, but the \$10,000 to \$13,000 fee would go a long way toward her nursing degree.

Rachel initially told the agency that she didn't want to use one of her own eggs. She wasn't sure she could give away a biological child. But to synchronize her ovulation cycle with that of the egg donor, she would have to take a megadose of hormones. And Rachel couldn't

"ARE YOU SURE?" THE PARENTS-TO-BE ASKED RACHEL WHEN THEY SAW HER IN TEARS. WERE THEY WRONG TO TAKE THE BABY?

even tolerate birth control pills, which gave her dizzy spells and migraines.

So she agreed to use her own egg, but she waited for the right match. One woman asked her to bear a child for her brother in Korea, whose young son had died in a car crash. The mother was too old to bear another child. But the plan struck Rachel as cold: The baby had to be male, would be raised by relatives in the United States, and would not be sent to his parents in Korea until he was fully grown. Another couple asked her to join a roster of surrogates, any of whom might be asked to be inseminated at any time. That didn't feel right either.

Finally she was asked to fly to New York to meet a couple from Germany. Despite a language barrier, they were all soon laughing and talking easily. In Gerda and Wolfe, Rachel felt she'd found the right parents.

But she wanted Brad's support, and he was resistant until the couple flew in to meet him and Rachel. At a local restaurant Brad gathered the courage to ask Gerda why she wanted to use a

(continued on page 136)

Dr. Art Ulene on Joint Health.



Every year, Americans consume billions of pills to treat pain and inflammation from damaged cartilage in their joints.

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Art Ulene, M.D.

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Surrogate Mother (continued from page 124)

surrogate. She gazed at him for a moment, then pointed silently to her plate, glass, and silverware. "Imagine for a moment," she said. "I have all these things: a house, an orchard, farmland, money in the bank, and I've traveled all over the world." With dignity but profound sadness she pushed her place setting over to Brad. "I would gladly give them all to you, for a child."

Gerda and her husband had tried for years to conceive. Eight years earlier she had become pregnant, but the umbilical cord had collapsed in the fourth month. The uterine scraping after the miscarriage caused enough scarring to make her sterile. But Gerda didn't learn that until a few years later, when she came to the United States for an examination. By then she was too old to adopt in Germany, where adoption is severely restricted.

Their story won Brad's sympathy and convinced him that Rachel was right in what she wanted to do. Explaining the decision to their parents would take some time; they groaned when they thought of telling their neighbors, the grocery clerk, Brad's coworkers. But Rachel and Brad wanted to talk to their two young sons right away. (Surrogates almost always have to figure out a way to "tell the kids," since a proven ability to bear children is usually a job requirement.)

Rachel told her sons that the "other mommy has a broken stomach" and couldn't have a baby without her help. Although there would always be a special bond with this child, Rachel added, she wouldn't be bringing the baby home from the hospital. That explanation sat fine with her boys.

But initially, at least, her first surrogacy seemed like a comedy of errors. The agency's New York lab repeatedly missed her ovulation date. Rachel persuaded Gerda and Wolfe to switch to the clinic where she worked. But when she marched into the office to be inseminated with Wolfe's sperm, Rachel found that the doctor had been called away on an emergency. And so Rachel's moth-

er, Sylvia, a medical assistant, grabbed a plastic inseminator and performed the task instead. It worked.

If the conception took place in comforting familiarity, the birth was a different matter. Several weeks before her due date, Rachel and the German couple flew to Arkansas, where the agency rented condominiums to its clients. Arkansas has no specific surrogacy laws, but it allows couples, even foreigners, to adopt children after residing in the state for only 30 days. Brad wasn't able to get time off from his job to attend the birth, but Rachel's mother and younger son came for the delivery.

And so, with Sylvia on one side and Gerda on the other, Rachel gave birth to her first daughter, Gretel, at an Arkansas

"ARE YOU TELLING ME YOU DON'T WANT HER?" RACHEL ASKED, PANIC IN HER VOICE. "I DON'T KNOW," ANDY ANSWERED.

hospital in December 1993. She was a lovely child, round and pink, with Rachel's dark shining eyes. The nurses immediately placed her on Rachel's belly. "I held her for a few minutes, and then I handed her to her mother," Rachel recalls. "I could see in Gerda's face that she was afraid she was hurting me. But I kept saying, 'It's okay. It's okay. Go.'"

The next day, before being discharged, Rachel asked for the baby to be brought to her room. She held Gretel close. She and Brad had always wanted a daughter. They'd even talked about adopting a little girl someday, since it seemed that together they would always have boys. But that was a far-off dream, and here was her daughter in the flesh—so tiny and alive.

"She responded so much to the sound of my voice," Rachel whispers, her voice quivering. "But I gave her a little kiss on the nose and told her she was going to

be fine. And then I put her back in the bassinet."

Gerda and Wolfe came in at that moment. Seeing Rachel's tears was a body blow. Were they wrong to take the baby away? "Are you sure? Are you sure?" they asked her in heavily accented English. Rachel smiled, wiped away her tears, and said, "Of course I am."

Rachel knew she needed to get away from Gretel immediately—no breastfeeding, no toe counting. When she got on the airplane, Rachel's milk-engorged breasts were sore, and her heart ached. But by the time she arrived home, all she wanted was sleep. And when she awoke two days later, she felt at peace.

With that surrogacy and the next one, Rachel learned to buffer her heart against the impending separations. She forced herself not to anticipate watching the babies grow up and focused instead on her affection for the prospective parents.

Karen and James, university professors in Australia, were just as concerned about Rachel's well-being. Years of fertility treatments hadn't helped Karen conceive, but they had rendered her a less desirable adoptive parent in the eyes of Australian social workers; her attempts at pregnancy meant she hadn't "adapted" to infertility. In a final try for parenthood, Karen and James decided to look for a surrogate in the United States. But Karen, a reformer of women's health care, worried about surrogacy's potential to exploit women.

"It would not be fair for me to grab my own happiness at Rachel's expense," she says. "We lived with the ambiguity that we might be honor-bound to let her keep this baby."

"I found myself holding back a bit," Karen continues. "But Rachel wanted to give us that feeling of excitement."

So when Karen arrived shortly before the birth, Rachel dragged her off to the mall. "You'll need a heavier blanket than that. You want this kind of car seat," the expectant mother told the mother-to-be.

"Rachel got me shaped up and organized and right into this baby thing," Karen says gratefully. "That was a turning point for me. And when Hannah popped out, I volunteered to cut the cord. She passed from being Rachel's baby to my baby as I cut the cord. She

was crying in that jaggedy newborn way, then grabbed my finger and quieted."

That moment was harder for Brad. He was able to be at this birth, but he didn't know what role to play. He held Rachel's hand and then her legs during the final moments of labor, and Rachel watched his face as the baby emerged. "I saw that look on his face for an instant: He forgot that this wasn't our child. Then the smile just went, that quickly."

Hannah was handed first to Rachel, then to Karen and her husband, who was sobbing so hard that he videotaped the floor instead of the birth. "I was basically not involved at all," Brad says. "I didn't touch the child. I didn't hold her. That's when it hit me: This really isn't my child, even though Rachel's giving birth. And I remember walking out of the room with tears in my eyes."

AFTER THEIR THIRD SON, Jason, arrived in 1996, Rachel decided she would not be a surrogate again. It was too hard on her marriage. Even though Brad outwardly supported Rachel's commitment to surrogacy, a feeling of distance had gradually grown between them.

Besides, Rachel's five pregnancies had been hard on her body. And she wanted time to care for her newest son. So she took a part-time job with the agency that had arranged her second surrogacy.

That's when Rachel met Andy. She'd had few friends during her years as mother and night student, and she found Andy's banter invigorating. During the long months of waiting for his adoption of Lucas to be finalized, Andy would call Rachel with questions, then stay on the line to talk and laugh about music, politics, their quirky family backgrounds.

Soon she, Brad, and the boys were visiting Andy and Lucas at their vacation home. But Brad had begun to feel uncomfortable about his wife's charming new friend. And he definitely didn't like it when Andy asked her to bear his child.

"She was having a child for another man," he says. "And even though I know she didn't sleep with him, that was tough on me."

Rachel, however, had made up her mind. Andy was a fine man, a devoted

CONTAINS NATURAL FLAXSEED

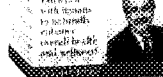
Dr. Art Ulene on the Benefits of Soy.



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father, a dear friend. And she'd realized, to her surprise, that she wanted to experience another birth. Eventually Brad agreed: She would have one last baby.

Andy and Rachel quickly settled all the particulars. Since she lived close by, she would stay in the baby's life, perhaps as "Aunt Rachel," until and unless the child wanted to know more about his or her origins. Rachel would be there to help Andy too, should a single-parenting crisis arise. As an added act of generosity, Rachel didn't charge Andy what she could have earned as someone with a proven ability to conceive, bear, and part with a healthy child. After all, this surrogacy was even less of a business proposition than her previous ones.

But on the advice of Rachel's boss, who doubled as Andy's lawyer, they signed a detailed contract, including a standard clause enabling Andy to get out of the deal for a set fee. The "breach of agreement" clause had always struck Rachel as a formality. "No one," she says, "ever backs out." In fact, of the estimated 12,000 surrogacies in the United States, fewer than 20 have gone to court.

Andy seemed likely to cherish the child Rachel would conceive. He had happy memories of helping to raise his younger sister, and he adored Lucas. There was, however, one complication. He wasn't sure he was up to the challenge of raising a girl, who might, even more than a boy, long for a mother. "How am I going to french-braid her hair?" he joked. The thought of dealing with female puberty fazed him completely. And so he asked if Rachel would consider using a sperm-washing technique to increase the likelihood of having a son.

Rachel wasn't offended. She and Brad had once discussed trying to raise the odds of having a girl, but they'd dropped the idea after Jason was conceived because they couldn't afford any more children. And Andy seemed satisfied with the knowledge that the procedure could increase his chance of having a boy, not ensure it.

A month after the insemination, a pregnancy test confirmed that Rachel had conceived. When she faxed Andy the results, "I got this happy, hysterically

crying man on the phone," she recalls. "He sent me flowers."

It wasn't until the sonogram, five months later, that Rachel learned how adamant Andy was about the gender of his planned namesake. Squinting at the monitor, he seemed concerned when he didn't see a penis. Rachel offered to have amniocentesis. And when that test conclusively showed Rachel was carrying a girl, Andy turned icy. "What happened?" he demanded in a phone conversation.

"She's all there, all ten fingers, all ten toes," Rachel told him, heart beating against her chest. Andy was silent. "Are you telling me you don't want her?" Rachel asked, panic setting in. "I don't know," Andy responded, and hung up.

He called once or twice after that, but only to talk about Lucas. He never asked about the girl growing in Rachel's womb, never talked about a name for her or his preparations for bringing her home. "I felt it falling apart," says Rachel.

The bottom fell out soon afterward. Andy accused Rachel of moneygrubbing, then of having sex with Brad near the time of insemination. Maybe the child wasn't even his. Then he came up with a plan: Rachel should keep the baby, then try again to have a boy. If this child, too, was female, she could have an abortion.

"You can't play God this way," Rachel told him angrily. "You don't pick and choose. That's not moral."

Finally Rachel's boss asked her and Brad to dinner. Halfway through, he told them that Andy had decided he didn't want the baby. Rachel hadn't prepared Brad for that possibility. His pale face turned blood red. "I thought his head would explode," recalls Rachel. Her boss added that she would still collect her fee, plus an additional sum to help with the expense of raising the child. "You think this is about money?" she screamed at him through tears. "This is about a life."

There they were: six weeks from delivery and nearly out of their minds with anger, confusion, and a sense of betrayal. Brad wanted to put the baby up for adoption. Rachel, who felt fine about giving her daughter to a biological parent, did not feel the same way about handing her over to a stranger. "If I put her up for adoption, she would have been rejected

NATURAL ANTIOXIDANT PROTECTION

Dr. Art Ulene on the Benefits of a Mediterranean Diet.



While we Americans struggle to cut fat out of our diet, the people of Spain, Italy and

Greece are eating what they want.

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by both biological parents," she says. "I didn't feel I could do that." But she knew the decision had to be Brad's as well. "It was almost like I had cheated on him to have this child."

So Rachel sat down and wrote her husband a five-page letter. "I will never hold this against you," she wrote. But they had wanted a daughter. Furthermore, they were in a better position to have another baby than they'd been in for years. If her daughter were to return in 20 years and ask why they hadn't kept her, Rachel wrote, "I would not have an answer." But she assured Brad that she would work to get over the loss.

She placed the letter on their bed and left the house. After Brad read it, he paced angrily for hours, made himself sick with worry, and eventually called his mother-in-law. "She's not even throwing a fit," he said. "It's as if she doesn't care." Sylvia talked to him for an hour. "You were talking about adopting a daughter," she pointed out as gently as she could. "If you could love a stranger's child, what makes you think you couldn't love

Rachel's?" He ranted and cried and agonized some more. But he confessed that he'd picked out a name.

"If you're already thinking about names," Sylvia said with amazement, "then you've made a decision." And so when Rachel came home that night, he met her with the news that baby Ariel could stay.

They added a bedroom they couldn't afford to the house that was already under construction. Bought a minivan to have room for an extra car seat. Told everyone, from the cashier at the grocery store to their real estate broker, that the unborn child intended for someone else was coming home with them. And they tried, slowly and painfully, to rebuild the trust between them.

Rachel got a tubal ligation, a double stroller, and the daughter she'd longed for, a raven-haired beauty with dazzling eyes and a winning smile. Rachel's three boys are delighted that, after their two other half-sisters were adopted overseas, they get to "keep" this one. And Brad—well, he looks like a man who's woken

from a bad dream, only to find that it wasn't such a nightmare after all.

"The feeling that she's not mine, I don't think that will ever go away," he says softly, looking down at the sleeping infant in his lap. "But there's no better feeling than picking her up when she's just woken up, when she's really warm, and putting her head on my shoulder. I love her tremendously. When I look into her eyes, I see Rachel."

Rachel's surrogacy days are over. But half a world away another little girl with dark brown eyes and a generous heart is making plans for the future. Recently, on the flight home from meeting Rachel, Hannah, who's three, announced that she's decided what she wants to be when she grows up. "What's that, Hannah?" her mother, Karen, asked.

"I'm going to be a birth mother," Hannah replied firmly. "Like Rachel?" Karen asked, startled. Hannah nodded.

Karen laughed and gave her daughter a squeeze. "I hope so," she said.

Alexis Jetter is a contributing editor.

Prescription Denavir—the antiviral medicine that heals cold sores. For more information, call 1-888-DENAVIR or visit our website at www.denavir.com

Brief summary. See complete prescribing information in SmithKline Beecham Consumer Healthcare literature.

DENAVIR™
penciclovir cream, 1%
For Dermatologic Use Only

INDICATIONS AND USAGE

Denavir is indicated for the treatment of recurrent herpes labialis (cold sores) in adults.

CONTRAINDICATIONS

Patients with known hypersensitivity to the product or any of its components.

PRECAUTIONS

Use Denavir only on herpes labialis on the lips and face. Because no data are available, application to human mucous membranes is not recommended. Avoid application in or near the eyes since Denavir may cause irritation. The effect of Denavir has not been established in immunocompromised patients.

Carcinogenesis, Mutagenesis, Impairment of Fertility

In clinical trials, systemic drug exposure following topical administration of penciclovir cream was negligible, as penciclovir content of all plasma and urine samples was below the limit of assay detection (0.1 mcg/mL and 10 mcg/mL, respectively). However, for the purpose of inter-species dose comparisons presented in the following sections, an assumption of 100% absorption of penciclovir from the topically applied product has been used. Based on use of the maximal recommended topical dose of penciclovir of 0.05 mg/kg/day and assuming 100% absorption, the maximum theoretical plasma AUC_{0-24 hrs} for penciclovir is approximately 0.129 mcg·hr/mL.

Carcinogenesis: Two-year carcinogenicity studies were conducted with famciclovir (the oral prodrug of penciclovir) in rats and mice. An increase in the incidence of mammary adenocarcinoma (a common tumor in female rats of the strain used) was seen in female rats receiving 600 mg/kg/day (approximately 395x the maximum theoretical human exposure to penciclovir following application of the topical product, based on area under the plasma concentration curve comparisons [24 hr AUC]). No increases in tumor incidence were seen among male rats treated at doses up to 240 mg/kg/day (approximately 190x the maximum theoretical human AUC for penciclovir), or in male and female mice at doses up to 600 mg/kg/day (approximately 100x the maximum theoretical human AUC for penciclovir).

Mutagenesis: When tested *in vitro*, penciclovir did not cause an increase in gene mutation in the Ames assay using multiple strains of *S. typhimurium* or *E. coli* (at up to 20,000 mcg/mL), nor did it cause an increase in unscheduled DNA repair in mammalian HeLa S3 cells (at up to 5,000 mcg/mL). However, an increase in clastogenic responses was seen with penciclovir in the L5178Y mouse lymphoma cell assay at doses ≥1000 mcg/mL and, in human lymphocytes incubated *in vitro* at doses ≥250 mcg/mL. When tested *in vivo*, penciclovir caused an increase in micronuclei in mouse bone marrow following intravenous administration of doses ≥500 mg/kg (≥810x the maximum human dose, based on body surface area conversion).

Impairment of Fertility: Testicular toxicity was observed in rats and dogs following repeated intravenous administration of penciclovir (160 mg/kg/day and 100 mg/kg/day, respectively, approximately 1155 and 3255x the maximum theoretical human AUC). Testicular changes seen in both species included atrophy of the seminiferous tubules and reductions in epididymal sperm counts and/or an increased incidence of sperm with abnormal morphology or reduced motility. Adverse testicular effects were related to an increasing dose or duration of exposure to penciclovir. No adverse testicular or reproductive effects (fertility and reproductive

function) were observed in rats after 10 to 13 weeks dosing at 80 mg/kg/day, or testicular effects in dogs after 13 weeks dosing at 30 mg/kg/day (575 and 845x the maximum theoretical human AUC, respectively). Intravenously administered penciclovir had no effect on fertility or reproductive performance in female rats at doses of up to 80 mg/kg/day (250x the maximum human dose [BSA]). There was no evidence of any clinically significant effects on sperm count, motility or morphology in two placebo-controlled clinical trials of Famvir, (famciclovir [the oral prodrug of penciclovir], 250 mg b.i.d.; n=66) in immunocompetent men with recurrent genital herpes, when dosing and follow-up were maintained for 18 and 8 weeks, respectively (approximately 2 and 1 spermatic cycles in the human).

Pregnancy

Teratogenic Effects—Pregnancy Category B. No adverse effects on the course and outcome of pregnancy or on fetal development were noted in rats and rabbits following intravenous administration of penciclovir at doses of 80 and 60 mg/kg/day, respectively (estimated human equivalent doses of 13 and 18 mg/kg/day for the rat and rabbit, respectively, based on body surface area conversion; the body surface area doses being 260 and 355x the maximum recommended dose following topical application of the penciclovir cream). There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use penciclovir during pregnancy only if clearly needed.

Nursing Mothers

There is no information on whether penciclovir is excreted in human milk after topical administration. However, following oral administration of famciclovir (the oral prodrug of penciclovir) to lactating rats, penciclovir was excreted in breast milk at concentrations higher than those seen in plasma. Therefore, when deciding whether to discontinue the drug, take into account the importance of the drug to the mother. There are no data on the safety of penciclovir in newborns.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

In 74 patients > 65 years of age, the adverse events profile was comparable to that observed in younger patients.

ADVERSE REACTIONS

In two double-blind, placebo-controlled trials, 1516 patients were treated with Denavir and 1541 with placebo. The most frequently reported adverse event was headache, which occurred in 5.3% of the patients treated with Denavir and 5.8% of the placebo-treated patients. One or more local adverse reactions were reported by 2.7% of the patients treated with Denavir and 3.9% of placebo-treated patients. Local adverse reactions reported in Phase III trials with Denavir included application site reaction (1.3%), hypesthesia/local anesthesia (0.9%), taste perversion (0.2%), erythematous rash (0.1%). Two studies enrolling 108 healthy subjects evaluated the dermal tolerance of 5% penciclovir cream (a 5-fold higher concentration than the commercial formulation), compared to vehicle using repeated occluded patch testing methodology. The 5% penciclovir cream induced mild erythema in approximately one half of the subjects exposed, an irritancy profile similar to the vehicle control in terms of severity and proportion of subjects with a response. No evidence of sensitization was observed.

DOSAGE AND ADMINISTRATION

Apply Denavir every 2 hours during waking hours for a period of 4 days. Start treatment as early as possible (i.e., during the prodrome or when lesions appear).

BRS-DV:L1

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Denavir™
(penciclovir cream) 1%