This month I am going to discuss about IVF (Test Tube Babies) both Mothers/Babies relating to In Vitro Fertilization and 10 charts were taken up for analysis in KP System (Source: Dr. Chandraraju Shankaramma, MD DGO, Gynaecologist, Dr. Ratna Kumari, Pediatrician, Niloufer Hospitals, Dr. Bhamidipati Satyanarayana Murthy, Pediatrician & Astrodatabank). Smt Geeta Vani Dhagay, Member of KPAF Hyderabad was extended her assistance in preparing this article.

Since a long time IVF topic was discussed in Yahoo groups KP System and touched on its peripherals without going deeply into the finding rules for the same in KP. In this connection during 2008 Sri Suprakash Gosh was made request to give information on this subject. Sri Sunilji (4 Step Fame) on 24.3.2008 indicated that rules are yet to be established for Test Tube Babies. In this connection Dr. Sheetal from Mauritius and Dr. Luther Ruth from Bubaneswar Orissa as Doctors enlightened about the Delivery process and IVF children, conception of Twins etc. With more medical awareness to the benefit of the non-medical astrologers. The information given by Dr. Sheetal is very very important in this Article to be discussed for the benefit of the Readers.

Dr. VBN Sharma who is direct disciple (Sishya) of Sri KSK Guruji discussed about this topic in a gathering of KPAF International Summit of 2008. He felt that IVF is not a new technique which was already adopted in our olden days during Mahabharath time that Drona Acharya was taken birth thru IVF process (Khumbha Sambhava i.e. born thru an earthen pot), all Kowravas along with their sister Dusshala (101) were born thru this process by division of Pindas into different pots. In those times God/Goddess is supporting for this type of Progeny but now in this technically advanced world where with the blessing of the almighty Doctors are able invent new techniques for giving birth to test tube babies.
Dr. Sheetal (Nagpur) disciple of Sri Sunilji also enlightened the following two points on Twin births and Biological/Astrological Birth Time (i.e. the first breathing of new born baby).

1. “25.3.2008 According to me, we have to apply separate formulae of adopted children and Test Tube babies because adopted children are genetically different from parents and test tube babies are usually genetical children of parent where vitro (outside) fertilization husband's sperm and wife's ovum is made and embryo at particular stage is injected inside the uterus. (Sometimes donar's gamete is also used for vitro fertilization but then one parent is genitically related). Also sometimes surrogate mother( other women) gives birth to child of genetically related parent. This may help in applying the formula for test tube baby.”

2. “22/12/2009 U can go through any basic obstetric text book like Ian Donald, Williams, Datta, C.S.Dawn and so many. U will find this in all the text books. These are the practical, established facts and also my experience for 30+ yrs, in my medical college service, also in my own private nursing home, & foreign services and not my beliefs only. Still birth can be (1) intrauterine (baby dies in uterus ie macerated stillborn) or (2) intranatal (during labour ie fresh stillborn) after start of labour pains. Here child shows all signs of life during 1st and 2nd stage of labour but due to asphyxia/ hypoxia due to any reason, child may aspirate in the passage and child fails to take breath at birth. This I wrote in response to Mr K P Naidu's mail where he wrote that child didn't cry at birth and was sent to incubator for 2days......etc Child didn't cry but he has definitely taken the first breath that's why he was alive and kept in the incubator. We note the birth time for all babies whether it is healthy, large, miniscule, or sick etc. Even we have to note birth time for fresh and macerated still born baby as it has taken birth, for medico legal reason though it has no astrological importance. Also I want to mention here that even healthy babies sometime don't cry loudly with first breath and just take sigh or look like yawning. (it is my personal experience) We make them cry by tickling or tapping on the planter aspect of the feet. We are not concerned here about the cry, it should be loud and clear to enable us to note the time but we are more concerned about the first breath when birth time is to be noted.”

3. “21/12/2009 The first breath of the child usually coincide with 1st cry of baby which in turn coincide with the physiological closure of blood vessels in umbilical cord making baby independent from mother biologically. Though actual anatomical closure of umbilical cord &vessels may take few hours to few days later. Even though if the cord is not clamped (anatomical separation) after delivery of baby, usually and normally blood vessels contracts and blood flow stops( mother stops maintaining the baby) . As soon as the baby takes the first breath, Oxygen enters the lungs of baby with force and it opens up the lungs alveoli, which brings about so many immediate chemical/ gaseous changes within seconds, in foetal circulation. This constrict the umbilical blood vessels automatically The forceful entry of air into hollow pipe of air passage produce a sound like cry. First cry may not produce strong sound but subsequent gushing of air brings about the successive cry sequence. During delivery, as soon as the baby's head is out of the entroitus, it is a routine practice to clean the baby's nose and mouth so that secretion should not be aspirated by the baby and that time only baby take the first breath. Many factors are responsible for stimulation of respiration eg skin contact with external stimulate, external air/atmosphere, touch etc. The entry of air through the respiratory passage produce first mild sound, many times followed by successive vigorous sounds which we call as CRY. During C.S. as soon as the baby's head is taken out of incision, there is a practice of cleaning the nose and mouth immediately for the same reason which coincide with the first breath/ cry and no body wait till whole body come out in normal or CS delivery( to avoid aspirations of the secretions on face.) There is usually no need of patting on back and all routinely. In medical practice, in past severing of the cord was noted as time of birth but now the first breath is noted as time of birth. But there are also difference of opinion about this. But correct time of birth is more important for astrologers so we have to think which time we should note as birth time.
In breech delivery, breech and body of the baby is delivered first and baby's head comes later and in that case time noted is after delivery of the head only. If the head delivery is delayed due to any reason (impaction), then external stimuli stimulate the respiration while the head is inside the pelvis and baby may die due to aspiration of fluid with respiration before delivery of head. Here we should think what should be taken as exact time of birth?

Sometimes baby doesn't breathe even after complete delivery of the body and we have to resuscitate the baby to start respiration, so which time should we not here as birth time? We note here as soon as complete body is delivered whether child is alive or not (as birth has happened) Mosty mistake is due to wrong time in watches in hospital but now a days due to belief in astrology by the pts and doctors, watches with correct time are used especially in private hospital. Commonly watch is hanged on the wall of labour room so that attending doctor is in habit of seeing the watch while cleaning the nostrils and lips of baby. But still there can be difference of few mts due to human error.

3. “19/04/2009” Twins are either uniovular or binovular. Uniovular twins means fertilization of single ovum by single sperm which are identical and always same sex. Binovular twins means fertilization of two ova by two sperms, which may be of same sex or different sex (Ovum is genitically always X (sex chromosomes) and sperms are either X or Y (sex chromosomes). Sex of child is determined by fertilizing sperms (X or Y type of sex chromosome), and not by ovum which has 2 X (XX) In uniovular twins devision of ovum occurs after fertilization where one ovum X is always fertilized by one sperm either X or Y and so sex of both children is same (either both XX female or both XY male). If in binovular twins, two sperms fertilizing 2 ovums are same (X-X or Y-Y) then both children will be of same sex but if both sperm fertilizing sperms are different then it will produce different sex-children. I have one query if u can answer.

Why we take 5th, 7th houses etc? Is it the conception time or breathing time (birth time)

Becos in twin whether uniovular or binovular conception time is same (nearly same) in binovular twins and in uniovular twins devision occurs after fertilization producing 2 children so can we consider 5th house for both the twins?

U can do final diagnosis of type of twins whether uniovular or binovular (whatever the sex of child) only after delively of placenta after delivery of child and seeing is cotylidons of placenta and blood circulations/ veins of two children whether separate of single. Secondly 1st and 2nd child, we are differentiating depending upon the appearance of the child in this world. We do not know which was conceived first in binovular and in uniovular it is one conception. How can we differentiate 5th or 7th house in twins? I thought u r interested in research so tried to give additional information. If it is of no use then just forget it.

The answer for this is 5th cusp sublord and 7th cusp sublord of the mother (in case of first conceiving and delivery or it is is second conceiving delivery you have to take 7th csl and 9th csl) are happens to be I cusp sublord/subsub lord of the Infants who have taken birth (in these twins the first cry of both the twins would be the time of birth wherein you can find different sublords at I CSL or alternatively subsublords at I CSL.

**In vitro fertilisation**

In vitro fertilisation (IVF) is a process by which egg cells are fertilised by sperm outside the womb, in vitro. IVF is a major treatment in infertility when other methods of assisted reproductive technology have failed. The process involves hormonally controlling the ovulatory process, removing ova (eggs) from the woman's ovaries and letting sperm fertilise them in a fluid medium. The fertilised egg (zygote) is then transferred to the patient's uterus with the intent to establish a successful pregnancy. The first successful birth of a "test tube baby", Louise Brown, occurred in 1978 (which Chart was included and discussed in this Article). Prior to that, there was a transient biochemical pregnancy reported by Australian Foxton School researchers in 1973 and an ectopic pregnancy reported by Steptoe and Edwards in 1976.
The term in vitro, from the Latin root meaning within the glass, is used, because early biological experiments involving cultivation of tissues outside the living organism from which they came, were carried out in glass containers such as beakers, test tubes, or petri dishes. Today, the term in vitro is used to refer to any biological procedure that is performed outside the organism it would normally be occurring in, to distinguish it from an in vivo procedure, where the tissue remains inside the living organism within which it is normally found. A colloquial term for babies conceived as the result of IVF, test tube babies, refers to the tube-shaped containers of glass or plastic resin, called test tubes, that are commonly used in chemistry labs and biology labs. However, in vitro fertilisation is usually performed in the shallower containers called Petri dishes. (Petri dishes may also be made of plastic resins.) However, the IVF method of Autologous Endometrial Coculture is actually performed on organic material, but is yet called in vitro. This is used when parents are having infertility problems or they want to have multiple births.

Indications: IVF may be used to overcome female infertility in the woman due to problems of the fallopian tube, making fertilisation in vivo difficult. It may also assist in male infertility, where there is defect sperm quality, and in such cases intracytoplasmic sperm injection (ICSI) may be used, where a sperm cell is injected directly into the egg cell. This is used when sperm have difficulty penetrating the egg, and in these cases the partner's or a donor's sperm may be used. ICSI is also used when sperm numbers are very low. ICSI results in success rates equal to those of IVF fertilisation.

For IVF to be successful it may be easier to say that it requires healthy ova, sperm that can fertilise, and a uterus that can maintain a pregnancy. Due to the costs of the procedure, IVF is generally attempted only after less expensive options have failed (It is observed that in advanced countries like US the cost of IVF would be around Rs. 10.00 lakhs in 2009).

This also avails for egg donation or surrogacy where the woman providing the egg isn't the same who will carry the pregnancy to term (9 months till delivery). This means that IVF can be used for females who have already gone through menopause. The donated oocyte can be fertilised in a crucible. If the fertilisation is successful, the zygote will be transferred into the uterus, within which it will develop into an embryo.

IVF can also be combined with preimplantation genetic diagnosis (PGD) to rule out presence of genetic disorders. A similar but more general test has been developed called Preimplantation Genetic Haplotyping (PGH).

Method: Ovarian Stimulation:

Treatment cycles are typically started on the 3rd day of menstruation and consist of a regimen of fertility medications to stimulate the development of multiple follicles of the ovaries. In most patients injectable gonadotropins (usually FSH analogues) are used under close monitoring. Such monitoring frequently checks the estradiol level and, by means of gynecologic ultrasonography, follicular growth. Typically approximately 10 days of injections will be necessary.
Spontaneous ovulation during the cycle is typically prevented by the use of GnRH agonists that are started prior or at the time of stimulation or GnRH antagonists that are used just during the last days of stimulation; both agents block the natural surge of luteinising hormone (LH) and allow the physician to initiate the ovulation process by using medication, usually injectable human chorionic gonadotropins.

**Egg Retrieval:**

When follicular maturation is judged to be adequate, human chorionic gonadotropin (hCG) is given. This agent, which acts as an analogue of luteinising hormone, would cause ovulation about 42 hours after injection, but a retrieval procedure takes place just prior to that, in order to recover the egg cells from the ovary. The eggs are retrieved from the patient using a transvaginal technique involving an ultrasound-guided needle piercing the vaginal wall to reach the ovaries. Through this needle follicles can be aspirated, and the follicular fluid is handed to the IVF laboratory to identify ova. It is common to remove between ten and thirty eggs. The retrieval procedure takes about 20 minutes and is usually done under conscious sedation or general anaesthesia.

**Fertilisation:**

In the laboratory, the identified eggs are stripped of surrounding cells and prepared for fertilisation. In the meantime, semen is prepared for fertilisation by removing inactive cells and seminal fluid in a process called sperm washing. If semen is being provided by a sperm donor, it will usually have been prepared for treatment before being frozen and quarantined, and it will be thawed ready for use. The sperm and the egg are incubated together at a ratio of about 75,000:1 in the culture media for about 18 hours. In most cases, the egg will be fertilised by that time and the fertilised egg will show two pronuclei. In certain situations, such as low sperm count or motility, a single sperm may be injected directly into the egg using intracytoplasmic sperm injection (ICSI). The fertilised egg is passed to a special growth medium and left for about 48 hours until the egg consists of six to eight cells.

In gamete intrafallopian transfer, eggs are removed from the woman and placed in one of the fallopian tubes, along with the man's sperm. This allows fertilisation to take place inside the woman's body. Therefore, this variation is actually an in vivo fertilisation, not an in vitro fertilisation.

**Embryo Culture:**

Typically, embryos are cultured until having reached the 6–8 cell stage three days after retrieval. In many Canadian, American and Australian programmes however, embryos are placed into an extended culture system with a transfer done at the blastocyst stage at around five days after retrieval, especially if many good-quality embryos are still available on day 3. Blastocyst stage transfers have been shown to result in higher pregnancy rates. In Europe, transfers after 2 days are common.
Culture of embryos can either be performed in an artificial culture medium or in an autologous endometrial coculture (on top of a layer of cells from the woman's own uterine lining). With artificial culture medium, there can either be the same culture medium throughout the period, or a sequential system can be used, in which the embryo is sequentially placed in different media. For example, when culturing to the blastocyst stage, one medium may be used for culture to day 3, and a second medium is used for culture thereafter. Single or sequential medium are equally effective for the culture of human embryos to the blastocyst stage. Artificial embryo culture media basically contain glucose, pyruvate, and energy-providing components, but addition of amino acids, nucleotides, vitamins, and cholesterol improve the performance of embryonic growth and development.

**Embryo selection:**

Laboratories have developed grading methods to judge oocyte and embryo quality. In order to optimize pregnancy rates, there is significant evidence that a morphological scoring system is the best strategy for the selection of embryos. However, presence of soluble HLA-G might be considered as a second parameter if a choice has to be made between embryos of morphologically equal quality. In addition to tests that optimize pregnancy chances, Preimplantation Genetic Diagnosis (PGD) may be performed prior to transfer in order to avoid inheritable diseases.

**Embryo Transfer:**

Embryos are graded by the embryologist based on the number of cells, evenness of growth and degree of fragmentation. The number to be transferred depends on the number available, the age of the woman and other health and diagnostic factors. In countries such as Canada, the UK, Australia and New Zealand, a maximum of two embryos are transferred except in unusual circumstances. In the UK and according to HFEA regulations, a woman over 40 may have up to three embryos transferred, whereas in the USA, younger women may have many embryos transferred based on individual fertility diagnosis. Most clinics and country regulatory bodies seek to minimise the risk of pregnancies carrying multiples. The embryos judged to be the "best" are transferred to the patient's uterus through a thin, plastic catheter, which goes through her vagina and cervix. Several embryos may be passed into the uterus to improve chances of implantation and pregnancy.

**Preimplantation Genetic Diagnosis (PGD):**

Preimplantation genetic diagnosis used in conjunction with IVF treatments appeared in the early 1990s, and since then hundreds of normal, healthy babies have been born using this advanced reproductive technology. PGD technology improves the likelihood of a successful pregnancy and birth for two distinctly different groups of patients. Couples with infertility related to recurrent miscarriage or unsuccessful IVF cycles and couples who are at risk for passing on inherited genetic disease to their offspring. Patients who also can benefit from PGD include:
Couples who have a family history of inherited disease
Couples who want to use gender selection to prevent a gender-linked disease
Women who have had repeated failures with IVF
Women with a history of unexplained miscarriage
Women who are more than 39 years old

PGD screens for chromosomal abnormalities. It screens individual cells from a pre-embryo during the IVF process. Before the transfer of a pre-embryo back to a woman's uterus, one or two cells are removed from the pre-embryos. These cells are then evaluated for normalcy. Typically within one to two days, following completion of the evaluation, only the normal pre-embryos are transferred back to the woman's uterus. In addition, PGD can reduce the risk of multiple pregnancies because fewer embryos are needed for implantation.[23]

Cryopreservation:
The first ever pregnancy derived from a frozen human embryo was reported by Alan Trounson & Linda Mohr in 1983 (although the fetus aborted spontaneously at about 20 weeks of gestation); the first term pregnancies derived from frozen human frozen freezing process was born in 1984. Since then and up to 2008 it is estimated that between 350,000 and half a million IVF babies have been born from embryos controlled rate frozen and then stored in liquid nitrogen; additionally a few hundred births have been born from vitrified oocytes but firm figures are hard to come by.

On the safety of embryo cryopreservation, a 2008 study reported at the European Society of Human Reproduction and Embryology discovered that children born from frozen embryos “did better and had a higher birth weight” than children born from a fresh transfer. The study was conducted out of Copenhagen and evaluated babies born during the years 1995–2006. 1267 children born after Frozen Embryo Replacement (FER), via controlled-rate freezers and storage in liquid nitrogen, were studied and categorised into three groups. 878 of them were born using frozen embryos that were created using standard in vitro fertilisation in which the sperm were placed into a dish close to the egg but had to penetrate the egg on their own. 310 children were born with frozen embryos created using ICSI in which a single sperm was injected into a single egg, and 79 were born where the method of creation of the embryos was not known.

17,857 babies born after a normal IVF/ICSI with fresh embryos were also studied and used as a control group or reference group. Data on all of the children's outcomes were taken regarding birth defects, birth weights, and length of pregnancy. The results of the study showed that the children who came from frozen embryos had higher birth weights, gave longer pregnancies and produced fewer “pre-term” births. There was no difference in the rate of birth defects whether the children came from frozen embryos or fresh embryos. In the FER group, the birth defect rate was 7.7% compared to the fresh transfer group which was slightly higher at 8.8%. The scientists also found that the risk for multiple pregnancies was increased in the fresh embryo transfers.
Around 11.7% of the ICSI and 14.2% of the IVF frozen cases were multiple pregnancies. In the case of fresh embryos, 24.8% of the ICSI and 27.3% of the IVF were multiple pregnancies. It should also be noted that maternal age was significantly higher in the FER group. This is significant since based on age one would have expected a higher rate of problems and birth defects. The study adds to the body of knowledge suggesting that traditional embryo freezing is a safe procedure. It was unclear however why the frozen embryo children did better than their fresh embryo counterparts.

If multiple embryos are generated, patients may choose to freeze embryos that are not transferred. Those embryos are slow frozen and then placed in liquid nitrogen and can be preserved for a long time. There are currently 500,000 frozen embryos in the United States. The advantage is that patients who fail to conceive may become pregnant using such embryos without having to go through a full IVF cycle. Or, if pregnancy occurred, they could return later for another pregnancy. Spare embryos resulting from fertility treatments may be donated to another woman or couple, and embryos may be created, frozen and stored specifically for transfer and donation by using donor eggs and sperm.

Leftover embryos or eggs:

There may be leftover embryos or eggs from IVF procedures if the woman for whom they were originally created has successfully carried one or more pregnancies to term. With the woman's or couple's permission, these may be donated to help other women or couples as a means of third party reproduction.

In embryo donation, these extra embryos are given to other couples or women for transfer with the goal of producing a successful pregnancy. The resulting child is the one and only considered the child of the woman who carries it and gives birth, and not the child of the donor, the same as occurs with egg donation or sperm donation.

**History of IVF Medical Technology:**

John Rock was the first to extract an intact fertilised egg. The first pregnancy achieved through in vitro human fertilisation of a human oocyte was reported in The Lancet from the Monash team in 1973, although it lasted only a few days and would today be called a biochemical pregnancy. In 1977, Patrick Steptoe and Robert Edwards successfully carried out a pioneering conception which resulted in the birth of the world’s first baby to be conceived by IVF, Louise Brown (discussed in this Article) on 25 July 1978, in Oldham General Hospital, Greater Manchester, UK followed by Courtney Cross on 16 October 1978 and Alastair MacDonald on 14 January 1979. This was then followed by the birth of Candice Reed in Melbourne in 1980. It was the subsequent use of stimulated cycles with clomiphene citrate and the use of human chorionic gonadotrophin (hCG) to control and time oocyte maturation, thus controlling the time of collection, that converted IVF from a research tool to a clinical treatment.
This was followed by a total of 14 pregnancies resulting in nine births in 1981 with the Monash university team. The Jones team at the Eastern Virginia Medical School in Norfolk, Virginia, further improved stimulated cycles by incorporating the use of a follicle-stimulating hormone (uHMG). This then became known as controlled ovarian hyperstimulation (COH). Another step forward was the use of gonadotrophin-releasing hormone agonists (GnRHA), thus decreasing the need for monitoring by preventing premature ovulation, and more recently gonadotrophin-releasing hormone antagonists (GnRH Ant), which have a similar function. The additional use of the oral contraceptive pill has allowed the scheduling of IVF cycles, which has made the treatment far more convenient for both staff and patients.

The ability to freeze and subsequently thaw and transfer embryos has significantly improved the feasibility of IVF use. The other very significant milestone in IVF was the development of the intracytoplasmic sperm injection (ICSI) of single sperms by André van Steirteghem in Brussels, 1992. This has enabled men with minimal sperm production to achieve pregnancies. ICSI is sometimes used in conjunction with sperm recovery, using a testicular fine needle or open testicular biopsy. Using this method, some men with Klinefelter's syndrome, and so would be otherwise infertile, have occasionally been able to achieve pregnancy. Thus, IVF has become the final solution for most fertility problems, moving from tubal disease to male factor, idiopathic subfertility, endometriosis, advanced maternal age, and anovulation not responding to ovulation induction.

Carl Wood was dubbed "the father of IVF (in vitro fertilisation)" for having pioneered the use of frozen embryos. In the US, ART cycles started in 2006 resulted in 41,343 births (54,656 infants), which is slightly more than 1% of total US births.

**Pregnancy past menopause:**

Although menopause is a natural barrier to further conception, IVF has allowed women to be pregnant in their fifties and sixties. Women whose uterus has been appropriately prepared receive embryos that originated from an egg of an egg donor. Therefore, although these women do not have a genetic link with the child, they have an emotional link through pregnancy and childbirth. In many cases the genetic father of the child is the woman's partner. Even after menopause the uterus is fully capable of carrying out a pregnancy.

(Courtesy: Dr. Chandraraju Shankaramma, MD DGO, Gynaecologist, Dr. Ratna Kumari, Gynaecologist, Niloufer Hospitals, Dr. Bhadmidipati Satyanarayana, MD, Pediatrician). – KPAF Member)
**IVF / Test tube baby.**

**Oocyte** with surrounding **granulosa cells**

"Naked" Egg

early embryo development following fertilisation

**In Medical Astrology** V house is for conceiving and birth children for which natural karaka is Jupiter and in Kalapursha (Natural Zodiac) Leo is the Sign Lord. Sun karaka for soul and stars governed in this Sign are Makha (Kethu), Purvaphalguni (Venus) and UttaraPhalguni-1 (Sun). Both Sun and Venus are related for conceiving a child birth as they are karakas for the same. Kethu is an abortive and barren planet.
Pregnancy and Delivery is indicated by Libra the Sign Lord Venus karaka for Semen and the stars governed in this Sign are Chitra 3-4 (Mars), Swathi (Rahu) and Visakha 1-3 (Jupiter karaka for children).

Rahu is found has a major significator of IVF children. As Rahu & Kethu the nodes are best known in Vedic astrology as negative planets with sarpa dosha for conceiving and birth of children. It is very important to note that Kethu being an abortive planet appearance as V CSL or starlord of V CSL or occupation in V bhava denies birth of children. This was well noted in Vedic Astrology a citation of Sri Ramanananda Swami’s, Visahapatnam book on Experiences of Saibaba Devotees wherein a resident of Nasik Mr. Dhumal (Pleader) was informed by an Astrologer that he will be not blessed with children as Kethu is in his birth chart in 5th house. However because of Shiridi Sai’s blessings he had children by natural births.

4th n 12th houses are negation for children as one is 12th to 5th another is disappointment but this will work wonderfully for IVF children birth which takes place in Labs in the test tubes; as both 4th is the professional talent of Doctor and 12th is the Hospital /Fertility Clinics where the conceiving process would take place. Moon is karaka for eggs & Venus is karaka for seamen which is essential for conceiving, when this planets weak are afflicted and relevant Cuspal sublords are connected to negative houses indicates lack of children or abortions. However as per Vedic Rahu Kethu always an hindrance to progeny. Here the conceiving outside in the labs through medical professionals (test tube babies) are working as an alternative.

(Source: KP System Yahoo Groups)
### ANALYSIS: IVF Mothers:

#### 01 Celine Dion:

**Date:** 30/03/1968  **Time:** 12:15:00 EST  **Place:** Charlemagne  **Day:** Saturday  
**Lat:** 45:43:00 N  **Long:** 73:29:00 W  **TZ:** 75:00:00 W  **Time Corr:** -0:06:04  
**Birth Star:** Ashwini-2  **Rasi:** Mesha Asc.  
**Can:** 9:13:46

Canadian French singer who did not speak English until 1987, when she learned in order to sing bilingually. On May 28, 2000, fertilized eggs were transferred into her uterus. Rene-Charles was born to his overjoyed mother on 25/1/01.

The native had IVF child during Mo-Ra (5/2000). Mo is karaka for ovum in Ke star (Aries Barren sign). V CSL Su(9,3) in Me(9,4,12)Ke in IV (Virgo BS). Ra in X house (Pis Fruitful sign) in Me star (9,4,12). The native is mother who had child through IVF.

#### 02 Suleman Nadya:

**Date:** 11/07/1975  **Time:** 21:59:00 PDT  **Place:** Fullerton  **Day:** Friday  
**Lat:** 33:52:00 N  **Long:** 117:55:00 W  **TZ:** 120:00:00 W  **Time Corr:** -0:51:40  
**Birth Star:** Makam-2  **Rasi:** Leo Asc.  
**Aqu:** 1:32:24

American mother of fourteen children, all born via in vitro fertilization and implantation. She made the news when she delivered Octuplets (8) in Jan 2009.

During Mo-Sa(1/2009) the native delivered 8 kids (Octuplets). Mo (in Leo BS) in Ke(3 Tau); Sa (5 Gem) in Ju (2-Pis FS) indicates multiples through Sa (5 Gem) and Ju in (Pis) Dual sings indicated number of kids. The native had transplanted 6 frozen zygotes out of which two became twins, total 4+2+2.

#### 03 Kunthi:

**Date:** 09/10/1981  **Time:** 06:43:00 Place: Undisclosed  **Day:** Friday  
**Lat:** undisclosed  **Long:** undisclosed  **E**  **TZ:** 82:30:00 E  **Time Corr:** -0:09:08  
**Birth Star:** Dhanista-1  **Rasi:** Makara Asc.  
**Lib:** 2:04:59

During Ju-Sa(2/2008) the native had an IVF child. Ju (12Vir BS) in Ma 10 House. Sa (12 Vir BS) in Mo(4 Cap) conjunction with Ke.

#### 04 Pointer Ruth:

**Date:** 19/03/1946  **Time:** 10:15:00 PST  **Place:** Oakland CA  **Day:** Tuesday  
**Lat:** 37:48:00 N  **Long:** 122:16:00 W  **TZ:** 120:00:00 W  **Time Corr:** -0:09:04  
**Birth Star:** Chitra-4  **Rasi:** Virgo  
**Asc.:** 25:20:17

American singer, one of four sisters who made their mark across the spectrum from soul to scat, country, jazz and pop, R&B singers and songwriters. She got pregnant with a donor egg and her husband’s sperm. Their test-tube twins, a boy and girl named Conor and Ali, arrived six weeks prematurely on 7/17/1993.

During Sa-Ve(7/93) the native had twins by IVF. Sa(2-Gem twins) in Ju star (5,8,11-Lib in FS). Ve(11 Pis FS) in Me (Pis 11 FS) karaka for twins. Mo is karaka for egg connected for the 3rd house doners egg.

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The native is mother who had child through IVF.
ANALYSIS: IVF Babies

05 Brown Louise: Test tube baby given birth to another normal child

Date 25/07/1978 Time 23:47:00 GDT Place Oldham Day Tuesday; Lat 53:33:00 N Lon 2:07:00 W TZ 0:00:00 E Time Corr - 1:08:28; KP-NA 23:27:48 Birth Star: Revathi Rasi: Meena Asc. : Ari 8:41:25

British child, the world's first test-tube baby, born by Caesarean section. Her mom's ovum was germinated in a lab experiment on 11/10/1977 and implanted five days later. John and Lesley Brown were unable to conceive, and they were happy to cooperate with Doctors. Edwards and Steptoe, who had put in ten years of research and 70 attempts to create in-vitro fertilization.

First Test Tube Baby from U.K. in July 25/78. I CSL Ju in his own star (4 Gem, 9, 10) indicate parental cusps 4 & 9 are well connected.

06 Mason Olivia: Mother Surrogate

Date 24/10/2001 Time 17:03:00 PDT Place Los Angeles CA * Day Wednesday; Lat 34:03:00N Long 118:14:00W TZ 120:00:00 W Time Corr - 0:52:56; KP-NA 23:47:16 Birth Star: Sravana-3 Rasi: Capricorn Asc. : Pis 15:23:28

American noted family, the daughter of Kelsey Grammer and his wife Camille, 33; their first child. Her unnamed surrogate mother is a nurse.

I CSL Ju (Gem) connected to 4,10,1 indicates father /mother. IV CSL Sa (3) in Mo (11,5) indicates surrogate mother.

07 Solomon Twins:

Date 01/10/2006 Time 15:33:00 PDT Place Baldwin Park Day Sunday; Lat 34:05:00 N Long 117:57:00 W TZ 120:00:00 W Time Corr - 0:51:48; KP-NA 23:51:24 Birth Star: Uttarashadha-2 Rasi: Capricorn Asc. : Cap 11:07:07

American twins, born to Nadya Suleman who made the news when she gave birth to octuplets. The twins were born via in vitro fertilization and implantation.

I CSL Ma (8,3,4,11) in Mo (12,7) indicates Mother connection but not 9th cusp. May be 8,4,12 involvement indicates IVF thru Labs.

08 Stuart Twins:

Date 01/12/1993 Time 02:55:00 MET Place Arnhem Netherland Day Wednesday; Lat 51:59:00 N Lon 5:55:00 E TZ 15:00:00 E Time Corr - 0:36:20; KP-NA 23:40:39 Birth Star:Mrigasira-2 Rasi: Gemini Asc. : Vir 16:33:21.

Dutch twins born by C-Section, the second one was born one minute after the first.

I CSL Sa(5,6 Aqua) in Ma(3,8 Sco) the twin births of I CSL connected to 5,6,3,8 indicates explaining block baby. IV & IX CSL Ra(2Conj Ve-2,9) in Sa(5,6) indicates the parents.
**9 Lalith:**
Date 16/10/2008 Time 07:31:00 IST Place Jaipur Day Thursday; Lat Undisclosed N Long Undisclosed E TZ 82:30:00 E Time Corr - 0:09:00; KP-NA 23:53:06 Birth Star: Bharani-1 Rasi: Mesha Asc. : Lib 20:12:53.

I CSL Ju(3,6) in Ve(1,8) indicates traditional with donor.

**10 Animika:**
Date 16/04/2002 Time 08:46:00 IST Place undisclosed Day Tuesday; Lat Undisclosed N Long Undisclosed E TZ 82:30:00 E Time Corr - 0:16:08; KP-NA 23:47:40 Birth Star: Krittika-4 Rasi: Vrishabha Asc. : Tau 16:39:19

I CSL Sa (1 Conj Ra-9,10) in Mo(12,3) indicates birth by donor.

*BS Barren Sign FS Fruitful Sign*

**Conclusion:** From the analysis of the above 11 charts for IVF Mothers and Test Tube Babies-

1. **IVF Mothers:-** Rahu Kethu involvement with 4, 12 cusps and Gemini, Pisces for twins, and barren signs and fruitful signs would play its role in delivering a child thru IVF process.

2. **Testtube babies:-** Out of 6 charts 3 charts I CSL Ju stood has I CSL (includes I test tube baby-Brown) in 2 charts Sa became I CSL where donations have taken place. In all the 6 charts I CSL invariably connected to 3&8 apart from other cusps.

Pranams to Guru Prof. KSK.