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Original article

Follicular phase dexamethazone administration in polycystic ovarian syndrome patients who are clomiphene citrate resistant



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ABSTRACT

Aim of the work: To compare the effect of adding short course follicular phase dexamethazone to clomiphene citrate versus increasing clomiphene citrate dose in cases of resistance. **Materials and methods:** The study was conducted on 85 with polycystic ovary syndrome who were resistant to 150 mg clomiphene citrate daily for 5 days for 3 months and were attending El Shatby Maternity University Hospital in the period between September 2011 and May 2013. These patients were randomly allocated by closed envelope method into one of the two groups: Group I: 44 patients received 200 mg daily of clomiphene citrate from day 3 and for 5 days together with 2 mg dexamethazone daily from day 3 and for 10 days. Group II: 41 patients received 200 mg daily of clomiphene from day 3 and for 5 days.

Results: We found that a significant higher rate of ovulation was reported in the dexamethazone group compared to clomiphene citrate only group, endometrial thickness was more favorable in dexamethazone group than the other group, mid luteal serum progesterone was a higher level in dexamethazone group compared to the other group and serum pregnancy rate was higher in dexamethazone group than the other group.

Conclusion: Although the mechanism underlying the beneficial effects of dexamethazone is not exactly understood, it is apparent from our data that dexamethazone therapy during the follicular phase can enhance follicular development and ovulation. Dexamethazone (corticosteroids) therapy combined with clomiphene citrate can improve folliculogenesis, ovulation, and pregnancy rate in clomiphene citrate resistant polycystic ovary syndrome.

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Administração de dexametasona na fase folicular em pacientes com síndrome do ovário policístico e resistentes ao citrato de clomifeno

R E S U M O

Palavras-chave:

Clomifeno

Gestação

Dexametasona

Objetivo do estudo: Comparar o efeito da adição de dexametasona em curso de curta duração ao citrato de clomifeno na fase folicular versus aumento da dose de citrato de clomifeno em casos de resistência.

Materiais e métodos: O estudo foi realizado em 85 mulheres com síndrome do ovário policístico e resistentes à medicação com citrato de clomifeno 150 mg/dia durante 5 dias por 3 meses e que se encontravam em tratamento na Maternidade do Hospital Universitário El Shatby no período entre setembro de 2011 e maio de 2013. Essas pacientes foram designadas randomicamente pelo método do envelope fechado em um entre dois grupos: Grupo I: 44 pacientes medicadas com citrato de clomifeno 200 mg/dia a partir do terceiro dia e durante 5 dias, juntamente com dexametasona 2 mg/dia a partir do terceiro dia e durante 10 dias; Grupo II: 41 pacientes medicadas com citrato de clomifeno 200 mg/dia a partir do terceiro dia e durante 5 dias.

Resultados: Constatamos que um percentual significativamente mais elevado de ovulações foi informado no grupo de dexametasona, em comparação com o grupo medicado exclusivamente com citrato de clomifeno; em comparação com o outro grupo, no grupo das mulheres tratadas com dexametasona a espessura do endométrio se revelou mais favorável, foram observados níveis séricos mais altos de progesterona na metade da fase lútea, e o percentual de gestação sérica foi mais elevado.

Conclusão: Embora o mecanismo subjacente aos efeitos benéficos obtidos com o uso de dexametasona não tenha ainda sido completamente esclarecido, fica evidente, com base em nossos dados, que o tratamento com dexametasona durante a fase folicular pode melhorar o desenvolvimento dos folículos e a ovulação. A terapia com dexametasona (um corticosteroide) em combinação com citrato de clomifeno pode melhorar os percentuais de foliculogênese, de ovulação e de gestações em mulheres com SOPC resistentes ao citrato de clomifeno.

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Introduction

Chronic anovulation is one of the examples of ovulatory dysfunction. The polycystic ovary syndrome (PCOS) is the most obvious and common heterogeneous endocrine condition associated with chronic anovulation affecting 4–6% of reproductive age group.¹ It is one of the examples of eugonadotropic eu-estrogenic anovulation, as it represents 75–80% of all ovulatory disorders. It was discovered by both Stein and Leventhal in 1935 by description of seven patients with amenorrhea, hirsutism, and enlarged polycystic ovaries.

Because the diagnostic criteria for PCOS have changed, it is difficult to obtain consistent prevalence information. Approximately 22% of women in the general population have polycystic ovaries as an incidental finding on ultrasound examination. A study using the NIH/NICHHD criteria (which relied on oligomenorrhoea/amenorrhoea and clinical/biochemical evidence of hyperandrogenaemia) estimated that 6.2% of white and 3.4% of black women attending for a mandatory pre-employment medical examination had PCOS.^{2–8}

Weight loss, exercise, and lifestyle modifications have been proven effective in restoring ovulatory cycles and achieving pregnancy in overweight women with PCOS and should

be the first-line option for these women. Morbidly obese women should seek expert advice about pregnancy risk. Clomiphene citrate (CC) has been proven effective in ovulation induction for women with PCOS and should be considered the first-line therapy. Patients should be informed that there is an increased risk of multiple pregnancies with ovulation induction using CC. The CC will induce ovulation in 60–80% of properly selected patients. The likelihood of response decreases with increasing age and body mass index and the extent of associated hyperandrogenemia in anovulatory women. Women with amenorrhea are more likely to conceive than those with oligomenorrhea, possibly because infertile women who menstruate also likely ovulate infrequently and are more likely to have other co-existing infertility factors. Cumulative pregnancy rates of 70–75% can be expected over 6 cycles of treatment. Thereafter, cycle fecundability falls substantially. When pregnancy is not achieved within 3–6 of CC induced ovulatory cycles, the infertility investigation should be expanded to exclude other infertility factors, or to change the overall treatment strategy. CC resistance: It is defined as failure to ovulate in response to CC on doses of 150 mg/day after 3 cycles. The CC resistance is an unpredictable and unpreventable event. It is virtually impossible to predict who will respond to which dose of CC. So far there is no general agreement

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