

# Clomiphene Citrate Combined With Letrozole



**Southern Ontario  
Fertility Technologies**

## Introduction

Once the “**basic**” **infertility investigation** is completed, ovulation induction is often used to promote fertility. Clomiphene has been one of the mainstays of infertility treatment since it was first used in 1963. **Letrozole** is a new alternative to clomiphene. Tamoxifene is also used in some clinics. Letrozole is often used in Toronto, Montreal and here in the S.O.F.T. clinic. Because it is new, it is not as widely used and many physicians and pharmacists may not be aware of this use. Both of these agents are used for ovulation induction and work in a similar manner but by slightly different mechanisms (detailed later).

It has been a consistent observation that if clomiphene can produce ovulation at its lowest dose (50 mg for 5 days) that the pregnancy rate per ovulation is higher than if higher doses of clomiphene have to be used. The reason for this is that clomiphene causes negative effects on the endometrium and cervical mucous. These negative effects may start to overcome the beneficial effect

of clomiphene in producing ovulation when higher doses are necessary. In women who are not ovulating, it is sometimes necessary to increase the dose despite this to produce ovulation because clomiphene will not cause ovulation at the starting dose.

Because letrozole works in a slightly different mechanism than clomiphene, it does not seem to have the same detrimental effects on the endometrium as clomiphene. This is discussed in more detail in the letrozole information sheet.

After extensive use of both clomiphene and letrozole, we wondered how both would work together. The combination of these two drugs has theoretical advantages over increasing the dose of one or the other. Because they both promote ovulation, **together, they should provide a more potent ovulation promoting stimulus.** In addition, because they have different side effect profiles, by **using the minimum dose of each, we should minimize the side effects.** Although theories like this are not always true, this does appear to be the case using early observations with the combination.

For women who are **not ovulating** (producing an egg) every month clomiphene or letrozole are usually the first treatment attempted. However, sometimes clomiphene or letrozole are not able to cause ovulation, even in higher doses. This is especially common in women who have the PCOS pattern but have very few spontaneous menstruations.

Initial experience in the S.O.F.T. clinic with combined clomiphene and letrozole in women resistant to clomiphene alone has demonstrated ovulation in 46% and pregnancies in 19% of the women who ovulated in their first cycle.

Also, clomiphene and letrozole may also be useful in couples with “**idiopathic**” **infertility, mild male factor, endometriosis-associated infertility, mild tubal factor infertility, female age-associated infertility or cervical factor infertility** who fail to get pregnant with clomiphene or letrozol alone. Usually if a pregnancy does not occur with

**IMPORTANT NOTICE**  
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clomiphene or letrozole, intrauterine insemination will be suggested. However, in patients who live at a distance and monitoring will be difficult, we have sometimes suggested a short course of ovulation induction and timed intercourse with a combination of clomiphene and letrozole. This suggestion is based on observations in our intrauterine insemination program using clomiphene and letrozole. At S.O.F.T., sometimes several cycles of intrauterine insemination with clomiphene and letrozole are suggested after intrauterine insemination with clomiphene or letrozole alone haven't worked. This is an alternative to moderate stimulation-IUI for people who cannot afford to add injectable infertility medication.

How many cycles of clomiphene and letrozole with "timed intercourse" will be suggested depends on the diagnosis, the previously attempted infertility treatments, the length of infertility, and the female partner's age. Clomiphene and letrozole in combination is effective for women who are not ovulating because it stimulates ovulation but it is also used in the other forms of infertility to mature more than one egg per month.

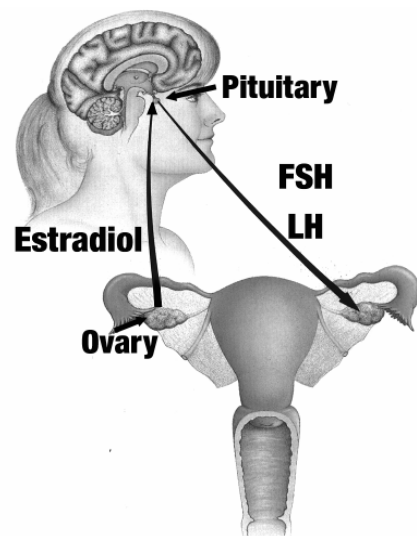
This combination has been used widely at S.O.F.T. At first it was used mostly in intrauterine insemination (IUI) cycles were close monitoring occurs. More recently, because we have had more experience with the cycle dynamics after monitoring many IUI cycles, we are using it with timed intercourse.

The most common use for the combination is when higher doses of clomiphene have failed to cause ovulation. It is well recognized that clomiphene increases pregnancy rates in anovulatory women but causing ovulation. However, this is most effective if ovulation occurs at the lowest dose. We feel the reason for this is clomiphene has both positive (causes ovulation) and negative effects (thins the endometrium, changes the cervical mucous). Women have different susceptibilities to the negative effects, just as they do to the positive effects. However, in the most part, the higher the dose required for ovulation and the longer the duration of use the more likely the negative effects will be significant.

The combination of clomiphene and letrozole was initially used when 150 milligrams of clomiphene from day 3 to 7 of the cycle would not cause ovulation. A small amount of letrozole (7.5 mg on day 3), early in the cycle seemed to sensitize these women to the clomiphene and allow ovulation to occur. In our IUI cycles we will now commonly use this combination instead of increasing the clomiphene and it has provided us with one of our higher pregnancy rates in IUI. Combinations are not as widely used in timed intercourse but may be in the future as we gain more experience with it in IUI.

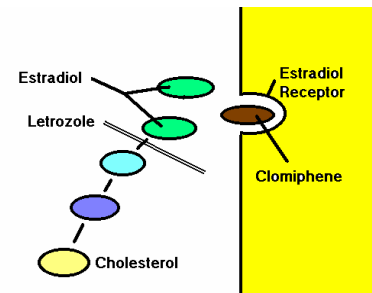
### How It Works

Menstruation and ovulation are complex processes depending on the action of hormones released from the ovary, pituitary and hypothalamus. An imbalance in the levels of these hormones can disturb normal ovulation and can contribute to infertility. **Follicle stimulating hormone (FSH)** is released by the pituitary and stimulates both egg maturation and production of estrogen (estradiol). The estradiol "feeds-back" to the pituitary to cause a decrease in the



secretion of FSH (see diagram). Blocking this “feed-back” of estradiol in the early part of the menstrual cycle allows the production of more FSH and stimulation of the ovary. Clomiphene has the same shape as estradiol and fits into the estradiol receptor blocking the function of estradiol in the early part of the menstrual cycle (see diagram). Letrozole blocks the last step (the aromatase enzyme) in the synthesis of estradiol. There is therefore reduced estradiol to feed-back and turn the pituitary off and more FSH is made. This results in more stimulation of the ovaries and therefore promotes ovulation (release of an egg) and perhaps the production of more than one egg.

Clomiphene and letrozole therefore work in a similar manner but by a different mechanism. When both are used together, letrozole decreases the estradiol available in the first part of the cycle by temporarily blocking its formation while clomiphene blocks the receptor so that the little bit of estradiol there is cannot enter the receptor and feedback to the pituitary. This appears to provide a very strong stimulus for ovulation induction.



### How to Take Clomiphene and letrozole

Our usual “combination of these two agents” is letrozol 7.5 mg (3 X 2.5 mg tabs) on day three added to either 50 mg of clomiphene citrate from day 3 to 7 of the cycle or whatever dose of clomiphene has been required or has not been successful at producing ovulation.

Letrozole is taken in a single dose of three pills on day three. Clomiphene is taken for five days beginning three days after the first day of menstrual bleeding (**day 3 to 7 of cycle**). The first day of the cycle is considered the first day of bleeding sufficient to require sanitary protection as long as it occurs before midnight. Clomiphene and Letrozole may be started after medication (**provera etc.**) is given to bring on a period in women who are not having regular periods.

### Cost of Clomiphene and Letrozole

Clomiphene at the lowest dose is usually about \$35.00. Double and triple doses of clomiphene cost \$60.00 and \$90.00 respectively. Three pills of letrozol are usually \$25.00. It is important to note that **some drug plans cover a given number of cycles of infertility treatment**. Clomiphene and letrozole does not work for everybody and you may have to move on to more expensive medication. Before submitting clomiphene to your drug plan, check exactly your coverage. If your drug plan covers only a number of cycles you may consider paying for the clomiphene in order to have more expensive cycles covered later on.

**Before starting any infertility treatment, make yourself familiar with the details of your drug plan!**

### Alternative Medications

The only other ovulation induction agent available is **Tamoxifene citrate**. In the clinic, we have not used tamoxifene very extensively.

### **The Success Rate and Number of Tries**

Clomiphene and letrozole are very effective at promoting ovulation in women where the reason for not ovulating is miscommunication between the pituitary and the ovary (usually referred to as polycystic ovary syndrome or PCOS – a separate information sheet is available). Clomiphene and letrozole will not work for women with pituitary or ovarian failure. These different causes of not ovulating will be evaluated with your initial infertility investigation. Between **50 - 90%** of women who take this combination will ovulate. We have had some dramatic success with it in women who are resistant to ovulation with just clomiphene. In fact, many pregnancies have occurred in women who would not ovulate with any other drug combination. A maximum of six ovulatory cycles / pregnancy are indicated before other infertility treatments are considered.

In many situations you may be advised to do **less than the suggested number of cycles**. With an increased length of infertility, increased dose of clomiphene required to produce ovulation or in older women, fewer cycles may be suggested as time may necessitate moving on to a more intensive treatment earlier. Fewer cycles may also be suggested with certain diagnoses such as mild male-factor or mild tubal-factor infertility as these may be associated with a lower chance of success with clomiphene. We will probably move on to more intensive treatments sooner in female age-related infertility.

In a few circumstances, **more cycles than mentioned above may be recommended**. If clomiphene and letrozole has produced a pregnancy but it has unfortunately ended in miscarriage it will often be tried again. In anovulatory women who cannot afford more intensive treatment or for patients whose endometriosis has been treated at the time of laparoscopy more cycles may be considered.

Lastly, the exact number of cycles of clomiphene and letrozole to be tried will be modified by **how you feel about it**. Clomiphene and letrozole is usually attempted before going on to ovarian cautery or injectable fertility medicines because it is inexpensive, easy (less time consuming), and requires less intervention. Side effects are very few (to be discussed) and the risk of multiple pregnancies is lower than many other infertility treatments. However, if your particular preference is to avoid clomiphene and letrozole, this will be discussed and respected.

### **Timing of Ovulation and Intercourse**

The dynamics and timing of a clomiphene and letrozole cycle appear to be almost the same or a little faster than a clomiphene cycle. This probably makes sense as the letrozole is usually used only to sensitize the woman to clomiphene. Release of the egg(s) usually happens 7 to 10 days after the last dose of clomiphene (day **14 to 17** of the cycle). If a pregnancy does not occur, menstruation will probably occur 21 or 25 days after the last dose of clomiphene (giving a **28 to 32** day cycle). Clomiphene and letrozole together tend to lengthen your existing cycle. The above prediction is based on a person who had a 28 day cycle but women who are not ovulating and do ovulate on this combination have similar cycle dynamics. Women, who usually have a 24 day cycle, may experience an ovulatory cycle which is only 26 or 28 days long. Women, who have extremely long cycles or no cycles at all, may ovulate in very long cycles.

Intercourse should occur **whenever you feel like it**. One of the more stressful aspects of infertility is that intercourse tends to become regimented and only for the purpose of conceiving. There is no good evidence that having intercourse, even frequently outside of the “fertile window” will decrease the chances of pregnancy. In fact, on the contrary, there is good evidence that couples that **have more frequent intercourse become pregnant faster**. Intercourse also has relationship building and stress relieving benefits. Recent evidence has also indicated general health benefits and improvement of sperm counts from frequent intercourse.

There is also no evidence that any particular sexual frequency clustered at ovulation is better. Advice has been given in the past that intercourse every two days will allow a higher sperm count. It is true that when we request a semen analysis, you are asked to abstain for 48 hours so that we can estimate the maximal sperm count. However, ejaculation into the vagina allows the number of sperm in the female to be additive and of different ages.

**One of the misconceptions about infertility is that intercourse should be only every other day in order to maintain a high sperm count. An example might help to clarify this. A couple has intercourse in the morning and 100 million sperm are deposited in the vagina. The couple then has intercourse later that same day and only 75 million sperm are deposited in the vagina because the sperm count is decreased by the earlier ejaculation that day. However, there are now 175 million sperm in the vagina, thus increasing the total number of sperm where it counts!**

We believe sperm live in the female reproductive tract about 48 hours. If intercourse occurs **at least every other day from the 10th to the 20th day of the cycle** there should always be sperm available when the egg is released. This recommendation is based on the usual scenario of clomiphene and letrozole making the cycle 28 to 32 days long. In circumstances where we think ovulation is occurring, but the cycle length is different than this, the recommendation for frequent intercourse times may have to be modified. For example, in the woman who’s usual cycle is 24 days and clomiphene and letrozole lengthens this to 27 days, intercourse should occur from day 9 to 17 of the cycle.

In rare circumstances when intercourse is not possible frequently (illness or work commitments which require separation of the partners), detection of ovulation may be important to time intercourse. In this circumstances, basal body temperature charts, urine based ovulation detection kits (I.E. Clearplan Easy or Ovukit), or the newer saliva kits may be used. Often this may be an indication for earlier graduation to intrauterine insemination. (Information sheets are available)

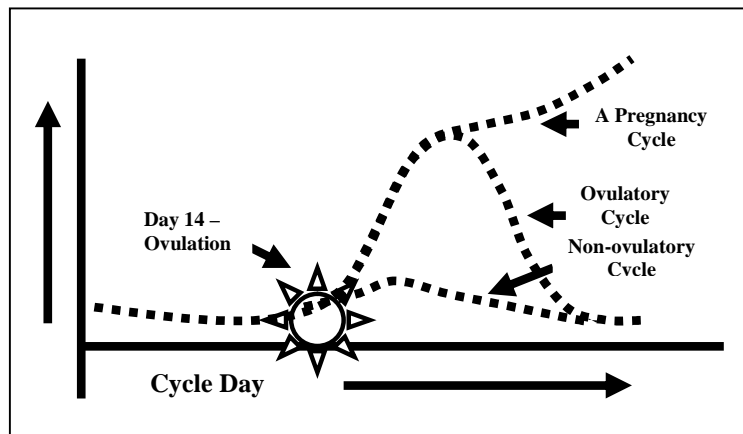
### **Determining If Ovulation Occurs**

It may not be critical to determine when ovulation occurs but it is important to determine whether ovulation is occurring. If menstruation is about 28 or 32 days after the first day of the last period, then ovulation has likely occurred. In this program, we prefer to confirm ovulation with “**luteal phase progesterone**”. This is usually done 6 days before the next period is expected to occur, if a pregnancy does not occur. Because the usual clomiphene and letrozole cycle is 28 to 32 days long, this would be day **21 to 23 of the cycle** but will be sooner in the cycle if clomiphene and letrozole produce a shorter cycle (I.E. day 18 in a 24 day cycle). If this information sheet has been given to you at the

clinic with a prescription for clomiphene, you should also be given a lab requisition for 6 repeats of your progesterone level. This can be done in at a lab nearest your home. If the desired testing day falls on a Sunday, the test can be done the Monday morning. The results will automatically be sent to the clinic and arrive about a week later. **It is probably only important to know the progesterone level if clomiphene and letrozole combination is not producing the usual cycle lengths.** Progesterone level of 16 or greater indicates ovulation. A progesterone level of less than 16 indicates that ovulation did not occur or did not occur at the usual time.

For example, if your period was 28 to 32 days in length and the progesterone is 16 or greater, you probably released an egg (ovulated). If another cycle of clomiphene and letrozole is prescribed, you should repeat the same cycle as long as it is within the pre-agreed number of cycles. If your period was outside this range and/or the progesterone was less than 16 and your pregnancy test is negative, you probably didn't ovulate or didn't ovulate at the usual time. We will likely advise you to increase your clomiphene dose (letrozole usually stays the same). If the clomiphene dose has already been increased, we may change your medication or do something to make clomiphene work better. Call S.O.F.T. (519-685-5559) for instructions. The clinic only calls you if your progesterone is less than 16. If we don't call you, then the progesterone level was likely over 16. In this case you will have to call the clinic if you want to know your exact level.

Higher is not necessarily better although occasionally very high progesterone levels may foreshadow a pregnancy. That is not because a higher progesterone indicates a better ovulation but because in a cycle where a pregnancy occurs, the progesterone continues to rise rather than having the usual "bell curve shaped" rise.



If your period does not come in 35 days, call the clinic for a lab requisition for a pregnancy test. If your BHCG is positive, we at S.O.F.T. will want to book an early pregnancy ultrasound.

### What If Ovulation Does Not Occur?

The most common circumstances for use of this combination is when higher doses of clomiphene have been unsuccessful at inducing ovulation. If you had regular cycles and clomiphene and letrozole was given to you to promote the production of more than one egg but appears to have caused you not to ovulate it may not be the right

**Clomiphene is associated with a doubling to tripling of the pregnancy rate in women who are already ovulating because it increases the number of eggs. However, in a small minority of ovulatory women (<5%), it causes them to not ovulate. In this case, it is of no benefit and other forms of treatment should be perused.**

combination for you. Sometimes it will be tried once more or a modest increase in the clomiphene component (IE 75 mg from day 3 to 7) will be tried but usually it will be abandoned early in favor of another treatment. If this occurs we will often monitor a cycle with blood tests and ultrasound, much like we monitor for intrauterine insemination. This will tell us exactly what is happening to your cycle and allow us to choose alternate treatments. Information on how this monitoring is done is available in the information sheet on intrauterine insemination with clomiphene citrate and letrozole.

Some women, who are not ovulating naturally, will not ovulate with clomiphene and letrozole. If you don't ovulate with the lowest dose of clomiphene, a higher dose will be tried (the letrozole component usually remains the same). Usually, the highest dose that is attempted is 150 mg from day 3 to 7 of the cycle. Even though higher doses may cause ovulation, they are less likely to cause pregnancy because of the negative effects of clomiphene on the endometrium and cervical mucous at higher doses.

If this happens, some treatments are available to make them

more sensitive to clomiphene and letrozole. Sometimes the addition of injectable fertility medication will allow ovulation to occur with a previously unsuccessful level of clomiphene and letrozole. This of course is only done with careful monitoring of the cycle and usually includes intrauterine insemination.

In up to 60% of women with polycystic ovary syndrome have **insulin resistance**? Insulin resistance occurs when the body is required to produce more insulin to keep the blood sugar normal than usual. It is not diabetes but predisposes to diabetes later in life or during a pregnancy. If your cycles are irregular or you have a family history of diabetes, you will likely be tested for insulin resistance with your day three blood work done for your initial workup. Treatment of this with metformin or advandia will often make ovulation more likely to occur with clomiphene and letrozole. Recently, several reports have indicated that metformin treatment may be beneficial even if the initial insulin resistance testing is within normal limits. An information sheet is available on decreased ovulation.

**Other specific medications** may be used in circumstances where there is increased production of androgens from the adrenal glands. A recent study has demonstrated that dexamethazone can be used to decrease the adrenal glands

**Increasing the dose of clomiphene is helpful in non-ovulatory women who do not ovulate on the lowest dose of clomiphene because higher doses may cause ovulation and therefore make pregnancy possible. There is however a down side to this. The higher the dose of clomiphene required to produce ovulation, the fewer pregnancies that occur per ovulation. This is because of the negative effects of clomiphene on the cervical mucous and endometrium and is why we will usually move on to a different treatment if ovulation dose not occur with 150 mg of clomiphene for 5 days.**

**Polycystic Ovary Syndrome was called Stein-Leventhol Syndrome after two gynecologists who first investigated women who did not ovulate. They took wedge biopsies from the ovaries of these women. However, they found that when they did the biopsies, the women would often start to ovulate! This is now believed to work because it decreases the intra-ovarian male hormone level and can be more easily done by burning the surface of each ovary in 6-10 places during a laparoscopy.**

production of male hormones in the first half of the cycle to promote ovulation. We are about to initiate a clinical trial to determine if there are predictors of when this approach will be useful.

**Ovarian cauterization or drilling** at the time of laparoscopy may also be considered. Ovarian cauterization or drilling has been demonstrated to cause the resumption of normal ovulation or cause an improved response to clomiphene in many patients. Although this sounds crazy, it works very well. It was discovered serendipitously like many things are in medicine (see box on previous page). More information is available on laparoscopy and ovarian cauterization in the information sheet on laparoscopy.

## Determining If Pregnancy Has Occurred

If a period does not occur after **35 days** from the first day of your last period, a **pregnancy test** should be done. You should call the clinic (or your family doctor's office) and a requisition for *BHCG* (blood pregnancy test) can be called or faxed in for you. (A pregnancy test can also be done at the clinic and usually the results will be available the same day - therefore *"it's worth the drive to London"*). If you are pregnant, the test will be positive but may take a few days to get to our office if done elsewhere. If you would like to know the results of your test faster, you may wish to write "copy to your family doctor or local gynecologist" in the forth box down on the left hand side of the requisition. If you are pregnant, you will be offered a vaginal ultrasound at the clinic to evaluate the pregnancy and especially to diagnose a twin pregnancy. If you are not pregnant and your period is delayed, it is unlikely that you have ovulated. You should contact the clinic so that medication to bring on a period (Provera etc.) and the dose of clomiphene in the clomiphene letrozole combination can be increased or some other change can be made for the next cycle. **If ovulation has not occurred on a given dose of clomiphene, that dose should not be continued**; a higher dose should be prescribed or other forms of treatment employed.

## What If It Doesn't Work

Clomiphene and letrozole with "timed intercourse" is often considered as part of the first line of infertility treatment. This is often referred to as ovulation induction. It is worth trying in almost any couple as long as at least one fallopian tube is open and extremely severe male-factor infertility is not present. In most studies the pregnancy rate per cycle using clomiphene letrozole or clomiphene with letrozole is about 5 to 10%. Although this may not seem very high, it is still very reasonable first line treatment as 6 cycles will allow up to 50% of women who are not ovulating, and 30% of women who are ovulating a pregnancy.

However, ovulation induction doesn't always work. Many options may be considered but the most common is the **intrauterine insemination**. This may originally be combined with clomiphene and letrozole or stronger medications. An information sheet on intrauterine insemination is available.

**The usual pregnancy rate using ovulation induction in most studies is 5% per cycle. Your expected pregnancy rate is estimated at the time of the consultation when clomiphene is suggested. It depends on whether ovulation is occurring without clomiphene, the female age, the length of infertility and the other causes of the infertility. If the pregnancy rate for ovulation induction is at least 5% per cycle, 6 cycles will be suggested. However, if because of a female age over 35, a length of infertility over 2 years, or a decreased chance of success because of male or tubal factor, fewer cycles may be suggested.**

## Side Effects

The major side effect of clomiphene is an increase in the frequency of multiple births. The addition of letrozole in the lowest dose does not appear to change this. **Twins occur in 5 to 8%** of these pregnancies and triplets are very rare.

Clomiphene and letrozole usually causes the ovaries to become larger as they are making more eggs. This does not cause pain but you may be aware that there is more going on in that area of your body and often gives the sensation of bloating or pressure. However, occasionally, abnormal **enlargement of the ovaries** or a persistent cyst can occur. This is very rare and can be easily diagnosed in the clinic with a vaginal ultrasound. If it does occur, it will respond to withdrawal of the drug for a cycle or two. Extremely rarely (0.1%), patients will over-respond to clomiphene and letrozole, forming many cysts. This can also easily be diagnosed at the clinic using a vaginal ultrasound. In this case, the dose of clomiphene in this combination is reduced or an alternate treatment will be suggested. In the past, patients on clomiphene required pelvic examinations between each cycle, but there is good evidence now that this is not necessary even when the clomiphene is combined with letrozole.

**Hot flashes** are the most common side effect while you are taking either of these drugs. This occurs because clomiphene works by fooling the body into thinking there is less estrogen and letrozole blocks its production. With less estrogen the body can simulate symptoms of menopause. Letrozole may cause headaches in a very small group of women (<1%) who are sensitive to low-estrogen headaches. This usually does not occur in the low dose usually combined with clomiphene but occurs more frequently when letrozole is used in higher doses by itself. Letrozole also seems to cause a very unique kind of fatigue or tiredness (usually again, in higher doses when it is used by itself). This is described by our patients as being a very pleasant feeling of “really being ready for bed” as apposed to a drugged tiredness.

**Other adverse reactions**, occurring less frequently (1% or less of patients), include breast tenderness, headache, nervousness, dizziness, nausea and vomiting, fatigue and temporary visual disturbances.

**Overall most women find clomiphene and letrozole give very few side effects and are easily tolerated. If you are experiencing many side effects or finding taking this combination unpleasant, please discuss this with us. If you have pain in the last half of a clomiphene cycle, please call the clinic and ask for a vaginal ultrasound.**

## **Safety**

Clomiphene has been in clinical use since 1963. For most of that time it has functioned as the usual first step in fertility treatment except for couples with blocked fallopian tubes or severe male factor infertility. No one knows how many pregnancies have occurred using clomiphene but it is probably in the hundreds of thousands, if not in the millions. No clinical trial has ever demonstrated an increase in congenital abnormalities using clomiphene. Clomiphene does cause an increase in the twinning rate from 1.2% to 5%. Twins are a more difficult pregnancy and associated with more complication.

No large study, similar to those of clomiphene, has been possible yet as letrozole has only been used for ovulation induction since 1999. However, letrozole has so far appeared very safe. Please read a detailed

**THE RECENT CONTRAVERSITY**  
**Recently, the use of Femara for infertility has come into question. We do not believe that Femara is dangerous in any way and this is detailed both on the femara and the femara for fertility information sheets. Before considering femara, one of these should be read. We are willing to discuss this with you at the clinic at any time.**

account of the issues surrounding the safety of femara before using it. Theoretically it should be even safer than clomiphene as it is eliminated from the body more rapidly. In fact, by the time ovulation occurs in most cycles almost no letrozole is left!

### Is Clomiphene and Letrozole Right for You?

Who knows? All the epidemiological data has been discussed earlier in this information paper but epidemiological studies describe the results in large groups of patients. This data will be used to decide how many cycles of clomiphene should be used. However, individuals get pregnant and it has been my experience that in individuals there is a **key to obtaining a pregnancy**. It is not always possible to predict what that key is. Sometimes, “just clomiphene has produced some remarkable results. Therefore unless the fallopian tubes are blocked or there are very few sperm, clomiphene is worth trying at least once.

### Clomiphene and Letrozole with “Timed Intercourse” Cycle – Day By Day

Cycle Day	Instructions	Patient Notes
Day 1	This is the first day of menstrual bleeding requiring protection (as long as the bleeding occurs before midnight)	
Day 3	Take letrozole 7.5 mg (3 X 2.5 mg)	
Day 3-7 (5-9)	Take clomiphene citrate as prescribed. The starting dose is 50 mg. If you don't ovulate this is increased each cycle by 50 mg.	
Day 10 to 20	Have intercourse a minimum of every two days.	
Day 21, 22 or 23	Go to the lab and for serum progesterone. You will be given a “Laboratory Requisition” with this information sheet. You can call S.O.F.T. for this result about a week after it is done. If you would like the result faster the test can be done at S.O.F.T.	
Day 35	If your period does not begin, call the clinic or your family doctor for a BHCG (pregnancy test). Pregnancy tests are done at S.O.F.T. on the same day.	
Day 54-56	If pregnancy test positive, call S.O.F.T. to book an early pregnancy vaginal ultrasound	

### When you're Pregnant

After a positive pregnancy test, you will be asked to attend the clinic about 40 days after your insemination for a vaginal ultrasound. By this time we should be able to clearly see the gestational sac (bag of waters) inside the uterus. A multiple pregnancy can also be diagnosed.



It also is possible to diagnose problems with the pregnancy such as a miscarriage or ectopic pregnancies.

Although a perfectly normal ultrasound cannot guarantee a normal pregnancy because it cannot predict the future, it is very reassuring. At least 90% will go on to be normal.

**Normal “luteal day 40” or  
“early pregnancy” ultrasound  
of a single pregnancy**

When the ultrasound is done, your due date will be calculated and a report will be sent back to your referring physician informing them of your pregnancy and asking them to take over your obstetrical care.

It is at this time we will also remind you of the **Clinic Rules**. Rule one is you have to send us a birth announcement and rule two is that you have to bring the baby to visit us.

James Martin MD ©

S.O.F.T.

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**Check out our web page at [www.soft-infertility.com](http://www.soft-infertility.com)**