Introduction
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Human sub-fertility and infertility have been source of personal misery. The desire to procreate is universal. Childlessness may be tragedy to the married women and can be a cause of marital upset as well as a personal unhappiness and ill health.

The having of children cements a marriage. Childlessness were once and still are in some communities, regarded as a disgrace, as a mark of Divine displeasure, as grounds for divorce and even for compulsory suicide on the part of female only.

Term infertility is defined as involuntary childlessness after one year of unprotected conception (WHO). It excludes the period during which contraception is used.

Infertility may be primary or secondary. Primary infertility – If conception has never occurred. Secondary infertility - If patient fails to conceive after having produced a child or had an undoubted miscarriage.

Incidence of infertility in general population is 10-15%. Pathological infertility may be due to male factor alone i.e. 8-22% or female factors alone i.e. 25-37%. Both may contribute for 21-38% of cases. In 8-14% of cases no cause is detected (FIGO Manual, 1990). Infertility due to female factors alone may be due to tubal factors i.e. responsible for 36-44% of cases, due to ovulatory factors i.e. responsible for 26-44% of cases and endometrial factors that are responsible for 1-100/0 of cases (FIGO Manual, 1990).

As ovulation is an obvious prerequisite to conception, ovulation must be documented as part of the basic assessment of the infertile
couple. A woman with regular menstruation at approximately 4.5 wk interval with monilial symptoms such as premenstrual breast swelling/tenderness and dysmenorrhoa almost invariably have ovulatory cycles. Ovulation may be documented by menstrual history, daily charting of basal body temperature, endometrial biopsy to know the hormonal status, Cervical mucus study, transvaginal ultrasonography and hormonal study of plasma progesterone and leutinizing hormone.

Ovulatory disorder may be oligoovulation i.e. infrequent ovulation or may be anovulation i.e. complete absence of ovulation. Ovulatory disorders may be due to menstrual defect at any level of hypothalamic pituitary ovarian axis or due to other endocrinological causes as thyroid disease, adrenal or hypoadrenergic oligoovulation.

According to level of defect in hypothalamus, pituitary or ovary ovulation is induced. If hypothalamic and pituitary functions are normal, clomiphene is drug of choice.

In patient with ovulatory function infertility with hyperprolactinemia treatment with bromo-cRIPTIN is added to ovulation induction. Addition of Dexamethasone to ovulation induction regimen for women with hyperandrogenism and ovulatory factor infertility is beneficial.

Women who fail to ovulate or to become pregnant with clomiphene citrate as well as after addition of bromocriptin or dexamethasone and in woman with hypogonadotrophic hypoestrogenic anovulation i.e. defect at pituitary level are treated with human menopausal gonadotrophins i.e. follicular stimulating honnone and leutinizing honnone, combination or follicular stimulating honnone alone or combination of clomiphene citrate with HMG.
type of the failure with functional pituitary and ovaries are the best candidates for ovulation induction with gonadotrophin releasing hormone GnRH.

Other treatment modalities to ovulatory disorder as in polycystic ovarian is wedge resection of ovary. In luteal phase dysfunction clomiphene and progesterone are given.

Out of the various modalities used for ovulation induction, clomiphene citrate is the first line of treatment. It is the simplest, least expensive, safe and non invasive form of ovulation. Clomiphene citrate is a non-steroidal compound, weak synthetic estrogen but it acts clinically as an estrogen antagonist for ovulation action at typical pharmacological doses. It binds to the cytoplasmic estrogen receptors and thus acts as antiestrogenic in humans. It induces gonadotrophin (Gn) secretion by blocking feedback inhibition of the pituitary and also antagonises some of the peripheral actions of estrogen. The ovaries respond to Gn stimulation by producing ovulation.

Success rates with the use of clomiphene citrate for ovulation induction are excellent i.e. ovulation rates of 80-85% and conception rates of 40%. The discrepancy between ovulatory rates and conception rates is most likely secondary to the presence of additional, nonovulatory infertility factors. Most pregnancies occur during the first 6 months of therapy.

Clomiphene citrate is typically used for ovulation induction in following manner - the drug is supplied in 50 mg tab. The usual starting dose - is 50 mg/day from day 2 or 3 after the spontaneous menstruation or progesterone withdrawal bleeding and is continued upto 5 days.
If ovulation does not occur at the initial dosage, the dosage is increased in each subsequent cycle by 50 mg/day may be given up to 250 mg/day. In the present study Clomiphene is used for 10 days in 100 mg doses in patients not responding to standard 5 days regimen with the theme that duration of therapy may be more important to its success than the total dose of clomiphene citrate per cycle and it is cost effective too.