**Comparison of Two Doses of Recombinant Human Chorionic Gonadotropin (rhCG) During Ovulation Induction in Intrauterine Insemination Cycles: A Prospective Randomized Clinical Trial**

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**Abstract:** The purpose of this study was to compare the effectiveness of two doses of recombinant hCG (500 and 250 μg) on the reproductive outcome through triggering of oocyte maturation. The study was a randomized controlled clinical trial. Healthy women undergoing IUI cycles (n = 66) were randomly assigned to one of two groups at the start of the cycle. Group control (n = 33) received rhCG (250 μg) and group experiment (n = 33) received rhCG (500 μg). Controlled ovarian hyperstimulation was achieved using clomiphene or letrozole and hMG. Semen specimens were washed using the swim up method and IUI using a volume of 0.3 mL was performed 42 h after rhCG injection. No difference was shown in terms of obtained total follicles and pregnancy rate in both groups. However, when all of the cycles which given 250 or 500 μg of rhCG were stratified by the BMI (more and less than 25 kg m⁻²), Total follicles (more and less than 2 follicles) and infertility duration (more and less than 5 years), the reproductive outcome in the patients with less than 5 years infertility duration and less than 25 kg m⁻² BMI was more pronounced than the patients with more than 5 years infertility duration and more than 25 kg m⁻² BMI but the other parameter was not affected the reproductive outcome. No clinical or statistical improvement could be demonstrated, except infertility duration and BMI, for the higher dose of recombinant hCG in women. However, further well-designed studies are essential to offer a final conclusion.

**Key words:** Recombinant hCG, body mass index, infertility duration, follicles, reproductive outcome

**INTRODUCTION**

In general, hCG has been used as an alternative to LH for inducing final follicular maturation and ovulation in women undergoing ovarian stimulation for intrauterine insemination (IUI) or intracytoplasmic sperm injection (ICSI) (Melli et al., 2007; Moslemizadeh et al., 2008).

The success in inducing ovulation of follicles is dependent on the optimum concentration of LH required for the initiating meiosis and triggering the release of the cumulus-oocyte complex into the follicular fluid (Salina et al., 2001; Ghasemzad et al., 2007; Iluekwunere et al., 2008).

Several clinical studies have shown that the 250 and 500 μg of rhCG which represents the lower and upper limits of the dose range, have been inconsistently effective in terms of obtained number of oocytes, clinical and ongoing pregnancies, delivery and miscarriage rates (Kahraman et al., 2010; Kashyap et al., 2010; Humaidan et al., 2010; Bstandig et al., 2005). However, the clinical use of rhCG is associated with certain unwanted effects attributed to its biological power, since it is assumed that the biological activity of rhCG is six fold higher than LH, mainly due to its longer half-life and affinity for the common receptor (Gomez et al., 2004; Lorzadeh et al., 2007). As an example, Ovarian Hyperstimulation Syndrome (OHSS) which is an hCG-dependent phenomenon (Guimera et al., 2009; Zargar et al., 2011), is mediated through the expression, production and secretion of Vascular Endothelial Growth Factor (VEGF) in human granulosa cells (National Collaborating Centre for Women’s and Children’s Health, 2004; Rafi et al., 2011).

The trouble of high Body Mass Index (BMI), duration of infertility and the poor response in overweight and elderly patients to a standard dosage of rhCG are also discussed (Arora and Samples, 2011).

Therefore, it is not clear, due to controversial literature which dose of recombinant hCG, 250 or 500 μg, is an effective dose to induce final oocyte maturation and also avoid OHSS in patients. The purpose of this study is to conduct a prospective randomized...
study in order to compare two doses of recombinant hCG in women, whether triggering of final oocyte maturation with either 500 μg or the gold standard of 250 μg of rhCG has any effect on the reproductive outcome.

MATERIALS AND METHODS

Drug and media: Recombinant human chorionic gonadotrophin (rhCG) was purchased from Serono Laboratories (Ovidrel; Serono). The sperm wash media was obtained from SAGE (USA).

Study design: The study was a randomized controlled clinical trial. Through the period from June 2009 to April 2010, healthy women between the ages of 22 and 44 years undergoing IUI cycles (n = 66) for the treatment of non-tubal infertility (ovulatory disorders, early-stage endometriosis, mild male factor and idiopathic infertility) were randomly assigned to one of two groups at the start of the cycle. Group 1 (control, n = 33) received rhCG (250 μg) and group 2 (experiment, n = 33) received rhCG (500 μg).

It’s worth mentioning that the Infertility is a failure to conceive during a year of unprotected intercourse and as well as for couples who are older or have problems with their reproductive organs, doctors sometimes consider them infertile after six months (Garrido et al., 2001). The Ethics Committee of Jundishapur Alhaz University of Medical Sciences approved this study.

Patient assessment included demographic information as well as medical and gynaecological histories with physical examination and routine laboratory screening (including BMI, CBC, pap smear, TSH, PRL and viral serology). The partner underwent semen analysis, CBC and viral serology.

Controlled ovarian hyper stimulation was achieved using clomiphene or letrozole and hMG (Ferargal; Serono). Ovarian response was monitored by ultrasound. When two or more follicles were > 16 mm rhCG by dose of 250 or 500 μg was used to induce ovulation.

Semen specimens were washed using the swim up method and a single IUI using a volume of 0.3 mL was performed 42 h after rhCG injection.

Pregnancy was documented by the serum hCG level 2 weeks after the insemination. If pregnant, a vaginal ultrasound was carried out 2 weeks later. The outcome of the pregnancy rate was determined.

End points: The end point of the study was a comparison of side effects and the pregnancy rates between the two groups.

Statistics analysis: All analyses were carried out with the SPSS 16 statistical software. Continuous variables were expressed as mean for numeric variables and also were expressed as number and percent for categorical variables. Categorical variables between groups were compared using Student's t, χ² tests or Fisher’s exact test where appropriate. Mann-Whitney test was employed to evaluate independent numerical variables because of abnormal distribution. For all other outcomes, a nominal p-value of p<0.05 was considered significant.

RESULTS

A total of 86 cycles were randomized and available for investigation. Twenty of the women refused to participate to the study. Of the remaining women, 33 patients were injected s.c. with 250 μg of recombinant hCG (rhCG) and 33 women were given 500 μg of rhCG s.c.

The mean ages of all of the patients was 32.3±4.5 years with a range of 22 to 44 years. The median duration of infertility of women was 8.7±8.0 years with a variety of 9 months to 14 years. The mean body mass index (BMI) was 26±6 kg m⁻² with a range of 20 to 44 kg m⁻².

Baseline characteristics were comparable in the two groups. The two groups were found to be identical with respect to age, BMI, kind of infertility, duration of infertility, number of previous trial, duration of stimulation, the type of procedures used, the total dose of gonadotropin injected, number of retrieved follicles and semen analysis(TMC, Motility and morphology of sperm) (Table 1).

When analyzing per cycle, the overall clinical pregnancy rates were 9.9 and 12.1% for group 1 and 2, respectively (Table 1). There was no significant difference in the order of the clinical pregnancy between these two groups.

Table 1: Baseline characteristics women who admitted to the department were comparable in the two groups

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Dosage of rhCG groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>250 μg</td>
</tr>
<tr>
<td>Age (years)</td>
<td>28.5±3</td>
</tr>
<tr>
<td>BMI (kg m⁻²)</td>
<td>27.2±5</td>
</tr>
<tr>
<td>Kind of sterility (primary)</td>
<td>19 (57.6)</td>
</tr>
<tr>
<td>Kind of sterility (secondary)</td>
<td>14 (42.4)</td>
</tr>
<tr>
<td>Duration of infertility</td>
<td>5.0±4.6</td>
</tr>
<tr>
<td>Number of follicles</td>
<td>5.5±1</td>
</tr>
<tr>
<td>Total sperm count</td>
<td>1.4500000±505</td>
</tr>
<tr>
<td>Morphology of sperm</td>
<td>8.7±2.9</td>
</tr>
<tr>
<td>Motility</td>
<td>38.9%</td>
</tr>
<tr>
<td>Dose of gonadotropin</td>
<td>18.0±1.2</td>
</tr>
<tr>
<td>Follicle (size = 16 mm)</td>
<td>2.1(25.3)</td>
</tr>
<tr>
<td>Pregnancy rate</td>
<td>3.9(9.9)</td>
</tr>
</tbody>
</table>

*Values are as Mean±SE, Values in brackets are percentage
Table 2: The variety of all of the cycles (n = 66) were categorized by the mean number of follicles into group 1:2 follicles and group 2:2 follicles

<table>
<thead>
<tr>
<th>Groups</th>
<th>1:2 follicles</th>
<th>2:2 follicles</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>250 µg rhCG*</td>
<td>6 (18.2)</td>
<td>27 (81.8)</td>
<td>0.001</td>
</tr>
<tr>
<td>500 µg rhCG**</td>
<td>5 (15.2)</td>
<td>28 (84.8)</td>
<td>0.001</td>
</tr>
<tr>
<td>Pregnancy rates</td>
<td>0 (0.0)</td>
<td>4.7 (100)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Values in brackets are percentage. *Patients were given 250 µg rhCG. **Patients were given 500 µg rhCG

Table 3: The variety of all of the cycles (n = 66) were categorized by the mean BMI into group BMI<25 kg m⁻² and group BMI>25 kg m⁻²

<table>
<thead>
<tr>
<th>Groups</th>
<th>BMI&lt;25 kg m⁻²</th>
<th>BMI&gt;25 kg m⁻²</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>250 µg rhCG*</td>
<td>14.0 (24.4)</td>
<td>19.0 (75.6)</td>
<td>0.05</td>
</tr>
<tr>
<td>500 µg rhCG**</td>
<td>11.0 (33.3)</td>
<td>22.0 (66.7)</td>
<td>0.05</td>
</tr>
<tr>
<td>Total follicles***</td>
<td>3.2 (52.5)</td>
<td>4.7 (47.5)</td>
<td>0.87</td>
</tr>
<tr>
<td>Follicle</td>
<td>2.3 (69.7)</td>
<td>1.0 (30.3)</td>
<td>0.05</td>
</tr>
<tr>
<td>(Size =16 mm) ****</td>
<td>4.0 (57.2)</td>
<td>3.0 (42.8)</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Values in brackets are percentage. *Patients were given 250 µg rhCG. **Patients were given 500 µg rhCG. ***Mean total follicles were obtained from each cycles, ****Mean number of follicles obtained that the size of them was more than 16 mm

Table 4: The variety of all of the cycles (n = 66) were categorized by the duration of infertility into group D1:5 years and group D>5 years

<table>
<thead>
<tr>
<th>Groups</th>
<th>D1 ≤5 years</th>
<th>D&gt;5 years</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>250 µg rhCG*</td>
<td>20 (60.0)</td>
<td>13 (39.6)</td>
<td>0.001</td>
</tr>
<tr>
<td>500 µg rhCG**</td>
<td>16 (48.6)</td>
<td>17 (51.5)</td>
<td>0.387</td>
</tr>
<tr>
<td>Mean total follicles***</td>
<td>6.7 (9.6)</td>
<td>3.3 (9.6)</td>
<td>0.001</td>
</tr>
<tr>
<td>Follicle</td>
<td>2.6 (78.8)</td>
<td>0.6 (11.8)</td>
<td>0.001</td>
</tr>
<tr>
<td>(Size =16 mm) ****</td>
<td>3.6 (76.6)</td>
<td>1.1 (23.4)</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Values in brackets are percentage. *Patients were given 250 µg rhCG. **Patients were given 500 µg rhCG. ***Mean total follicles were obtained from each cycles, ****Mean number of follicles obtained that the size of them was more than 16 mm

No significant undesirable reactions at the place of injection were noted in any of the patients. There were no subjects of severe Ovarian Hyper Stimulation Syndrome (OHSS).

Since the mean number of follicles, BMI and also duration of infertility may be have a direct relation with reproductive outcome through triggering of oocyte maturation by the variable dosage of rhCG, the differences between each of them were assessed.

When all of the cycles (n = 66) were categorized by the mean number of follicles into group 1 = 2 follicles and group 2:2 follicles, there was no significant difference in the distribution of rhCG doses between the groups. Also, this difference was not strong statistically and did not affect the pregnancy rates (Table 2). The proportion of follicles with diameters more than 16 mm to the total follicles was not significant in both more and less than two follicles groups whether one or two rhCG preparations were injected (Table 2).

When all of the women were stratified according to their BMI (BMI = 25 kg m⁻² and BMI>25 kg m⁻²), there was no significant difference in the distribution of rhCG doses between the groups as well. However, When 250 µg rhCG was used, a significant difference was observed in the mean of the BMI = 25 kg m⁻² in comparison to the mean BMI>25 kg m⁻² in terms of total follicles. Nevertheless, this difference was not strong statistically to affect the rate of pregnancy. The proportion of follicles with diameters more than 16 mm to the total follicles was not significant in both more and less than 25 kg m⁻² BMI groups whether one or two rhCG preparations were injected (Table 3).

When all of the patients were stratified according to their duration of infertility (D1 ≤5 years and D>5 years), there was significant difference in the distribution of rhCG doses between the groups.

Also the significant differences were found in the D>5 years group in comparison to the D1 ≤5 years group in terms of total follicles and follicles with more than 16 mm size (p<0.05 and p<0.05). Additionally, the pregnancy rates in the patients with less than 5 years infertility duration was more pronounced than the patients with more than 5 years infertility duration (p<0.05) (Table 4).

**DISCUSSION**

The results of the present study have shown that both doses were capable of inducing follicular maturation and ovulation. Indeed, the number of oocytes, on the day of intrauterine insemination was not significantly higher with two of recombinant hCG preparations than with the single dose. However, whether the quality of the follicles released in these forms is optimal stays to be clarified. These findings are also in accordance with other three studies done by Chang et al. (2001), Sakhel et al. (2007) and Tsoumpou et al. (2009). Chang et al. (2001) were showed that both of doses are effective and well tolerated in the induction of MII oocyte and ovulation in patients undergoing IVF treatment. Sakhel et al. (2007) have also found similar clinical outcomes with 250 µg of recombinant hCG or 500 µg urinary hCG during IVF treatment in normal responder patients. Tsoumpou et al. (2009) obtained the same number of mature oocytes and similar implantation rates in embryos derived from women treated with single and two dose of hCG.

In contrast, Gomez et al. (2004) reported that low dose of rhCG is more efficient to achieve optimal oocyte maturation, with fewer incidences of OHSS, than a high dose of rhCG. Busso et al. (2010) observed that the rhCG at the highest dose increase VP and expression of VEGF that may be running the risk of provoking Ovarian Hyper Stimulation Syndrome (OHSS) or Poly Cystic Ovarian Syndrome (PCOS).
The present study also identified that the mean number of follicles with more than 16 mm size were identical in single and two doses of rhCG, but comparison of clinical pregnancy and also healthy ongoing rates could be a supplementary step towards understanding the advantages and disadvantages of different gonadotropin doses.

Although, the events initiated by the mid-phase surge of LH and FSH are presented together, certain amount of LH and FSH may be needed in order for these events to happen (Moeini et al., 2009). Bornsel-Helmreich et al. (1989) was shown that lower doses of hCG induce nuclear maturation but inducing follicular maturation needed higher doses. This may also be the case in humans where a time-or dose-dependent phenomenon leads to the initial elevation in progesterone 12 h before the LH surge, the final maturation of the oocyte 32 h after the surge and ovulation 36 h after the LH surge (Segers et al., 2008; Fauser et al., 2002; Kilic et al., 2010). Thus, it would be logical to determine the optimal rhCG dose to induce ovulation.

In the present experiment no difference was shown in terms of obtained total follicles and pregnancy rate in patients, if they were not categorized according to their BMI, infertility duration and the range number of follicles, whether 250 or 500 µg of rhCG was injected for the final maturation of follicles. However, when all of the cycles were stratified by the above mentioned parameters (BMI: 25 = vs. >25 kg m⁻²; group 1 = 2 follicles > group 2 and infertility duration 5 = vs. >5 year), the reproductive outcome in the patients with less than 5 years infertility duration and as well as less than 25 kg m⁻² BMI was more pronounced than the patients with more than 5 years infertility duration and more than 25 kg m⁻² BMI but the other parameter was not affected the reproductive outcome.

In patients undergoing IVF treatment, fatness has been associated with require for higher doses of gonadotropins, increased cycle cancellation rates and less oocytes retrieved (Awartani et al., 2009; Erel and Senturk, 2009). Moreover, in obese women undergoing IVF treatment, the rate of embryo transfer, pregnancy and live birth was decreased but the miscarriage rate was increased (Devroye et al., 2009; Fedorosak et al., 2004). On other hand, other studies have been able to find positive influence of slenderness on ART outcome (Lorusso et al., 2008; Anifandis et al., 2005; Martinuzzi et al., 2008).

In contrast, other studies have reported that cycle parameters, such as clinical pregnancy, implantation and the occurrences of moderate and severe OHSS, were also found to be no significant in both higher and lower BMI, infertility duration and mean number follicles groups (Chen et al., 2010; Bastek et al., 2008).

Within the considerations of this prospective randomized experiment it can conclude that 250 µg of recombinant hCG, except in women with a BMI higher than 25 kg m⁻² or infertility duration more than 5 years, is sufficient and safe to trigger ovulation.

No clinical or statistical advantage could be demonstrated, except infertility duration and BMI, for the higher dose of recombinant hCG in women. However, well-designed, further studies are essential to say a final conclusion.

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REFERENCES


