JTGGA CME/CPD CREDITING

Answer form for the article titled *"Pharmacokinetic, pharmacodynamic, and clinical aspects of ovulation induction agents: A review of the literature"* within the scope of CME/CPD

1. **Which of the following statements regarding selective estrogen receptor modulators is incorrect?**
   a) Increasing the dose of clomiphene citrate (CC) up to 250 mg daily does not have any detrimental effect on endometrial receptivity.
   b) Tamoxifen may also be utilized for ovulation induction in lie of CC.
   c) Enclomiphene is the more potent form of CC with shorter half life.
   d) Tamoxifen has a slightly higher elimination half life than CC.
   e) Raloxifene is primarily administered for treatment of osteoporosis.

2. **Choose the incorrect advantage of aromatase inhibitors over selective estrogen receptor modulators during ovulation induction.**
   a) Following oral administration their elimination half time is 2 days.
   b) Hypotalamopituitaryovarian axis remains intact during ovulation induction treatment and this advantage results with monofollicular ovulation and lower multiple pregnancy rates.
   c) Absence of hostile antiestrogenic effect of CC on endometrium and cervix is another benefit of aromatase inhibitors.
   d) When compared with CC, higher live birth and ovulation rates have been achieved with ovulation induction by using letrozole among infertile women with the polycystic ovary syndrome.
   e) When compared with CC, higher live birth and ovulation rates have been achieved with ovulation induction by using letrozole among unexplained infertile women.

3. **Which of the following statements about injectable gonadotropins is the weakest one regarding evidence based medicine?**
   a) Achievement of higher number of oocytes with lower total doses and shorter stimulation time, recombinant follicle-stimulating hormone (rFSH) has been found to be more potent than urinary FSH.
   b) In poor responders, r-hLH supplementation of r-hFSH compared with rhFSH alone may result in significantly higher oocyte number, clinical pregnancy rate and ongoing pregnancy rate.
   c) Equivalent pregnancy rates and ovarian hyperstimulation syndrome (OHSS) incidences have been found between rhCG or rhLH and urinary human chorionic gonadotropin (uhCG) when used for final follicular maturation in in vitro fertilization.
   d) Recombinant gonadotropins seem to be more advantageous regarding pregnancy rates when compared with urinary derived gonadotropins.
   e) Urinary derived products consist a mixture of the gonadotropins with unpredictable clinical efficiencies and biologically active mediators like binding proteins, growth factors and prion proteins.

4. **Select the inconvenient clinical situation for administration of gonadotropin-releasing hormone (GnRH) agonists to trigger ovulation.**
   a) Expectation of >25 mature follicles during ovulation induction.
   b) Oocyte donors.
   c) Women demanding to freeze autolog oocytes for fertility preservation.
   d) Women proceeding with fresh embryo transfer accompanied by conventional luteal phase support.
   e) Women with extremely high serum estradiol levels during ovulation induction.

5. **Which of the following statements is not an advantage of antagonist protocol over long agonist protocol during ovulation induction?**
   a) When compared with long GnRH agonist protocols, the antagonist protocol was associated with a wide decrease in OHSS rates.
   b) Total gonadotropin dose and duration of stimulation are significantly lower by using antagonist regimens when compared with long agonist regimen.
   c) Antagonist regimens seem to be more successful for poor responder patients when compared with long agonist regimens.
   d) Unlike long agonist protocol, possibility for utilization of GnRH agonist trigger strategy during antagonist protocol lowers OHSS risk.
   e) Antagonist regimens exert their effect on blocking premature luteinizing hormone (LH) surge more rapidly than agonist regimens.

6. **Choose the incorrect statement for different clinical conditions regarding selection of ovulation induction drugs.**
   a) Selective estrogen receptor modulators should be the first drug of choice for polycystic ovary syndrome patients.
   b) Gonadotropin regimens including LH activity seem to be more successful regarding achieved oocyte number for women older than 35 years.
   c) The clinical indications for utilization of commercially developed fixed dose (2/1) (FSH/human menopausal gonadotropin) including drugs have been exactly defined.
   d) Modification of luteal phase support following GnRH agonist triggering increases the pregnancy rates.
   e) Aromatase inhibitors should be the drug of choice for women who have a history of any cancer stimulated by estrogen.

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Questions on the article titled *"Pharmacokinetic, pharmacodynamic, and clinical aspects of ovulation induction agents: A review of the literature"* within the scope of CME/CPD

1st Question				
A	*B*	*C*	*D*	*E*

2nd Question				
A	*B*	*C*	*D*	*E*

3rd Question				
A	*B*	*C*	*D*	*E*

4th Question				
A	*B*	*C*	*D*	*E*

5th Question				
A	*B*	*C*	*D*	*E*

6th Question				
A	*B*	*C*	*D*	*E*

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