

## Follicular phase estradiol administration can be the easiest way of cycle scheduling and follicular synchronization



Dear Editor,

We read the article by Banker et al. (1) with pleasure because their results support our prior observations (2–4). We had also compared 2 matched cycles of 59 oocyte donors, 1 with follicular estradiol scheduling (FES) and 1 without (2, 3). Both were flexible gonadotropin-releasing hormone antagonist cycles; however, different from the study by Banker et al. (1), we administered 2 mg of estradiol valerate tablets 3 times a day, from cycle day 2 until commencement of gonadotropins on a scheduled day (1, 2).

We collected a similar number of oocytes after significantly longer stimulation (on average by 1 day) and higher gonadotropin consumption (on average, 93 IU) (2). Yet, the differences were probably clinically insignificant. In contrast, Banker et al. (1) reported significantly higher oocyte yield with similar duration of stimulation and gonadotropin consumption with FES (1). The differences in oocyte numbers can stem from the different duration of FES in the 2 studies, on average 2 versus 5.7 days, in our study and the study by Banker et al. (1), respectively (1, 2). The longer duration of FES may have served to synchronize follicular cohort. Both our study and the study by Banker et al. (1) are nonrandomized cohort studies, which can be considered hypothesis generating, and whether FES increases oocyte yield through synchronization after a certain duration seems worthy of triage by an adequately large randomized controlled trial. We would suggest that this trial would include women undergoing assisted reproductive technology with autologous oocytes for better assessment of implantation potential. If FES proves to be an easy method of cycle scheduling and synchronization of the follicular

cohort with potential to improve oocyte yield, its use can be extended to a wider patient population.

Although the claim of Banker et al. (1) to be the first to develop FES in donors is incorrect given our prior publications (2, 3), they are to be commended for providing the serum follicle-stimulating hormone levels, following up recipients, and reporting the implantation and pregnancy rates with or without FES.

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