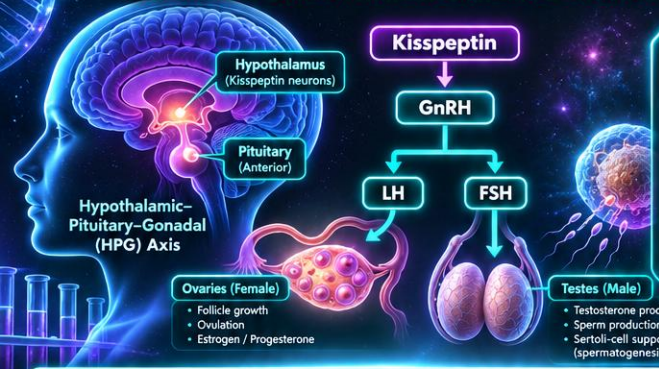
PEPTIDE PERSPECTIVES®

THE FERTILITY SUPPORT STACK

Reproductive Peptides, Hormone Signaling & Complementary Supplements



WHY FERTILITY IS DIFFERENT

- Fertility is a coordinated hormone-timing problem, not a single-hormone problem.
- Meaningful outcomes: ovulation, mature eggs, sperm production, pregnancy, and live birth.
- More LH, FSH, or testosterone does not automatically improve fertility.

5 STACKS / CLINICAL STRATEGIES

DOSES BELOW ARE COMMUNITY-REPORTED OR SPECIALIST-CONTEXT EXAMPLES, NOT VALIDATED SELF-TREATMENT PROTOCOLS.

A FSH + hCG

Selected female protocols / selected male fertility use



WHAT IT TARGETS: Follicle growth + LH reception signaling.

DOSING: Typical specialist-context dosing: FSH 75–225 IU daily during stimulation; hCG trigger 5,000–10,000 IU once (or 250 mcg r-hCG once).

✓ Established specialist treatment in selected diagnoses. Monitoring required.

B hCG + FSH (Male Fertility)

Hypogonadotropic hypogonadism



WHAT IT TARGETS: Intratesticular testosterone + Sertoli-cell support.

DOSING: Community / specialist-reported ranges: hCG 1,500–2,000 IU 2–3x/week; FSH 75–150 IU 2–3x/week.

✓ Response may take months. Not appropriate for every cause of low sperm count.

C GnRH Agonist + hCG

Dual trigger IVF approach



WHAT IT TARGETS: Endogenous LH/FSH surge + LH receptor activation.

DOSING: Specialist protocol example: leuprolide 0.2–0.5 mg once + hCG 1,000–5,000 IU once.

✓ Selective IVF use only. OHSS risk and timing matter.

D Kisspeptin + hCG

Investigational upstream/ downstream pairing



WHAT IT TARGETS: Hypothalamic reproductive signaling + direct LH receptor activation.

DOSING: Community-reported / investigational context: kisspeptin 100–200 mcg episodic use; hCG 250–500 IU 2–3x/week or trigger-contest dosing.

✓ No validated combined safety or pregnancy advantage.

E Kisspeptin + GnRH-related Therapy

Experimental adjacent-step signaling



WHAT IT TARGETS: Upstream kisspeptin signaling + GnRH receptor pathway.

DOSING: Community-reported context: kisspeptin 100–200 mcg episodic use; gonadorelin 100–200 mcg pulsatile or episodic.

✓ Can overlap or interfere with signaling. Entirely experimental.

IMPORTANT CLINICAL COMPARATORS

- **Letrozole:** 2.5–7.5 mg daily for 5 days in selected ovulation-induction protocols.
- **Progesterone support:** protocol-dependent, often 100–200 mg vaginal or oral support in selected cycles.

COMPLEMENTARY NUTRIENTS

Nutrient	Key Note
Folic acid	400 mcg/day before conception and early pregnancy
CoQ10	200–600 mg/day discussed in fertility research
Zinc	15–30 mg/day if intake is low; avoid excess
Selenium	100–200 mcg/day; avoid excess
Vitamin D	Correct deficiency when identified
Omega-3s	1–2 g/day EPA/DHA commonly discussed
Myo-inositol	2–4 g/day often discussed in PCOS
Iron	Only when deficient
Choline	Important in pregnancy planning
Protein / energy intake	Undernutrition can impair fertility

WHAT GOOD FERTILITY RESEARCH MUST MEASURE

- Ovulation or mature egg yield
- Sperm production and semen quality
- Clinical pregnancy
- Live birth
- Complications and safety



KEY CAUTIONS

- Pregnancy and fertility care require specialist oversight.
- Hormone combinations can cause OHSS, cycle disruption, multiple pregnancy, or suppressed sperm production.
- Community protocols are anecdotal and not validated treatment plans.