be saddled with the meaningless pseudo-scientific inertia-creating diagnostic label 'empty follicle syndrome'.

It shows instead the need to examine practices within the clinic itself. These should include as illustrated by our experience, analysis of the timing of the oocyte collection and an appraisal of the expertise of the operative and embryologist on duty that day. As illustrated by Dr Zegers-Hochschild et al., an assessment of the quality of the drugs being used at the time is also wise.

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Laparoscopic unwinding of hyperstimulated ovaries during the second trimester of pregnancy

Dear Sir,

We read with great interest the report by Levy et al. (1995) which concerns the safety of laparoscopic unwinding of the ovary during the second trimester of pregnancy.

The statement concerning the lack of data on the safety and efficacy of this procedure is not strictly accurate. The authors fail to recognize that this technique had already been described after being performed during pregnancy in two cases (Shalev et al., 1990) and later in a cumulative 4 year series (1988–1991) of 10 pregnancies (Shalev and Peleg, 1993).

Since that report, we have performed ovarian cyst unwinding during pregnancy in four additional cases. In all, we have carried out 14 cases during pregnancies of gestational age 5–18 weeks; all had positive outcomes.

References

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Dear Sir,

We appreciate the comments raised by Dr. Shalev in regard to our paper (Levy et al., 1995).

We were aware of Dr. Shalev’s previous publications (Shalev et al., 1990; Shalev and Peleg, 1993). Nevertheless, we did not cite these papers in view of their irrelevance to our current study.

Our paper deals with tormented hyperstimulated ovaries in the second trimester of pregnancy and suggests special safety measures during laparoscopic detorsion, whereas our colleagues’ papers deal with detorsion of unstimulated ovaries during early pregnancy.

Furthermore, the first series dealing with pregnancy outcome after unwinding of twisted ischemic adnexae was published prior to Dr. Shalev’s study and were extensively cited in our text (Bider et al., 1989; Ben-Rafael et al., 1990; Mashiach et al., 1990).

References

Prophylactic intravenous albumin for the prevention of severe ovarian hyperstimulation syndrome

Dear Sir,

We read with great interest the article by Ng et al. (1995) entitled 'Intravenous albumin does not prevent the development of severe ovarian hyperstimulation syndrome in an in-vitro fertilization programme'. In this study the authors demonstrated that the administration of 5% human albumin solution does not prevent the development of severe ovarian hyperstimulation syndrome (OHSS) in at-risk patients, while it does appear to blunt the severity of the condition. However, in this study OHSS presented on average 8.9 days post-oocyte retrieval in the albumin and the control groups, which may be regarded as late rather than early OHSS. Since a dose of 25–50 g of albumin is usually retained only transiently in the circulation, it should be repeated every 1–2 days in order to achieve a sustained effect. Therefore, pharmacodynamically, it would be right to assume that this prophylactic therapeutic measure may...