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 were 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
modulate early rather than late severe OHSS, and it is not surprising that Ng et al. (1995) could not demonstrate an effect of human albumin on the development of late severe OHSS.

Moreover, we applied this treatment to 30 patients from a group of women undergoing in-vitro fertilization (IVF) in our unit and at risk of developing OHSS according to the advocated criteria. Two of these patients subsequently developed severe early OHSS, necessitating early transabdominal aspiration of ascites and intensive fluid and colloid replacement.

Considering the prevention of any disease (Orvieto et al., 1993), it should be emphasized that the possibility of primary prevention depends on two main requirements: firstly, the aetiology of the disease must be known, including causative and predisposing factors; and secondly, it must be feasible to avoid or manipulate such factors as part of a preventive strategy. Furthermore, secondary prevention requires knowledge of the pathophysiological mechanisms of the disease, availability of early detection methods, and means to intervene and correct these pathophysiological changes. In view of the fact that secondary prevention requires the availability of early detection methods, and because there is considerable disagreement regarding the sensitivity and predictive values of the various patient characteristics, it would be premature to draw definitive conclusions on the efficacy of i.v. human albumin in the secondary prevention of severe ovarian hyperstimulation syndrome (SOH). Moreover, although albumin is probably not the ideal preventative measure against SOH, we believe that the role of i.v. human albumin should be re-examined in a specific subgroup of patients prone to developing SOH, as detected by a more reliable predictive test such as one using interleukin (IL)-2 concentrations, which were recently demonstrated to be significantly higher in follicular fluid obtained at the time of oocyte retrieval in patients who subsequently developed severe OHSS, in comparison with a matched control group of patients who did not develop OHSS (Orvieto et al., 1995).

Further research should be directed extensively toward investigating the fundamental cause(s) of OHSS, in order to secure primary prevention of the disease. The development of a simple and more reliable predictive test for OHSS will allow accurate detection of the specific subgroup of patients who may benefit from any means of secondary prevention.

References

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