right internal jugular vein thrombosis despite mini-dose heparin prophylaxis. After successful treatment with heparin, the twin pregnancy was ongoing. Emergence of vascular thrombosis during prophylactic anticoagulation therapy is extremely rare. As discussed by the authors, haemoconcentration occurring during OHSS and alteration in blood viscosity promoting stasis and the usual immobility can increase the risk of thromboembolic events. Furthermore, changes of hypercoagulability and the fibrinolytic system are observed. Other important risk factors for haemostasis-like thrombotic defects may be pre-existent in this patient group. Factor-V-Leiden (APC-resistance) is the most important thrombophilic mutation (Bertina et al., 1994) with a frequency of 7% in the population (Svenssson and Dahlback, 1994). The individual risk rises 10-fold in a heterogeneous carrier of this genetic disorder (Svenssson and Dahlback, 1994). To minimize the risk of a thromboembolic event during human menopausal gonadotrophin (HMG) stimulation or even more during OHSS, the presence of a factor-V gene mutation should therefore be excluded as recently reported by Horstkamp et al. (1996). Other coagulation abnormalities, e.g. in the protein-C/protein-S system or the anti-thrombin III, are less frequent but should also be ruled out in patients with suspicious histories. If a prothrombotic defect is detected, prophylactic anticoagulation therapy during HMG stimulation, pregnancy and puerperium should be initiated. The development of OHSS should then result in enhanced anticoagulation therapy.

References

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Dear Sir,

Thank you for forwarding the letter by B. Horstkamp commenting on our paper (Hignett et al., 1996). We realize that certain inherited coagulation abnormalities increase the incidence of potential thrombosis, but presently in our country, it does not appear to be cost efficient to test everyone prior to the therapy as the incidence is low, even though the potential consequences are high. In the ideal world, it would be nice if we could test everyone and try to avoid thromboembolic disease.

Reference

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Spontaneous pregnancy after previous pregnancy by oocyte donation due to premature ovarian failure

Dear Sir,

Oocyte donation has been proven to be successful in establishing pregnancy in a functionally agonadal patient. An exaggerated conception rate was noted in a premature ovarian failure (POF) patient after oocyte donation (Check and Chase, 1984). However, a report on the resumed fertile condition after a successful pregnancy by oocyte donation in a POF patient has not been documented. Here, we present a case of spontaneous pregnancy after a successful pregnancy by oocyte donation in a POF patient.

The patient was a 37 year old female (gravid 3, para 0, artificial abortion 3) with a history of secondary infertility for 10 years. She had the onset of menarche at age 15 and regular menstruation till the age of 27, when oligomenorrhea developed and finally amenorrhoea occurred at the age of 32. She visited a private clinic where pelvic sonographic examination and hysterosalpingography did not reveal any abnormality. POF with high serum gonadotrophin and low oestrogen concentrations was diagnosed at that time. Hormone replacement therapy (HRT) and corticosteroids were prescribed and she was referred to our infertility clinic for further management. Initial physical and general laboratory examinations were normal; no goitre or lymphadenopathy was present. There was no previous history of autoimmune endocrine disease in this patient or her family members. The serum concentrations of thyroxin, thyroid-stimulating hormone, testosterone, prolactin and cortisol were all within normal ranges. The serum concentrations of follicle stimulating hormone (FSH) and luteinizing hormone (LH) were 74.2 mIU/ml and 35 mIU/ml respectively. The serum oestradiol concentration was <20 pg/ml. The patient was treated with a high dose of human menopausal gonadotrophin (HMG; Pergonal, Serono, Rome, Italy) without any response. After a thorough counselling, oocyte donation was selected as the option which offered a reasonable chance of achieving pregnancy. Two oocytes were retrieved from her sister by transvaginal aspiration. The patient’s cycle was synchronized to that of her sister by a sequential and incremental treatment of premarin (Wyeth-Ayerst, Philadelphia, US). Premarin was given orally 1.25 mg on days 3–8, 2.5 mg on days 9–11, and 3.75 mg on days 12–28. Progesterone in oil 25 mg was given i.m. from the day of oocyte retrieval for 2 days and then 50 mg daily from the day of embryo transfer for 14 days. Two 4-cell embryos fertilized by her husband’s spermatozoa were transferred into the left Fallopian tube by laparoscope and a twin pregnancy was confirmed by ultrasond 3 weeks later. The woman was kept on hormone replacement consisting of premarin 5 mg/day and i.m. progesterone 100 mg/day for the first 10 weeks’ gestation. At 38 weeks’
gestation, two healthy babies (2862 g and 2780 g respectively) were delivered via Caesarean section. HRT with premarin 1.25 mg/day for 25 days and medroxyprogesterone acetate (provera; Upjohn, Kalamazoo, Michigan, USA) 10 mg/day on days 13–25 were administered 2 months after delivery. Regular withdrawal bleeding occurred with HRT. She conceived spontaneously 9 months later and a healthy male baby was delivered at 38 weeks gestation, again by Caesarean section.

It has been observed that women who have a previous successful pregnancy following oocyte donation are likely to conceive in a subsequent trial (Edwards, 1992). Our case demonstrates spontaneous ovulation and conception after previous pregnancy by oocyte donation. The patient had well-documented history of POF and the gonadotrophin treatment was not successful, so how did the spontaneous pregnancy occur? Some theories have been suggested, such as: (i) pregnancy and HRT may restore ovarian receptors to FSH and LH, thus restoring the ovulation function (Kreiner and Droesch et al., 1988); (ii) the hormone change during pregnancy may induce the proliferation and differentiation of primordial follicles and induce spontaneous ovulation (Kreiner and Droesch et al., 1988; Masson and Fonseca et al., 1992); and/or (iii) pregnancy may improve ovarian vascular circulation and permit the access of gonadotrophin to the ovaries (Nelson et al., 1992). Successful pregnancy by oocyte donation may play a role in initiating the cascade of events leading to spontaneous conception. The events may possibly act through more than one of the mechanisms mentioned above. If so, HRT was administered soon after delivery.

Although the effect of HRT on POF patients seems unjustified (Richards and Midgley, 1976; Sauer and Paulson, 1993), we recommend immediate HRT after a successful pregnancy by oocyte donation in POF patients to increase the possibility of spontaneous conception in future.

References


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Information access and donated gametes

Dear Sir,

The paper by Broderick and Walker (1995) seems to be a valuable comment on the shortcomings of methodologies used in surveys about access to information and the use of donated gametes. There is no doubt that serious researchers would welcome the evaluation of methodologies so that when flaws are discovered steps can be taken to rectify these mistakes. This process will lead to better research and more meaningful results. However the writers have extrapolated their results to reach a conclusion which needs to be challenged.

It needs to be clearly understood that I have no criticism of the conclusion they have reached regarding the accuracy of the surveys and the methodologies. The authors have concluded that since the survey results are questionable the therapeutic injunction regarding disclosure to the child is ipso facto also invalid. This conclusion is ill-founded. The decision to disclose information to the child is an ethical decision which needs to be based on principles and reasoned arguments and is not necessarily related to any survey results. The ethical decision-making process may be assisted by being aware of people’s attitudes and what the majority think; however, to assume that a majority view is necessarily a good ethical decision is false.

Furthermore, to believe that ethical issues are solved by surveying people and using the majority view as the ethical stance is to sink into the mire of relativism or to fall for the 'is—ought' trap.

The 'strongly argued line' for full disclosure of information is contained in the excellent arguments put forward by Bok (1978), Berger (1982), Davis and Brown (1982), Scott (1984), Kass (1985), Winkler and Midfords (1986), Noble (1987) and Matot and Gustin (1990) to name just a few. These authors have mounted powerful arguments for truth about disclosure independent of any survey results.

References


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