

### Should we explore OHSS full clinical scope?...

Dear Sir,

A rather impressive number of publications can be found in recent years describing 'interesting' clinical manifestations of ovarian hyperstimulation syndrome (OHSS) (Lesny *et al.*, 1999; Khalaf *et al.*, 2000; Lamon *et al.*, 2000; Loret de Mola *et al.*, 2000; Rabinerson *et al.*, 2000; Semba *et al.*, 2000; Tang *et al.*, 2000). One may have the impression that we are haunted by a morbid desire to explore the full scope of OHSS clinical manifestations, while mumbling the inevitable mantra: '...severe OHSS still cannot be completely eliminated' (Tang *et al.*, 2000). It is time to change our attitude.

Let us take a closer look at the most recent publication cited above (Tang *et al.*, 2000). An IVF patient had a cycle during which the oestradiol concentration had reached 17504 pmol/l on the day of administration of human chorionic gonadotrophin (HCG) and 19 oocytes were retrieved, clearly, a 'high responder' patient at risk of developing OHSS. Since pregnancy was not achieved, a second stimulation was performed, using the same protocol as the first. This time around, oestradiol reached 20808 pmol/l on the day of HCG and 20 oocytes were retrieved. A transfer of two embryos led to pregnancy and severe OHSS. It is time to admit: this outcome is unacceptable. Either all embryos should have been frozen, or coasting be applied. Yet, a better approach in a known 'high responder' patient is to utilize a GnRH antagonist-based stimulation protocol and a bolus of GnRH agonist to trigger ovulation as was recently described (Itskovitz-Eldor *et al.*, 2000; Kol and Itskovitz-Eldor 2000), eliminating any risk of clinically significant OHSS.

In summary, based on currently available medications and protocols, severe OHSS should be a disease of the past. The relentless quest of exploring its wide range clinical manifestations should be stopped.

### References

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eliminate the syndrome, but the chances of pregnancy are excellent with subsequent frozen-thaw transfers. *Hum. Reprod.*, **12**, 1573–1576.

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Dear Sir,

I would like to thank Dr Kol for his interest and comments on our paper. The aim of the case report is to make us aware of the possible presentation of OHSS so that we will not miss it in case this rare condition occurs.

While I agree that the clinicians should try their best to minimize the risk of severe ovarian hyperstimulation syndrome (OHSS), there is still doubt as to whether it can be completely prevented. We are certainly aware of the various proposed methods of prevention of OHSS. The fact that there are still rather impressive numbers of publications in the recent years means that this condition still exists. We did mention in our paper that the dose of human menopausal gonadotrophin (HMG) could perhaps be reduced in the second cycle. While the strategy of elective cryopreservation of all embryos or coasting may reduce the risk of severe OHSS, the risk is not eliminated entirely (Queenan *et al.*, 1997; Lee *et al.*, 1998). The use of GnRH antagonist is an interesting development. However, in the paper mentioned by Dr Kol (Itskovitz-Eldor *et al.*, 2000), only eight patients were studied. Even the authors themselves said: ‘... further studies are needed to establish this potential advantage’. More studies with the GnRH antagonist are required before a firm conclusion can be drawn as to whether OHSS can be completely prevented.

## References

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