

hundred fifty-eight women at an increased risk for OHSS had been treated without administration of human albumin and a subsequent 49 patients received 50 mg of human albumin in divided doses before and immediately after oocyte retrieval. They noted that 2 of 49 (4.0%) patients who received prophylactic human albumin and 10 of 158 (6.3%) who did not developed severe OHSS. They concluded that the administration of 5% human albumin did not prevent the development of severe OHSS in at-risk patients, but it did appear to blunt the severity of the condition. Thus, although albumin may not be absolute preventative, it may decrease the likelihood of developing severe OHSS.

We agree with Dr. Mukherjee and colleagues that human albumin may be promising as prophylactic administration to minimize or prevent OHSS; however, clinicians must be vigilant about the possibility of developing severe OHSS.

Further elucidation of the basic pathophysiology of OHSS will be required to develop optimal therapeutic options. We agree with Dr. Mukherjee and colleagues that "untempered enthusiasm" for albumin's ability to eliminate the development of severe OHSS is premature. Responsible clinicians must pay careful attention to E_2 concentration and follicular response and must maintain close surveillance of patients at high risk for developing this condition.

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Differential Age of the Endometrium

To the Editor:

The manuscript by Borini et al. (1) seems to provide convincing evidence that despite the fact that

pregnancies have been obtained using donor oocytes even in women >60 years, there is a decrease in uterine receptivity with advancing age. They state that their conclusions are different from a study that we published, also using a shared oocyte program to evaluate uterine senescence, in which Borini et al. suggest that we reached the conclusion that there was no difference in uterine receptivity according to age (2). Actually, we agree with Borini et al.'s conclusions; we previously found a significantly lower pregnancy rate (PR) in recipients ≥ 40 years than those <40 years but found that the older group had a greater frequency of endometria with inadequate thickness (3). By adjusting for endometrial thickness we were able to attain similar PRs in the older and younger groups (2). Similarly, Meldrum (4) found much lower PRs in older versus younger recipients until the dosage of luteal-phase P was increased in the older group. Borini et al.'s study did not adjust for endometrial thickness or dosage of luteal-phase P and thus did not in any way refute the conclusion of our manuscript that "a decline in uterine receptivity for embryo implantation with advancing age is at least remediable with hormonal adjustments" (2). Borini et al.'s study is also interesting because PRs per transfer for donors was the same for younger recipients. Most IVF centers demonstrate higher PRs in donor-oocyte recipients than the normal IVF patients. Borini et al.'s data strongly suggest that the mechanism for the high PRs in recipients is related to the use of superior oocytes. However, recently we have found a significantly higher PR in recipients than donors despite using shared oocytes; also donors were much younger (31.7 years) than recipients (41.2 years) (5). Interestingly, our data showed equal PRs per transfer in donors and recipients from subsequent frozen ETs, suggesting that controlled ovarian hyperstimulation (COH) has a significant role in reducing PRs. The mean age of donors in Borini et al.'s study was similar to ours (30 years) and the COH regimen was similar; also their PR was far superior (48.4%) than the PRs reported by most IVF centers. Thus, Borini et al.'s excellent results may actually lead to erroneous conclusions concerning the mechanism for superior PRs in donor-oocyte recipients. The hope is that by understanding the reason for lower PRs in normal IVF patients, improvements may be made to increase the PRs for the group accounting for most IVF procedures.

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Reply of the Authors:

We thank Dr. Check for his interest on our article (1). Dr. Check suggests to adjust the endometrial thickness by increasing the P dosage. However, we reported in the Materials and Methods section that "before the transfer cycle, endometrial development was assessed in a 'mock' cycle as previously described (2). In the transfer cycle, endometrium line thickness was checked the first day of P, no supplementation being begun if the line was thinner than 9 or thicker than 12 mm. There were no differences between group A and B patients." As you can see, we did not need to adjust the endometrium line thickness. Furthermore, as reported in the Materials and Methods section, we already use 100 mg in oil IM or 600 mg micronized P intravaginally.

We are grateful to Dr. Check for considering as excellent our results, but probably, those are not exceptional results for young women with a large number of oocytes. In our Centre in the last 3 years 140 clinical pregnancies were obtained over 394 transfers performed in women < 35 years with a pregnancy rate (PR) per transfer of 35.5%.

Dr. Check reports his data about a possible detrimental role of controlled ovarian hyperstimulation (COH) for implantation. We never had problem with COH, and if the endometrium is thicker than 8 and thinner than 13 mm, we perform the ET.

We do not think that our results can lead to erroneous conclusions about the mechanism for superior PRs in donor oocyte recipients as Dr. Check suggests. We would like to highlight our study design. Each donor kept part of the eggs for herself and donated the other ones, which were shared by two recipients of different ages. In this way we could control the influence of uterus age and drug regimen. Our data seem to suggest that there are no detrimental effects by COH and that, once again, uterine senescence is involved in the reduced PR. On the other hand, we agree with Dr. Check when he states that "a decline receptivity for embryo implantation with advancing age is at least remediable with hormonal adjustments." In a recent study (3) considering cyclic women > 40 years of age undergoing oocyte donation, we found higher implantation rates and PRs after a long-term downregulation with GnRH-analogue before starting the hormonal replacement therapy. Apparently, we can speculate that uterine senescence decreases implantation rate, but menopause or menopause-like situations allow embryo implantation as well as in young uteri.

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Laparoscopic-Assisted Resection of Colon

To the Editor:

We read with interest the report in the January 1996 issue of *Fertility and Sterility*[®] describing the transvaginal segmental resection of the rectosigmoid colon for endometriosis (1). However, we were surprised to find no reference to the pioneering work