to ultrasound-guided transvaginal transmyometrial embryo transfer. Preliminary results in our first 226 transfer procedures using this protocol showed that in the 13 patients who have had transmyometrial embryo transfer following a failed immediate transcervical mock embryo transfer the pregnancy rate was 30.8% (Sharif et al., 1995c). We recommend this step-wise embryo transfer protocol as a logical solution to the problem of difficult embryo transfer.

References

Khaledoun Sharif, Dimitri Bilalis, Wil Lenton and Masoud Afnan
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Empty follicle syndrome

Dear Sir,

Adding to the literature on the empty follicle syndrome through your journal, Zegers-Hochschild et al. (1995) suggest the problem may be with in-vitro biological activity of human menopausal gonadotrophin (HMG). I question this. Perhaps we are luckier than others but in the 1418 oocyte recoveries carried out since October 23, 1989 to date, we have only ever encountered one such case in this unit.

This was the first oocyte recovery carried out after a hiatus of some 9 months following translocation of the unit from another hospital. Clomid/HMG was the ovulation stimulation regime. Despite assiduous flushing no oocytes were obtained from the seven follicles entered.

Despite flushing follicles at egg collection we do not always obtain oocytes. Our retrieval rate is 80.4 ± 20%. But rather than labelling the above as a case of empty follicle syndrome and calling situations where not all follicles entered yielding oocytes as cases of partial empty follicle syndrome we consider the phenomenon as part of the margin of error that attends oocyte recovery and identification.

A syndrome surely this is not. To label the total absence of oocytes from follicles at retrieval as other than an operative aberration surely attaches unwarranted importance to something which in this unit’s experience does not actually exist.

Reference

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Dear Sir,

In response to the letter sent by Dr Robert F. Harrison, it seems to me that he did not read the article with enough attention. I would like to clarify the following:

Firstly, the article does not refer to an abnormality in the in-vitro biological activity but to an abnormality in the in-vivo biological activity of the drug.

Secondly, in the article no reference is made to an abnormality in human menopausal gonadotrophin (HMG) but rather to human chorionic gonadotrophin (HCG). In fact, it clearly shows that the ovarian response to HMG is normal.

Thirdly, the article does not refer to the absence of oocytes in just one or two follicles, but to the absence of identifiable oocytes in each of the follicles aspirated in six consecutive women.

Lastly, it is difficult to understand how the absence of HCG and progesterone in follicular fluid as well as the absence of circulating HCG 12 h after i.m. injection of 10 000 IU of HCG can be interpreted as an ‘operative aberration’.

In his letter, Dr. Harrison reports a retrieval rate of 80 ± 20% which means that in some cases, he obtains eggs in only 60% of the follicles aspirated. If this is the case, in young women with adequate ovarian response perhaps a more profound explanation should be provided before labelling such a case as an expected ‘margin of error that attends oocyte recovery and identification’.

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Dear Sir,

Our inclusion of the words ‘in-vitro’ and ‘HMG’ rather than ‘in-vivo’ and ‘HCG’ were careless typographical errors on our behalf which should have been detected. For these we apologise.

However, in terms of the main thrust of our letter, if, instead of suggesting empty follicle syndrome to be ‘an operative aberration’ we had used the phrase ‘an occurrence of iatrogenic origin’ perhaps Dr Zegers-Hochschild would have realized we were actually supporting him, albeit for different reasons.

When no oocytes whatsoever are obtained at a collection in the presence of apparent adequate stimulation this does not immediately indicate that the problem lies with a woman’s ovaries per se. Therefore, she does not deserve to