Sir,

The ovarian hyperstimulation syndrome (OHSS) is a serious complication of ovulation induction therapies used in infertile patients.\textsuperscript{[1,2]} Enlargement of the ovaries, ascites, pleural...
effusion, electrolyte imbalance and oliguria are the characteristics of this syndrome.\textsuperscript{[1,2]} The pathophysiological mechanism of OHSS is not fully elucidated but biochemical substances like histamine, cytokines and prostaglandins are thought to play a role in its etiology.\textsuperscript{[3]} Increased capillary permeability causes protein-rich fluid to leave the intravascular compartment and results in hemoconcentration.

OHSS in the absence of exogenous gonadotropins is very rare and only a few cases have been reported in literature. OHSS can occur spontaneously and it can also cause acute abdominal pain during pregnancy. Prompt diagnosis and successful medical management is likely to avoid any unnecessary surgical interventions.

A 21-year-old nulliparous woman presented with lower abdominal pain, nausea, abdominal distension and shortness of breath. She was unable to urinate for the last 24 hours. Both her past medical and gynaecologic history was unremarkable. Transvaginal ultrasound showed a singleton pregnancy of 11-weeks, massive ascites and bilateral multilobulated cystic ovaries both measuring 12 x 9 cm [Figure 1]. Physical examination revealed severe abdominal distension and marked diffuse tenderness with guarding and rebound was also noted. Laboratory testing showed hemoconcentration, hyponatremia and hyperkalemia. Serum levels of hepatic transaminases were slightly elevated and serological tests (Anti-HAV IgM, HbsAg, Anti-HCV) remained negative.

OHSS was the initial diagnosis but the patient denied usage of any medication for ovulation induction. Ovarian torsion and malignancy were ruled out with normal Doppler sonography and normal tumour marker levels. With the diagnosis of spontaneous OHSS, conservative medical treatment was considered appropriate. The patient responded well to intravenous fluid therapy of normal saline (1 lt/day) and 20% albumin (200 ml/day). A reasonable urinary output was maintained in 48 hours and abdominal pain also relieved. She was discharged on 10\textsuperscript{th} day post admission and ovaries returned to normal in 3 months. She had a normal vaginal delivery at term and gave birth to a healthy male infant.

Vassart et al\textsuperscript{[1]} provided a novel insight into the pathophysiology of OHSS, explained in detail the normal structure and function of glycoprotein hormone receptors as well as their different mutations. Activating mutations of FSH receptor results in excessive stimulation of the ovaries and OHSS ensues.

Figure 1: Transvaginal ultrasonography in a 21-year-old woman with spontaneous OHSS shows: (a) Right ovary with multilobulated cysts (b) Embryo (11 – weeks) and gestational sac (c) Left ovary with multilobulated cysts

Akerman et al\textsuperscript{[4]} investigated HCG/LH receptor gene mutation in one case and claimed increased response to normal HCG levels because of this mutation. Unfortunately, we could not get consent from the patient to search for FSH or HCG/LH receptor gene mutation.

In literature, different cases were reported in which spontaneous pregnancy with OHSS and hypothyroidism was found together. It was claimed that high levels of thyroid stimulating hormone can stimulate ovaries in women with hypothyroidism and can cause ovarian hyperstimulation.\textsuperscript{[5]}

This case showed us that ovarian hyperstimulation syndrome can also be spontaneous and that it can cause acute abdomen during pregnancy. It is vitally important to diagnose and manage spontaneous OHSS promptly to prevent any unnecessary surgical interventions.

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References

Sir,
Ulceration of the cornea due to fungi (mycotic keratitis) is an important ophthalmologic problem in the developing world, where agriculturalists are at risk for ocular trauma by fungus-laden plant material or soil particles.\textsuperscript{[1]} Keratitis caused by rare or emerging fungi may pose diagnostic challenges to the clinician under such circumstances. We describe in this paper, keratitis due to Cylindrocarpon (Fusarium) lichenicola, an emerging fungus, in a 56-year-old Indian male.

Keratitis due to Cylindrocarpon lichenicola

The patient, a farmer, presented with complaints of pain, redness and irritation of the left eye following ocular injury caused by hay 5 days earlier. He was not a contact lens-wearer and did not give a history of any prior ocular disease. Slit-