Construction on our facility expansion has formally begun, with all necessary ground evaluations and drilling to assess what kind of a foundation the expansion will require already behind us. We are exited that things will be very quickly moving forward now, with Phase-1 being further excavation of our current basement and rock below, and expansion of the basement for the full length of the current courtyard. This will become the foundation for the 3-floor( above ground) addition. The third-floor addition will occupy only a small part of the current courtyard, while the first two floors, like the basement, will stretch for its whole length.

Our current basement, which up to now served only as a storage facility, will, together with its expansion into the courtyard, become a normally “inhabited” floor, with office space for administrative and scientific laboratory staff and expanded laboratory facilities, mostly for research purposes.

Phase-2 of the construction will involve building the new three-floor structure in the courtyard. The new above ground floors, hopefully, will be completed and sealed off from the elements later this year. Once that is accomplished, Phase-3 of construction starts with building out the interiors of the new addition, including a brand-new IVF Unit, which will no longer be on the 4th floor but will be located directly off the main waiting area on the ground floor, with entrance from the main waiting room. Patients undergoing procedures, therefore, will no longer have to utilize the elevator (nor will heavy gas balloon deliveries, which should extend the lifespan of our beloved “antique” elevator).

Phase-3 will also involve moving the office of our Chief Operating Officer (COO), who is currently located where the entrance into the new IVF Unit will be. Her new office, larger and much more visitor-friendly, will move to the third floor, occupying the limited third-floor space of the new addition we were given Landmark Commission permission for.

Phase-3 of the construction will also include build-out of the new Clinical Coordinator Center (CCC) and Conference Room, which together will occupy the second floor of the new addition, above the new IVF unit. Both of these two units will be bigger than they were before, and will be quickly convertible into a small lecture room for after-hour seminars, which have become more frequent events at CHR in recent years, as we are welcoming more visiting scientists from all over the world for scientific exchanges.

Probably most pressed for space have been our clinical coordinators. The new CCC will not only give them the needed additional space but also make their lives easier (and more efficient) in many other ways: First, the CCC will be separate from the area where coordinators provide physician support. That area, on the third floor of the current facility, remains the same. The new CCC, thus, represents additional space for the coordinators, where each will have her own “office-space” for direct patient management.

Second, the new CCC is centrally located, on the same floor where coordinators daily participate in morning ultrasounds/monitoring, and only one flight of stairs up from the new IVF Unit. All of their activities will, therefore, be concentrated on floors 1-3, with their individual “offices” located right in the middle on the 2nd floor.

Once the IVF Unit has been moved into its new quarters, Phase-4 of the construction will begin, completely rebuilding the center’s 4th floor. Currently, a significant part of CHR’s administrative functions is, because of lack of space, located at a satellite office on Madison Avenue. This office manages all of CHR’s continuous medical education (CME) activities, including Grandrounds; the center’s extensive editorial activities; the center’s comprehensive websites; communication activities and other additional marketing and commercial responsibilities.

With completion of Phase-4 all of these activities will move back “home” into the building, which will simplify internal communications, and shorten the “commute” to meetings for our staff currently located at this remote site.

So, no surprise that we all, here at CHR, are very exited that the shovels are finally going into the ground, after a long New York City approval process and a very detailed planning process to ensure that this construction will not cause significant interruption to normal functions at the center. We have selected our contractor not the least because of his demonstrated ability to carry through complex construction problems like ours on time, at cost and with minimal interference to ongoing operations. A project of such size, of course, also requires a little bit of luck in staying on schedule. We are doing everything possible from our end to help ourselves to as much good luck as can be purchased. The rest is up to higher authorities!

The construction process will, of course, very quickly become visible, and that fact alone can become somewhat disruptive. Should that be the case, we apologize in advance.

Please be assured that security throughout the center during the construction period has been further tightened for all areas that require confidentiality of medical records or restricted access to safeguard eggs, sperm, embryos or other biological specimens. Should you, as a patient, nevertheless, have concerns at any given point, please
Many consider OHSS potentially the most dangerous complication of fertility treatments and, most certainly, of ovarian hyperstimulation with fertility drugs. Why some women develop OHSS is still not well understood, especially since some women can develop the condition even if not severely hyperstimulated, based on number of growing follicles and/or estradiol hormone levels.

The risk of OHSS increases with number of follicles a woman develops under stimulation. Because these follicles produce the female hormone estradiol, the risk also increases with rising estradiol levels. It is also known to increase in cycles that lead to pregnancy because human chorionic gonadotropin (hCG), produced by the pregnancy, rekindles the risk of OHSS.

The severity of OHSS can vary from mild to moderate to severe. Fortunately, moderately severe and severe cases of OHHS, the latter by definition requiring hospitalization, are very rare in experienced hands. This, indeed, has been the reason why we have not addressed OHSS in these pages for quite some time. Mild cases of OHSS, which are more frequent, are really only characterized by relatively mild symptoms, mostly involving abdominal discomfort, and rarely require significant intervention. OHSS of moderate severity can, due to fluid accumulations in pelvis and abdomen, be more disabling and painful but, in well-trained hands, can usually be managed safely on an outpatient basis.

In contrast, severe OHSS usually requires hospitalization because it, fortunately only in extremely rare cases, can be life-threatening.

Reaching the correct diagnosis

The principal reason why OHSS develops is that bodily fluids escape from blood vessels and accumulate in pelvis/abdomen. In severe cases, fluids also build up in the lung, possibly leading to severe breathing difficulties. The more severe the OHSS, the more fluid has escaped from blood vessels into what is called 3rd spaces. In moderate, and certainly in severe cases, liters of such fluids can accumulated in the abdomen, not only making affected woman look like they are at advanced stages of pregnancy, but also giving them severe discomfort. Patients often experience excruciating pain. They may experience breathing difficulties even if fluid has not yet entered the lungs, because, laying down, the abdominal fluid pushes against the diaphragm. Removing the fluid is a relatively easy office procedure, and instantly makes patients feel better.

Reaching the correct diagnosis of OHSS is not always easy, however, and this is the main reason we discuss OHSS here today. The diagnosis is to a significant degree determined by the patient’s symptoms, and symptoms are always subjective. Some patients have lower, others higher, pain thresholds. But, as already noted above, what complicates the diagnosis even further is that women sometimes can develop OHSS when nobody suspects them to be at risk because they demonstrate only relatively small follicle numbers and modest estradiol levels. In addition, just because a woman is in infertility treatment does not mean she cannot develop other medical conditions, which clinically can present with similar abdominal symptoms, like appendicitis, a twisting ovary or even an abdominal bleeding episode following an egg retrieval in association with in vitro fertilization (IVF).

To make a correct diagnosis in a woman presenting with acute abdominal symptoms is never easy. It is especially difficult if the woman at the same time is also in infertility treatment or just completed a treatment cycle.

Like everywhere in medicine it, therefore, is essential that such women receive care from physicians with the most experience in dealing with such patients. There is only one medical specialty where physicians have frequent experiences with such patients, and that is the infertility specialist! This, of course, is not to say that competent gynecologists, surgeons or emergency room physicians may not reach the correct diagnosis in a woman presenting with OHSS. Many will, but many others will, only after exposing the patient to unnecessary exploratory surgeries.

OHSS is practically never an indication for surgery. Treatment, even in most severe cases, is medical. The same, on a side note, is also true in association with post-retrieval bleeding episodes. Unless the patient is hemodynamically unstable, such patients should never be operated on because bleeding vessels can almost never be identified, the bleeding usually stops, and the blood gets absorbed.

For gynecologists, general surgeons or emergency room physicians less experienced with such patients and rightly very concerned about a very symptomatic patient, with signs of what is called an acute abdomen, it, therefore, is very tempting to recommend what, usually, is the recommended treatment of an acute abdomen: surgical exploration. Except that there are always exceptions to rules in medicine, and what we are discussing here is such an exception. Yes, the patients will demonstrate the typical signs of a “surgical” abdomen; but if she is in or shortly after a fertility treatment, call her physician before taking her into the operating room.

We, therefore, tell all of our patients, egg donors included, if you develop any kind of unusual symptoms while under treatment at CHR, we are for all such circumstances your emergency room. We are available 7 days a week, 24 hours a day (with help of the answering service). If, for some reason, you cannot get hold of us or
if you for whatever reasons still end up in an emergency room, tell the treating physician that you are in infertility treatment (or that you are an egg donor), and have him/her call us before they do anything to you!

And here, a final request of colleagues who may come across one of our patients or egg donors in their office or in an emergency room: Please call us before taking the patient into the operating room!

Why are we addressing this issue now, after not having addressed OHSS in so many years? Because one of our young egg donors recently did end up in a local emergency room! She was one of these young women who did not have lots and lots of follicles and did not have an excessively high estradiol. She called us after her uneventful egg retrieval with symptoms, which sounded like she may have mild OHSS, and was told to come right away to CHR. She, instead, chose to call an ambulance and was taken to a local emergency room.

We are sure you, by now, know the end of the story: She was found to have “ovarian cysts” on ultrasound (every woman after egg retrieval has “ovarian cysts”). Somebody allegedly raised the possibility of appendicitis. Her physician did not bother to call us, took her into surgery and surgically removed some of these completely normal cysts from her ovaries. No other pathology was found!

Remember, here at CHR, we are available for our patients 24 hours a day, 7 days a weeks, 365 days a year. Just call!

- The CHR

“Fighting for every egg and embryo!”