strictures over a short term follow up (now three years) have confirmed our hopes that it supplantated its potential to replace sphincterotomy in managing patients with spinal injuries and, in particular, as an alternative non-invasive treatment for prostate obstruction. We reported our first series of 15 patients earlier this year.

As this is a new treatment, not yet fully evaluated, we have confined its use to those patients for whom conventional surgery would be hazardous and those with large glands in whom radical prostatectomy would be preferable to transurethral prostatectomy. The technique used is as described for urethral strictures,1 but the procedure is carried out under local anaesthesia. We believe that retrograde urethrography is inaccurate, in the presence of urethral strictures. Instead we carry out the procedure under continuous monitoring with transurethral ultrasonography, confirming the position of both the bladder neck and distal sphincter mechanisms visually with a flexible cystoscope.

Our experience of 15 cases supports the report of Williams and colleagues. The mean age of our patients was 69.6 (SD 2.4) years and incorporated the following clinical groups: acute retention (five patients), acute on chronic retention (six patients), chronic retention (one patient), and severe outflow obstruction (three patients). All patients were satisfied with the procedure except one, in whom the procedure will be undertaken as a cure for stress incontinence. We reviewed one of the early cases endoscopically and found at six month follow up that the stent was nearly completely epithelialised, confirming our observations with the use of this prosthesis in the urethra. The follow up of these patients is still too short (4-10 (0.5)-months, range 1-7) to allow definitive comment, but the technique seems to have potential as an alternative to conventional surgery.

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We describe prostatic holoplasty, the term used to describe the procedure described is that it is a form of prosatal augmentation. The procedure is performed under local anaesthesia,2 and the springs are positioned endoscopically by direct vision without radiographic control; the procedure takes from five to 10 minutes. Of 15 patients treated to date, eight patients subsequently voided normally, and seven with chronic retention or dementia, or both (four), failed to void satisfactorily; three of these subsequently had a transurethral prostatectomy but were still unable to void satisfactorily. Our results indicate that patients who are mentally alert who have reasonable bladder function do very well; those with severe dementia and chronic retention of large volumes of urine do rather badly (as commonly occurs after conventional prostatic resection).

The indications for endoprosthetic holoplasty are therefore the same as those for transurethral prostatectomy. However, owing to lack of long term follow up (the longest a spring has remained in situ is six years) selection of patients is advisable. We believe that the procedure is indicated in five groups of patients. These include patients who are medically unfit for surgery (for example, with myocardial infarction or receiving anticoagulant treatment), those with concurrent local or systemic malignant disease who have a short life expectancy, and those in whom the outcome of a transurethral prostatectomy is uncertain (for example, patients with dementia, Parkinson’s disease, severe diabetic neuropathy, and small volume obstructed unstable bladders), when the procedure can be used to evaluate the presence of any extravesical infiltrates. If the procedure is unsuccessful the spring can be removed. In addition patients who require catheterisation for a few weeks before operations would also benefit from this procedure, which permits normal micturition and sexual function. The final group is perhaps more controversial, comprising young patients who have outflow obstruction but are keen to avoid any of the permanent sexual complications that may be associated with conventional transurethral prostatectomy (such as retrograde ejaculation and impotence).

The use of endoprosthetic stents is an important topic for research and a major advance in treating outflow obstruction. Many patients have already benefited from this procedure. Long term follow up and careful study of failures and complications are, however, required before the procedure can be regarded as a standard alternative to conventional transurethral prostatectomy.

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Sir,—Dr G Williams and colleagues’ use of a puncture technique for urinary outflow obstruction (Br Med J 1989;298:1429 [27 May]) would be preferable to that proposed by Fabian.1

We have used the Fabian Uroseptral Endoprosthesi (Porger) for the past nine months. This is a flexible string which keeps the prostatic urethra open and is connected by a straight portion across the external sphincter to a further helical element. This allows spontaneous sphincter control to be preserved. The device (22 French gauge) is smaller than the Wallsten and does not permit catheterisation of the bladder when the urethra is occluded. These disadvantages are compensated for by the ease with which it can be moved or removed at will. For critically sick patients we therefore believe that doing so may be a risk in the BMJ.

The accusation was that a patient had been coerced into donating oocytes in return for a speedy sterilisation. If true, such an inducement must be condemned, but the lack of specificity in this letter stigmatises all units performing oocyte donation.

We welcome the opportunity to relate our practice concerning the recruitment of egg donors.

The success of donating eggs for managing formerly untreatable cases of infertility such as premature menopause has led to a shortage of eggs. In our unit 82 patients on our waiting list telephone each month to inquire whether eggs are available. This is a severe stress to add to the problem of infertility.

From January 1988, 100 patients have received eggs from 64 donors, resulting in a clinical pregnancy rate of 28%. Six babies have so far been born. Of these donors, 20 were patients already receiving treatment in our assisted conception programme, who had agreed to donate a maximum of six eggs in excess of 12 produced during their treatment. The 44 other donors were all volunteers recruited from patient contact or through the media.

The Voluntary Licensing Authority has stated that donors of eggs should remain anonymous and that sisters or friends of potential recipients should not be used. When our potential recipients have indicated that friends or relatives would be prepared to donate for them they have been informed of this moral objection. We have attempted that these potential donors might wish to donate eggs for other recipients and have thus been able to find 10 donors while still maintaining anonymity.

The 34 other volunteers resulted from publicity from friends, relatives and television programmes. Thirty contacted our unit directly to donate eggs, and four contacted their local gynaecologist or general practitioner, looking for sterilisation and expressing a willingness to donate eggs at the same time. The remaining 20 came from hospitals or local hospitals they were directed to our unit for both procedures. None were private patients offered a free procedure, and none came from NHS hospitals with long waiting lists for sterilisation.

All donors were extensively counselled about the risks of induction of ovulation, the anesthetic, the operative procedure, and also their views about bonding or identification of any offspring. We have surveyed the first 35 donors about their attitude to the procedure and are reassured that 27 would like to donate again; 28 thought that any type of payment would be inappropriate, although another 7 thought that it would be acceptable only if it encouraged other women to donate. It is also reassuring that 47% (7/15) of the infertile patient donors became pregnant in their donor cycle and 87% (7/15) had further eggs frozen for future use; thus the donation of eggs should not limit the success of their own endeavours to become pregnant.

Volunteer donors accept a small extra risk from ovulation-stimulating agents and television programmes, and the surgical procedure, which would be unnecessary if recruitment was entirely from infertile patients during the process of assisted conception. Nevertheless, although the incidence of minor side effects was only 60% in all 100 patients serious hyperstimulation did not occur and 60% (12/20) of volunteer donors indicated that they would be willing to donate again.

Finally, 55% of all our donors have resulted from the public, while the majority of the remainder wished to donate because of the public media: there is no need for any sort of inducement.

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Egg donation and medical ethics

Sir,—An anonymous letter indicating a possible ethical transgression must be a rarity in the BMJ. The accusation was that a patient had been coerced into donating oocytes in return for a speedy sterilisation. If true, such an inducement must be condemned, but the lack of specificity in this letter stigmatises all units performing oocyte donation.

We welcome the opportunity to relate our practice concerning the recruitment of egg donors.

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