Editorial

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Infertility & Endocrinology in Reproductive Age Female Cancer Survivors

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Improved survival rates among reproductive-age females diagnosed with cancer have increased the main target on long-term quality of life. Cancer-directed therapies like high-dose alkylating agents and radiation to the pelvis, which deplete ovarian reserve, radiation to the brain, which affects the hypothalamic-pituitary-gonadal axis, and surgical resection of reproductive structures can decrease the likelihood of having biological children. Standard fertility preservation strategies such as embryo and oocyte cryopreservation before the onset of therapy offer the opportunity to conserve fertility, but they may not be feasible because of the urgency to start out cancer therapy, financial limitations, and a scarcity of access to reproductive endocrinologists.

Ovarian tissue freezing is taken into account experimental, with limited data associated with pregnancies, but it minimizes treatment delay. Studies evaluating gonadotropin-releasing hormone analogues have had mixed results, although a recent randomized, prospective study in women with carcinoma demonstrated a protective effect. More than 35,000 women between the ages of 15 and 39 years are diagnosed annually with cancer. Losing the ability to have biological children has been identified as a source of distress to cancer survivors affecting their quality of life.

Despite these guidelines, surveys of physicians suggest that discussions about fertility preservation aren't routinely occurring. Educating individual physicians may improve the frequency of discussions and referrals because a lack of knowledge is often cited as a barrier to providing fertility preservation services. However, establishing institutional standards for fertility preservation, including the event of a fertility preservation program with dedicated staff, is more likely to enhance the reliability with which females of reproductive age are made aware of their risks and options.

Established fertility preservation methods include cryopreservation of oocytes or embryos. This technique involves stimulating the ovaries with subcutaneously injected gonadotropins for about 8 to 14 days. Frequent monitoring with transvaginal ultrasound and serum hormone testing during this point is required, and this is often followed by transvaginal oocyte retrieval under sedation. Oocytes are then examined for maturity and cryopreserved.

Providing clinicians with information about the fertility effects of cancer treatment and options for fertility preservation is not enough to ensure that they will discuss these issues with their patients. A small but growing body of literature has emerged that describes key elements needed to create a program to deal with fertility.

Fertility preservation is important to reproductive-age females diagnosed with cancer, and conversely, facing the risk of or developing infertility can be a source of stress and grief. Although imperfect and often costly, fertility preservation interventions exist and may offer the opportunity to have biological children to females at risk. Improvements in reproductive technologies, including the event of the capacity to mature immature oocytes from cryopreserved ovarian tissue, will provide a more reliable option for females who cannot delay therapy. Importantly, the expansion of coverage for these procedures will greatly expand the amount of people who can avail themselves of fertility preservation techniques.