Storage of sperm and embryos

Cryopreservation of sperm should be offered to men with testicular cancer

EDITOR,—Patients with testicular cancer often become infertile as a result of the disease and its treatment. It has been argued that all such patients should be offered cryopreservation of semen,¹ but in 1980 Braken and Smith reported that only 4% of patients had semen of suitable quality for a fertility programme.² The advent of intracytoplasmic sperm injection now allows even low quality sperm to be used successfully,³ but many clinicians are unaware of recent advances and the facilities available.

To determine the awareness and availability of this service we sent a questionnaire to 292 consultant urologists, of whom 197 (67%) replied; we also contacted the 41 cryopreservation centres in the United Kingdom. We found that 71 urologists routinely used cryopreservation facilities, while 123 left the oncologists to organise this. Of the 71 who routinely used the services, most (48) recommended storage of semen samples obtained after unilateral orchidectomy that was performed within one week of diagnosis; only a minority (23) thought that a short delay between diagnosis and orchidectomy would have an adverse effect on the clinical outcome. Of the 41 cryopreservation centres, only five offered storage on the NHS, but a further 10 had contracts with oncology services at preferential rates. All of the centres offered immediate access to facilities, so that the treatment of patients with cancer would not be greatly delayed.

Cryopreservation of semen has been available for over 20 years in the United Kingdom but is still used by a minority of urologists. Infertility after the treatment of testicular cancer may be a cause of litigation, and this will become an increasingly important issue. Low cost storage of sperm is readily available in most of the United Kingdom and should be offered to patients with testicular cancer at the start of their treatment.

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Storage facility exists for sperm from patients positive for antibody to hepatitis C virus

EDITOR,—We recently encountered considerable difficulties in arranging the storage of sperm

from a 19 year old man with severe haemophilia A who was positive for antibodies to hepatitis C virus after an infusion of infected pooled blood products. He had normal transaminase activities and had developed no other viral complications. He had been diagnosed as having stage IIE Hodgkin's disease and needed to start chemotherapy. He had a good prospect of being cured of this disease and was keen to have the option of starting a family later. Ten fertility centres with facilities for long term storage of sperm were approached. Only two were able to offer help, albeit with some delay.

As a result of this case, the University College Hospital Trust has set up a separate storage facility at the Thorn Institute at the Middlesex Hospital, London. It is disappointing that such a service is not provided more widely, and until this action was taken no such facility was available at all. Hepatitis C virus has a low rate of sexual and intrafamilial transmission,^{1 2} and we are not aware of any cases in which it has been transmitted by stored bone marrow or semen. A case of hepatitis B acquired from stored bone marrow was recently described,³ and hence vigilance is required for all potentially transmissible agents. With isolated storage facilities now provided, all patients who are positive for antibody to hepatitis C virus should be able to preserve their long term fertility.

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Couples having IVF should be asked their wishes about spare embryos before egg retrieval

EDITOR,—The recent mass destruction of embryos in Britain could have been prevented if couples had been asked to give their consent for embryo donation before cryopreservation.¹ Many couples who are unable to have children could have benefited from the donation and transfer of these embryos.

Since 1986 the state of Louisiana, uniquely in the United States, has had a law (Civil Code Article La RS 9:121-133) that allows the anonymous donation of embryos but prohibits the deliberate destruction or sale of unimplanted embryos and the culture of embryos solely for research. In disputes arising between any parties about the embryo after in vitro fertilisation the judicial standard is to decide in the best interest

of the embryo. This law does not supersede the decision in the case of *Roe v Wade*, whereby women may obtain a legal abortion of an intra-uterine embryo or fetus.

To ensure that legal rights would extend to the embryo the statute declares the embryo to be a juridical person. This law, which was enacted before the first cryopreservation procedure was performed in Louisiana, was written with the aid of attorneys, embryologists, and directors of in vitro fertilisation programmes, representing both Roman Catholic and Protestant points of view. In the view of the law and many people of all faiths in the state of Louisiana, the embryo is a human being (J Krentel, R P Dickey, Vth world congress on in vitro fertilisation and embryo transfer, April 5-10, 1987).²

All couples who are considering in vitro fertilisation are informed that, once their embryos have been frozen, they cannot be purposefully destroyed but must be given a chance of survival; the couple are also told that they may select a host uterus or allow the clinical staff to select an infertile recipient for anonymous donation. Alternatives, such as immediate donation of fresh eggs or embryos, donation of excess eggs for research, and insemination of a limited number of eggs, are also offered. Couples are contacted annually about their wishes regarding their embryos. We have found that many couples are willing to receive the donated embryos and to have the chance of having a child.

Clearly, the time for the biological parents to indicate their wishes in all eventualities, including death or loss of contact with the clinic for years, is before egg retrieval. Had this been done

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