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Opinion

Fertility Preservation: An Important Consideration Prior to Malignancy Treatment

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With advances in cancer prevention, diagnosis and treatment, patient outcomes and survival rates are increasing. Although healthcare providers' primary focus remains improving overall survival, supportive care methods focusing on fertility preservation are also significant. Survey results from cancer survivors have revealed that 30-40% of the time providers did not discuss fertility preservation prior to initiation of cancer treatment and about half of the time patients self-inquired about fertility preservation.

According to the World Cancer Research Fund about 8.5 million women are diagnosed with cancer each year. Many of these women will undergo a wide variety of therapies such as surgery, radiation therapy, chemotherapy, immunotherapy and targeted therapy. The risk of treatment-related infertility varies greatly depending on the treatment modality utilized as well as patient-specific characteristics (i.e. age, sex).

Alkylating agents such as carboplatin and radiation pose the highest risk of infertility. There are many therapies in which the risk of infertility is unknown and not well documented. The risk of infertility should be openly discussed with patients as early as possibly, before treatment is initiated.

The American Society of Clinical Oncology (ASCO) published the most recent guidelines on fertility preservation in 2018. Despite efforts to increase ovarian protection modalities, fertility preservation remains underutilized in clinical practice. There are several barriers for this: urgency to initiate treatment, lack of provider consultation, inadequate information in terms of treatment goals, and limited resources.

It's important to note the differences between male and female options for fertility preservation. Many modalities available to females (e.g. embryo and oocyte banking) require several weeks for oocyte harvest. In disease states such as acute leukemias and aggressive lymphomas, it is often not feasible for female patients to undergo prolonged modalities of fertility preservation without jeopardizing survival outcomes. It should also be noted that ovarian suppression can be achieved through manipulation of the hypothalamic-pituitary-gonadal-axis (HPGA) by luteinising-hormone releasing hormone (LHRH) antagonists, however, data to support this latter method is limited.

Infertility consultation is an important part of cancer treatment and it should be discussed with patients early on, prior to cytotoxic treatment initiation. Patient's long-term goals as well as fertility preservation modalities should be reviewed by providers in order for patients to make informed decisions about their care.