Fertility Protection in Female Oncology Patients: How Should Patients Be Counseled?

Abstract

Protecting the fertility of patients with oncologic disease is becoming more and more important, as fulfilling the wish to have children is increasingly occurring at a later stage in life and long-term survival rates after cancer are continuing to improve. A number of fertility-preserving options exist. In addition to techniques which have been around for some time such as medical ovarian suppression, ovarian transposition, and organ-preserving surgery, there are other, more recent, innovative methods which have developed over the last few years such as cryopreservation of oocytes or ovarian tissue transplantation after completing cancer therapy. As every procedure has its specific advantages and disadvantages, informed patient consent is essential. The physician’s aim must be to select the optimal procedure for each patient. The extent of patients’ information about the options to preserve fertility in women with oncologic disease remains limited. One of the main reasons for this is that clinicians are not sure how to inform patients about existing procedures and methods. The aim of this review article is to provide help in clinical practice.

Introduction

In industrialized countries two developments in recent decades have focused the attention of researchers in reproductive medicine on the preservation of fertility. Socially, there is a trend to postpone having children until later in life, in some cases until the still existing biological limits prevent women from fulfilling their wish to have a child. Between 1993 and 2013 the average age of women in Germany when they gave birth to their first child increased from 25 to 29.3 years [1]. It has long been known that female fertility begins to decline from the age of 30 years (Fig. 1) [2]. The decreasing number of children born is accompanied by far-reaching social changes. At the same time, overall life expectancy still continues to increase. One of the reasons for this is the advances in oncologic therapy which have led to improved long-term survival rates for cancer patients. However, these successes are accompanied by a loss of fertility due to premature ovarian insufficiency triggered by the gonadotoxic side effects of chemotherapy and radiotherapy [3–4]. Many women report that they would still like to have children despite their
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The decrease of fertility with age (based on H. A. Carcio: Management of the Infertile Woman) [57].

Table 1 Risk of gonadal damage after the administration of different cytostatic drugs [10–16].

<table>
<thead>
<tr>
<th>Level</th>
<th>Drugs</th>
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<tbody>
<tr>
<td>High risk</td>
<td>cyclophosphamide, mitomycin C</td>
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<tr>
<td>Intermediate risk</td>
<td>anthracyclines, cisplatin, vinca alkaloids</td>
</tr>
<tr>
<td>Low risk</td>
<td>methotrexate, 5-fluorouracil</td>
</tr>
<tr>
<td>Unclear risk</td>
<td>taxanes, gemcitabine</td>
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The most highly gonadotoxic chemotherapeutic drugs are alkylating agents such as cyclophosphamide or platinum derivatives, which are used in gynecology to treat breast cancer, cervical cancer and ovarian cancer. Anthracyclines pose an intermediate risk. Taxanes, which play an important role in the treatment of breast and ovarian cancer, and antimetabolites and vinca alkaloids are associated with the lowest risk of ovarian damage [10]. The chemotherapy-induced amenorrhea rates reported in various clinical studies range from 30–76%. Amenorrhea was reported in more than 90% of women after the administration of high-dose chemotherapy [11, 12]. For cyclophosphamide a clear correlation was demonstrated between age and rate of amenorrhea. The incidence of amenorrhea was found to increase significantly above the age of 35 years, rising to more than 80% in women aged > 40 years [13]. In women with Hodgkin’s lymphoma treated with cyclophosphamide, van der Kaa et al. showed that the probability of premature ovarian failure increased by 23% per year of age [14]. Studies of anthracycline-based chemotherapies administered without the addition of alkylating agents showed that secondary amenorrhea occurred in less than 10 to 34% of treated women [15]. Pérez-Fidalgo and colleagues noted only a slight and reversible increase in the amenorrhea rate after chemotherapy regimens which included taxanes [16]. Table 1 provides an overview of the extent of gonadotoxicity of the most common cytostatic drugs used in gynecology and obstetrics.

The data on gonadotoxicity is less clear for the more recent targeted therapies. There are no data on gonadal damage from prospective studies into the leukemia drug imatinib. In a mouse model imatinib had no effect on folliculogenesis or spermatogenesis [17]. It has even been suggested that imatinib could reduce platinum-related gonadotoxicity [8]. However, imatinib use is contraindicated in pregnancy because of the increased risk of congenital malformations. There is also no evidence for trastuzumab-related gonadal damage. A clinical study carried out 5 years ago found no increase in the rate of secondary amenorrhea in breast cancer patients treated with trastuzumab [12]. However, the administration of trastuzumab during pregnancy can result in oligohydramnios, leading to fetal lung hypoplasia and joint contractures [18]. To date no clinical studies have been published on the impact of the anti-VEGF antibody bevacizumab on fertility. There is one case report of two patients treated with bevacizumab for uveal melanoma, who suffered from transient amenorrhea [19]. In 2011 the FDA came out in favor of a warning on the package inserts of the anti-VEGF antibody about the potential undesirable effect on ovarian function. Clinical observations of the drug used to treat intestinal cancer in combination with adjuvant chemotherapy noted a significantly increased risk of amenorrhea, amounting to 34% in premenopausal women compared with only 2% of women treated with chemotherapy alone [20]. Nevertheless, the data on the effect of bevacizumab on fertility is still insufficient. The data on the impact on ovarian function of
the selective estrogen receptor modulator tamoxifen are inconsistent. This is mainly due to the fact that in premenopausal women, tamoxifen treatment usually follows gonadotoxic chemotherapy and radiotherapy. A follow-up study of premenopausal women with breast cancer showed a twofold increased risk of amenorrhea when tamoxifen was added to adjuvant chemotherapy. However, the increased risk was not significant for women who developed breast cancer before the age of 40 years. Moreover, AMH levels were not affected, leading the authors to conclude that tamoxifen only affected follicle development [12].

Overview

Protecting fertility in women with cancer: options, safety and success

Organ-preserving surgery

One option to enable women with oncologic disease to have children later on consists of organ-preserving surgery. Cervical conization would therefore be the surgery of choice for women with stage IA cervical cancer, and tracheectomy for women with stage IB cancer of the cervix wishing to have children. It is important, particularly with tracheectomy, to inform the patient about the potential risk of carcinoma recurrence. In the literature, the risk of recurrence is reported to be 11% after 44 months. Tumor size > 2 cm and stromal invasion of > 50% are associated with a higher risk of recurrence [21]. Women opting for tracheectomy must also be informed about the increased risk of miscarriage and premature delivery in any future pregnancy. In a study of 77 pregnant women after fertility-preserving tracheectomy, Hauerdberg et al. reported a first trimester miscarriage rate of 21.6% and a second trimester miscarriage rate of 2.7%. 12 of 53 children (23%) were born prior to 34 + 0 weeks of gestation [22]. Organ-preserving surgery is the standard procedure to treat borderline ovarian tumors. The 5-year survival rate is reported to be 97% [23,24]. In women with stage I (G1–3) ovarian cancer, preserving the contralateral ovary can be justified. A pregnancy rate of 60–100% after preservation of one ovary and a miscarriage incidence of less than 30% is realistic. The risk of disease recurrence is 9–29% depending on the histology and degree of differentiation; the 5-year survival rate is 83–100% [25]. In women with higher stage disease the options for organ preservation need to be weighed up very carefully against the significantly increased risk of tumor recurrence. There is almost no data on Fallopian tube carcinomas because of the rarity of the entity. If the tumor is limited to the Fallopian tube, organ preservation of the contralateral side is an option. In up to one third of cases, however, both Fallopian tubes are affected, usually in the ampullary region.

Transposition of the ovaries

This term describes the surgical transposition of the ovaries away from the area targeted for radiation. With this approach, the ovaries on one or both sides are transposed from the lesser pelvis and, for example, attached proximally to the peritoneum of the abdominal wall. Indications include anal or rectal carcinoma [26]. Patients must be informed about the risks of surgical laparoscopy, although surgical laparoscopy is associated with a low rate of complications. Serious complications such as organ injury or secondary bleeding requiring treatment occur in fewer than 1% of all laparoscopies [27,28]. However, transposition of the ovaries does not protect against the gonadotoxic side effects of chemotherapeutic drugs. One advantage of this method is that ovarian transposition can be carried out together with staging laparoscopy or pelvic lymphadenectomy. Shou et al. reported a success rate of 69.2% with regard to ovarian preservation [29].

Medical ovarian suppression

Ovarian suppression before and during gonadotoxic therapy is done using certain GnRH analogs such as goserelin and leuprolinel acetate. They are administered in the form of depot injections for the duration of chemotherapy. The idea is that this downregulates ovarian function with the result that the ovules will react less sensitively to radiotherapy or chemotherapy [30,31]. However, this method cannot be considered the method of choice for fertility preservation as damage to the ovaries including primary ovarian failure can occur despite downregulation [32]. Overall, medical ovarian suppression is not considered to be very effective. Patients need to be informed that primary ovarian failure occurs in up to 60% of cases despite prophylactic medical downregulation [8]. According to the current ASCO recommendations there is no evidence that medication-based procedures preserve fertility, meaning that such an approach cannot be recommended, at least not on its own, as a method to protect fertility [33].

Cryopreservation of oocytes

Ovarian stimulation treatment is required to obtain enough oocytes for fertility protection procedures. The principle of treatment consists of hormonal stimulation of the ovaries in accordance with predefined protocols using gonadotropins and suppression of endogenous LH peaks using GnRH analogs such as leuprolelin acetate or GnRH antagonists (e.g. cetrorelix). Follicle puncture for oocyte retrieval is done 36 hours after triggering ovulation. Depending on whether the patient has a long-term male partner, the fertilized or unfertilized ova can be cryopreserved in the pronuclear stage [34]. Careful control is necessary for oocytes to survive the process of cryopreservation. Factors such as oocyte architecture, size and shape affect oocyte survival. Oocytes are cryosensitive due to their high water content. There is a real risk of damaging the oocyte if ice crystals form in the region of the cytoplasm or extracellular matrix. Two methods are used to freeze oocytes, the slow-freezing method and vitrification. In the slow-freezing method the oocyte is slowly frozen in several stages over several hours until reaching ~196°C. The technique was first established in 1979 by Whittingham [35]. The disadvantages of this method are the length of time and the complex and expensive equipment required for slow freezing [36]. It has since emerged that achieving successful conception is more difficult with this method due to differences in freezing protocols, the use of different cryoprotective culture media and the problem which arises if only a few oocytes can be harvested. A number of different cryoprotective culture media are also used in vitrification, with ethylene glycol and dimethyl sulfoxide the most commonly used media. For vitrification, the oocytes are rapidly cooled to ~196°C and stored in liquid nitrogen (also known as shock freezing). Vitrification can be done using either an open system (direct contact between oocytes and liquid nitrogen) or a closed system (oocytes separated from the liquid nitrogen by a membrane) [37]. A systematic review by Edgar et al. compared slow freezing with vitrification and came to the conclusion that vitrification was associated with better oocyte survival and better development of the embryo. The authors were of the opinion that slow freezing of unfertilized oocytes was more likely to result in damage to the oocyte compared to vitrifi-
They considered vitrification as the standard procedure for the cryopreservation of oocytes [38]. According to a review by Cobo et al. published in 2009, oocyte survival rates after vitrification were 97% with an open vitrification system, a significantly higher rate than the 75% rate obtained with a closed system [39]. According to recent data, the pregnancy rate after transfer of vitrified fertilized oocytes was 38% [40]. According to Cobo et al., it was even possible to achieve a clinical pregnancy rate of around 60% for oocytes of equal quality after ovum donation [41]. Conversely, this also means that on average only half of all women who undergo harvesting of oocytes for fertility preservation will become pregnant; this is an issue women need to be informed about in advance.

**Cryopreservation of ovarian tissue**

The removal and cryopreservation of ovarian tissue after creating thin tissue sections for slow freezing or vitrification followed by autotransplantation of this tissue has, in recent years, become an established fertility-preserving treatment. After a number of successful animal studies in the 2nd half of the 20th century, the first human birth after transplantation of ovarian tissue was achieved in 2004 [42]. The ovarian tissue used for transplantation can be autologous (tissue is obtained from the patient herself) or allogeneic (tissue is obtained from another patient). Ovarian tissue is transplanted either orthotopically (in the region of the ovary) or heterotopically (at a distance from the ovary, e.g. in the region of the abdominal wall) (Figs. 2 and 3). The amount of ovarian tissue removed depends on the expected extent of loss of ovarian function [43]. Surgical access can be obtained using either laparoscopy or laparotomy. As has occurred in other medical specialties, the minimally-invasive surgical approach has evolved to become the method of choice [44]. Globally, a total of 39 children were born after transplantation of ovarian tissue, although there are still some ongoing pregnancies. There is also data available on 12 births after allogeneic transplantation of fresh ovarian tissue [45, 46]. Although orthotopic transplantation of ovarian tissue is considered the standard procedure, as the majority of pregnancies and births have been reported with this technique, a report from Australia last year gave an account of a twin birth after heterotopic transplantation of ovarian tissue and IVF. This success could lead to a greater prevalence of heterotopic or simultaneous orthotopic and heterotopic transplantations, as this has the advantage of offering better access for follicle puncture and easier detection of potential tumor recurrence [47].

The decision to cryopreserve oocytes or ovarian tissue must always be taken on an individual basis after close consultation with the patient. The advantage of preserving oocytes is that patients will not have to undergo surgery with its associated risk of potential complications. However, studies have shown that the laparoscopic removal of ovarian tissue followed by its transplantation at a later date is associated with a very low risk of complications of < 1% [48]. The disadvantages of cryopreserving oocytes are that the number of oocytes obtained may be low, prior hormone treatment may delay the start of oncologic therapy, and there may be potential drug-induced side effects (e.g. ovarian hyperstimulation syndrome). Nowadays, the latter problem can be effectively prevented by optimizing the stimulation protocol, with induction of oocyte maturation through a combined treatment with GnRH analogs and GnRH antagonists [49]. The advantages of cryopreserving ovarian tissue are that oncologic treatment can be started immediately after tissue removal, it is possible to obtain larger numbers of ovules, and spontaneous conception may be possible after successful completion of oncologic treatment, whereas oocyte extraction always requires embryo transfer. It is important to weigh up the stresses for the patient caused by what usually amounts to 2 laparoscopic procedures against the risk of recurrence of disease caused by a potential transplantation of tumor cells. The overall risk of recurrence due to transplantation is low, but it remains a very real risk, particularly with hematologic malignancies [50]. Table 2 gives an overview of the safety associated with the removal and transplantation of ovarian tissue for different tumor entities. The option to restore fertility and endocrine ovarian function after completing cancer therapy is a clear argument in favor of the cryopreservation of ovarian tissue. If ovarian tissue is not cryopreserved, the patient will often experience premature ovarian failure resulting from the gonadotoxic effects of chemotherapy or radiotherapy. Simple removal of up to 50% of functional ovarian tissue does not adversely affect ovarian function in the long term, even if the removed ovarian tissue is not re-implanted [51]. The patient must be informed prior to any removal and transplantation of ovarian tissue that generally this method will require at least 2 laparoscopic procedures. According to a recent publication which calculated the pregnancy rates in a total of 80 women after ovarian tis-
The removal and later transplantation of ovarian tissue in women with malignant ovarian tumors should be considered very critically because of the risk of tumor cell dissemination, although the literature provides no evidence that this will necessarily occur. Lotz et al. analyzed ovarian biopsy samples taken from a total of 23 premenopausal women with epithelial or non-epithelial ovarian malignancies. No malignant cells were detectable under light microscopy or histologically at 24 weeks after xenotransplantation of these ovarian tissue biopsies into severe combined immunodeficient (SCID) mice [56].

**Ovarian tumors**
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Fig. 4 Decision tree for fertility protection options depending on the oncologic disease.

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Findelkle S et al. Fertility Protection in... Geburtsh Frauenheilk 2015; 75: 1243–1249
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