Many couples seek evaluation and treatment for infertility, especially as couples delay childbearing to establish careers. A male factor alone may be present in up to 20% of infertile couples and is a contributing factor in another 30% to 40% of all couples presenting for infertility evaluations. Infertility affects approximately 6.1 million people in the United States, or roughly 10% of the reproductive-age population; it is not just an inconvenience for these couples, but rather a disease of the reproductive system.

There are many causes of male infertility that are reversible, and understanding the basics to the male infertility evaluation is an important part in providing complete urologic care to the male patient.

1. A couple presents with a 14-month history of primary infertility. He is 27; she is also 27 and has had a negative female-factor evaluation. During the discussion of his history, the male mentions that as a child and adolescent, he was treated on multiple occasions for bouts of “asthma or pneumonia” but “grew out of it” during college. How will you focus your evaluation?
   a. Examine for situs inversus.
   b. Evaluate for gynecomastia, small testes, and azoospermia.
   c. Examine for presence/absence of the vas deferens and epididymes.
   d. Inspect to establish the location of both testes.

2. What is the estimated prevalence of varicocele in the general male population?
   a. 10%
   b. 15%
   c. 25%
   d. 30%

3. For the analysis of a semen sample to be as accurate as possible, all of the following recommendations should be observed except:
   a. There should be a period of abstinence of 2 to 5 days.
   b. It should be processed within 60 minutes of collection.
   c. It should be collected during intercourse.
   d. A sperm-friendly collection container must be used.

4. All of the following lubricants are toxic to sperm except:
   a. Saliva.
   c. Surgilube®.
   d. Petroleum jelly.

5. What is an indication for genetic testing and/or karyotype analysis during a male infertility evaluation?
   a. Severe oligospermia
   b. Retrograde ejaculation
   c. History of undescended testicle/testes
   d. Elevated estradiol

6. Hypogonadotropic hypogonadism is defined by:
   a. Elevated testosterone, elevated LH, normal FSH.
   b. Normal testosterone, normal LH, elevated FSH.
   c. Decreased testosterone, elevated LH, elevated FSH.
   d. Decreased testosterone, decreased LH, decreased FSH.

Answers

1. C – Many of the less-severe cystic fibrosis (CF) mutations do not result in the classic CF presentation, but rather respiratory problems that appear to resolve with adulthood. Male patients may have anatomic abnormalities to the reproductive structures without the electrolyte abnormalities commonly associated with CF (Turek, 2000).
Professional Enhancement

continued from page 378


3. C – Attempts to collect a sample via coitus interruptus are not recommended (ASRM and AUA, 2001).

4. D – Saliva, K-Y jelly, and Surgilube are all well-established spermatotoxic lubricants (Sigman, Lipshultz, & Howards, 1997).

5. A – Severe oligospermia (very low sperm count) can be an indicator of a problem of sperm production and sperm transport, and is commonly associated with a genetic abnormality (ASRM and AUA, 2001).

6. D – Only this option describes hypogonadotropic hypogonadism. Option A describes partial androgen resistance, B describes abnormal spermatogenesis, and C describes primary panhypogonadism (Sokol & Swerdloff, 1997).

References

