Worcestershire Acute Hospitals NHS Trust

Management of Severe Male Factor Infertility

Key Document code:	WAHT-TP-027	
Key Documents Owner:	Kiritea Brown	Consultant Gynaecologist
Approved by:	Gynaecology Governance Meeting	
Date of Approval:	14th December 2020	
Date of review: **This is the most current version and should be used until a revised document is in place**	20th February 2025	

Key Amendments

Date	Amendment	Approved by
26th January 2019	Documents extended for 3 years	Mr Hughes
14th December 2020	Documents approved for 3 years	Miss Blackwell
29th December 2023	Document extended for 6 months whilst under review Owner updated	Alex Blackwell
20th August 2024	Document extended for 6 months whilst under review	Alex Blackwell

Introduction

This SOP describes the steps which should be taken with any male patient presenting with severe male factor infertility.

I. Referral

1.1. Patients with a very poor semen analysis: i.e very low sperm count and/or poor motility. Will usually be identified through the initial semen analysis. Patients may come through fertility clinic. They may also be referred through urology department.

1.2. Any female factors such as age and raised FSH must be taken into account when agreeing a plan

1.3. It is likely to help the couple manage a difficult situation if a clear plan is laid out with them from start

2 Initial management when sperm is present but the count is less than 5 million per ml

2.1 In clinic the low count and the likely need for IVF with ICSI should be discussed.

2.2 Bloods should be taken from the man and the reasons explained for: karyotype, cystic fibrosis, FSH, LH, testosterone and HIV, Hep B & C (see below 3.3)

3 Initial management when no sperm is identified on routine semen analysis

3.1 In clinic, the findings should be explained and the couples reaction discussed. This allows a Detailed management plan to be developed with the couple. This plan should include discussion of whether an SSR will be arranged if no sperm are found in the semen assessment.

3.2 The man should be examined and the size of the testicles documented

3.3 Bloods should be taken for karyotype, cystic fibrosis, FSH, LH, testosterone, prolactin, TSH and HIV, Hep B & C. Forms should be completed

3.4 If blood is to be taken by GP practice as the man was not present in fertility clinic, all request forms must be filled out on ICE and printed for the patient to show to the nurse taking the sample.

3.5 For some men, where the cause is known e.g. failed vasectomy reversal, bloods would not be necessary. HIV, Hep B & C are always necessary.

3.6 He should then be referred for semen assessment with double spin down. This may identify Some sperm which can then be frozen and used in IVF/ICSI

3.7 If double spin down yields no sperm, he may wish to proceed to surgical sperm retrieval (SSR). The procedure and its risks should be discussed and a leaflet given (Azoospermia and severe oligozoospermia). If sperm is identified, again, IVF/ICSI would be necessary. Document in the clinic letter if SSR to be arranged after a negative semen assessment.

3.8 The likelihood of retrieving sperm depends on the likely cause of the azoospermia, the size of the testicles, and on the results of the hormone profile. If FSH is raised, approximately 50% of men will still have sperm identified. The man should be given an estimate of the chances of Retrieving sperm and this should be documented.