The conversation

One of the most challenging tasks a male reproductive medicine and surgery specialist faces arises after sperm extraction procedures for men with nonobstructive azoospermia. Although sperm retrieval success rates are high, for some patients these cases result in no sperm being found. While we always do our best to establish appropriate expectations for the patient and his partner during preoperative counseling, the news of an unsuccessful sperm extraction can still be devastating. The long walk from the operating room to the family waiting area provides clinicians with the opportunity to consider the couple, how the news will affect them, and how they can best be supported as they move forward in their quest to become parents.

Grief counseling is not a formal component of medical training in most residency or fellowship programs. However, the ability of the physician to deliver "bad news" clearly and compassionately is critical for couples at this important crossroad. From time to time, we in the subspecialty of reproductive health encounter patients who have received unfavorable news from prior providers without further explanation of additional reproductive options or mental health resources. This approach to health care often leaves couples feeling confused and abandoned at a time when they need the support and engagement of their health care team the most.

Although the reproductive medicine literature is robust with studies detailing grief after unsuccessful fertility treatments in female patients, the number of studies pertaining to infertile men is much more limited. The historic literature regarding the psychosocial impact of infertility on couples would suggest that women experience a greater degree of overall suffering than do men. However, more contemporary studies assert that this paradigm may be inaccurate and that psychological distress must be considered in the broader context of gender specific differences in reaction to stress, anxiety, and grief (1, 2). For example, in alignment with "masculinity norms," a man may suppress his emotional responses to be able to effectively support his partner, or he may withdraw to avoid exposing her to his pain (3). Although on the surface it might appear that these men are not suffering, recent studies with long-term follow-up show that men with involuntary infertility have significantly worse quality of life scores and lower self-esteem measures when compared with fertile male controls with children. These same long-term studies suggest that, among couples who have undergone unsuccessful attempts at IVF, men and women are negatively impacted to a similar degree in the domains of depression and psychological well being (4).

Couples typically assume that they will be capable of conceiving uneventfully by natural means, and entry into the realm of reproductive medicine diagnostics and therapeutics can be extremely daunting. Most of these individuals seeking treatment are otherwise young, healthy, and relatively unfamiliar with the concept of being "a patient." When even the most sophisticated technology cannot result in procreation using the couples' gametes, the associated distress can be overwhelming for each partner individually and destructive for the couple as a whole. Careful assessment of men in the wake of unsuccessful sperm extraction procedures often reveals individuals who suffer from remorse over perceived past behavior that they link causally to their infertility and guilt that they have failed their partner in a foundational aspect of their relationship. Expedited access to a mental health counselor with a genuine interest in these patients and familiarity with the literature is key in helping these couples successfully navigate this challenging and emotionally charged turn of events.

In our clinical practice, we often refer to "the pathway to parenthood." For many couples with infertility, the implementation of behavioral, medical, and/or surgical therapies will result in pregnancy. For ever-increasing numbers of couples, assisted reproductive techniques provide the mechanism to overcome anatomical or physiological barriers to conception with the couples' gametes. However, at present, we still do not have a means to bypass the fundamental absence of sperm in the male partner. In the face of this outcome, an abundance of studies reveal that most couples still wish to pursue options to become parents. For some couples, the absence of sperm in the male partner will lead them to pursue adoption. For others, the use of donor sperm is chosen as a next step. With both approaches, the medical literature regarding long-term outcomes reveals high degrees of satisfaction for these couples. When more specifically considering the use of donor sperm and relationship stability, there appear to be no substantial differences between couples using donor sperm and those using their own gametes in the setting of IVF. The critical issue, then, is for clinicians to "be there" for the couple as they contend with the acute distress and grief associated with the absence of sperm. In the immediate short term, this means attending to the man during his physical recovery from the surgical sperm extraction procedure. During this same time frame, when the couple is ready, the clinician should help coordinate a pivoting of efforts to explore alternate pathways to parenthood. It is at these times, when even our most advanced medical and surgical techniques are not enough, that our patients truly need and deserve the very best clinical guidance, support, and care that we can deliver.

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