

Marital Infertility

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ABSTRACT

When the desired pregnancy is absent and after 2 years of trying to come to her, we can talk about marriage infertility. This condition is caused by functional or organic damage to the individual parts of the reproductive system that will obstruct the joining of the ovary and spermatozoa, to disenable fertilization and the birth of the desired child. According to the World Health Organization definition, “infertility is a reproductive system disease defined as absence of clinical pregnancy after 12 months or more of regular, unprotected, sexual intercourses.” With this problem, it meets between 7% and 26% of couples, while medical assistance is sought by 50% of infertile couples, and only about 22% of them are subjected to treatment.

Key words: infertility, man, treatment, woman

INTRODUCTION

Determining the reason for marital infertility is a very complex process that requires close cooperation between experts from different fields of medicine and, of course, man and woman. In any case, the review should start with the exhaustive history of the disease from both partners. Clinically, a woman’s examination is performed by a gynecologist and a male urologist. Thereafter, it is necessary to perform laboratory diagnostics, including examinations: Hormonal status, autoimmune disease, genital tract infection, coagulogram, male spermograms, and in women, to determine ovulation and ovarian capacity. When this clinical review indicates an ultrasound examination: Uterus, ovaries, testicles, and thyroid glands.

MARITAL FERTILITY AND MARITAL INFERTILITY

It is estimated that one in seven couples has difficulty getting pregnant.^[1] Worldwide, 80 million couples have some difficulty in getting pregnant. Many couples prefer to keep this fact private and so it is not until you start talking about your problems that you discover that some of your friends and family may be or have been in a similar situation.

It is a sad fact that some couples may never have a baby, yet there are many who go on to have a family successfully. For some couples, it is simply a question of time. For others, pregnancy may not happen. The uncertainty of whether pregnancy will or will not happen can add to the stress, with each month becoming a rollercoaster with every period.

Becoming parents is very closely tied, in the minds of many, to the proper functioning of their bodies.^[2] A man sees a biological child as proof of his virility. For a woman, a biological child means being able to experience pregnancy, birth, and breastfeeding. For both, the inability to produce a child is a threat to their sexual identity.

Fertility rates have been declining in most Western nations over the past several decades, although it is not entirely clear if an increased rate of infertility substantially contributes to this.^[3] As compared to other species, the reproductive efficiency of humans is relatively low. Factors related to fertility include age, exposure to sexually transmitted diseases, frequency of intercourse, coital timing, as well as diet and lifestyle habits. Infertility is considered a disease due to its major disruption of major organ systems and life functions. An infertility evaluation is recommended after 12 months or more of regular, unprotected intercourse and may be considered after

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6 months for those female patients over the age of 35 or with other known abnormalities. A proper infertility evaluation is a comprehensive examination of possibly identifiable infertility factors of both female and male partners, lending itself to the most appropriate and potentially effective treatment.

MALE INFERTILITY

The male accounts for nearly half of known instances of infertility.^[4] Determining the prevalence of male infertility is hampered by lack of thresholds for normal and infertile measures in the semen analysis and other tests of sperm quality and function. Thorough evaluation of the male factor should be a part of the infertility and is essential for defining the course and content of a couple's care. Pathophysiology and management for principal diagnoses are also presented. For many infertile men, attribution of the cause for semen abnormalities is not possible. For them, and for men whose conditions are not amenable to specific therapy, intrauterine insemination and assisted reproductive technology (ART) with intracytoplasmic spermatozoa injection (ICSI) offer pathways to fertility.

A male factor is the dominant cause of subfertility in 20–26% of couples.^[5] Semen analysis is the main method of male fertility assessment. Although azoospermia is an undisputed cause of male infertility, male subfertility is much more difficult to diagnose. The World Health Organization (WHO) criteria stated that a man can be judged normally fertile if his sperm count is $20 \times 10^6/\text{ml}$, progressive motility $>50\%$, and normal morphology $>30\%$. In addition, two studies reported the relationship between semen variables and the achievement of pregnancy within 12 months to define cutoff values below which fertility is judged impaired 12–13. They reported remarkably similar cutoff values: $14.3 \times 10^6/\text{ml}$ and $13.5 \times 10^6/\text{ml}$ for sperm concentration, 28 and 32% for progressive motility, and 5 and 9% for normal sperm morphology (Kruger criteria), respectively.

FEMALE INFERTILITY

Infertility may be narrowly defined as 1 year of unprotected intercourse without successful conception.^[6] Increasing recognition is being given to the impact of a woman's age, and it is recommended to begin an evaluation after only 6 months in women over 35 years. It also makes sense to begin treatment immediately when there is a known significant issue such as amenorrhea associated with polycystic ovarian syndrome and recognized azoospermia following cancer treatment. Based on observational data, infertility affects up to 15% of all couples. Infertility can be further classified as primary and secondary. Primary infertility is described in a patient who has never been pregnant. In contrast, secondary infertility

is seen in a patient with a history of pregnancy regardless of outcome, i.e., spontaneous abortion, ectopic pregnancy, stillbirth, or live birth. From the perspective of evaluation, taking into account insurance coverage issues, consideration should be given to both defining infertility and initiating an evaluation based on the lack of delivery rather than lack of conception. As such, a 36-year-old woman who conceived twice in the past year but miscarried without a delivery should be evaluated. The Centers for Disease Control and Prevention estimates that 6.7 million women were either unable to conceive or carry a baby to term and that 7.4 million women had, at some point, used fertility services.

The simultaneously biological, personal, and social drama of infertility is played out in the woman's body.^[7] Regardless of which partner in an infertile couple is ultimately discovered to have the biological "problem," it is the woman who fails to become pregnant. It is in her body that the emotional rollercoaster of midcycle hopefulness followed by end-of-cycle disappointment is played out. Regardless of which partner has a "problem," it is the woman who is the focus of most infertility treatment. Even if a woman's partner has a low sperm count, it is her body that is the locus of artificial insemination or *in vitro* fertilization. It is her basal body temperature and her blood levels that must be monitored. It is the woman's body then, that is, most often subjected to the medical gaze.

DONATION OF EGGS AND DONATION OF SPERM

Donated eggs are used when a woman carries an inherited disorder or is unable to produce fertile eggs (due to menopause, genetic malformation, ovarian failure, or sterility following surgery or chemotherapy).^[8] A donor may have completed her own family or may be undergoing fertility treatment herself, with stimulation to produce multiple oocytes. These women are sometimes encouraged to share their surplus eggs to help other women or to donate them for research purposes.

The will to apply some degree of cosmetic matching is evident in the very common fertility procedures of egg donation and donor insemination - even if choosing a sperm donor is far less ethically and technologically demanding than selecting an embryo.^[9] Before the widespread availability of ICSI in the 1990s, donor insemination was the only effective treatment for couples whose infertility was caused by a sperm problem in the male partner. And then, as today, there was a deliberate effort to match the basic characteristics of the sperm donor with those of the recipient patient.

These characteristics are first and foremost related to ethnicity and then to culture, religion, physical traits (such as height or complexion), and background. Clinics and sperm

banks in the US, for example, where federal regulations strictly control the testing and screening of sperm donors for infectious diseases, are otherwise happy to reveal quite personal information about their donors in the belief that such knowledge will make the recipient couple a little more at ease with their “anonymous” donor. Fairfax Cryobank in Virginia, for example, lists donor xxx as “100% Vietnamese. hard working and determined. shy at first but very polite”. Indeed, there are numerous examples - and one assumes a great many more than have been publicised—of donor sperm recipients doing as much as allowed to ensure that the donor meets their personal requirements. There were unconfirmed reports (in the ever-inventive British press) in 1998 that Hollywood actress Jodi Foster had been inseminated by “a tall, dark, handsome scientist with an IQ of 160.”

PSYCHOSOCIAL IMPLICATIONS OF MARITAL INFERTILITY

Infertility care, perhaps more than any other area of obstetrics and gynecology, involves psychosocial implications which require appropriate support to reduce patient distress and help them come to terms with their situations and make important life decisions.^[10] Training aimed at recognizing and managing these biopsychosocial aspects of infertility and assisted reproduction should be part of training requirements for generalists and subspecialists. This should include psychosexual counseling, the role of cognitive behavioral therapy and issues relating to same-sex partnerships, single parenthood, gender identity, gamete preservation, and surrogate motherhood.

Clinicians should be prepared to confront and address these issues not only using a patient-centered holistic approach in all interactions and at each step of the investigation and treatment process but also through referral to tailored counseling services in specific situations which require a trained mental health professional.

In cases involving infertility treatment, the fundamental ethical consideration is the welfare of the resulting children, but where donated eggs or sperm are involved, various other issues arise; for the recipients, sperm donation requires extraordinary commitment by the man to the child, who is not his genetic offspring.^[11] For the woman, egg donation is not quite so traumatic because she is biologically involved by carrying her pregnancy and giving birth to the child.

THE DESIRE FOR PARENTHOOD

While a number of couples use different methods to limit their fertility and prevent new life, on the other hand, a number of them - and it is constantly growing - has only one desire: To acquire own child.^[12] To accomplish this desire them no

price is too high. Own desires, social pressures, as well as scientific-technical optimism and promises of reproductive medicine encourage them to constantly new attempts. The results do not remotely monitor all efforts, suffering and expenses incurred. Some of today’s conventional medical methods are morally speaking, problematic, and contrary to human dignity.

The acceptance of the technical capabilities may at first glance mean relief and regaining control over the problem of infertility and their own bodies and thus of life plans. In reality, such a decision is an admission of its own helplessness and control over the body entrusted to experts. For the person, it means subjecting extensive tests, the control of hormones, the daily blood tests, ultrasound scans, hospital stays for taking eggs or expressed words of one directly affected person, “the constant hopes and fears and infinitely many disappointments.” This regimen shall be subject to the overall life of the person concerned and often the spouse. Hence, much investment of time to solve the problem of infertility is lack of time for other areas of life, profession, and social relations, even among the married and cohabiting partners.

MEDICALLY ASSISTED INSEMINATION

We currently live in an era of family planning and female work-force emancipation while experiencing an ever-increasing lifespan.^[13] With this has come the freedom and ability to delay the age of childbearing and facilitate conception. However, for some women, this delay may result in having to undergo assisted reproductive treatment to achieve pregnancy or even in the inability to conceive at all. While calendar or “chronological age” is very much related to biological or “reproductive age,” they can also represent separate entities. This means that while some women will be able to achieve a spontaneous pregnancy at age 35 without any problems, others may then have already missed their window of optimal opportunity.

Medically assisted insemination means biomedical procedures to heal proven infertility of one or both partners and the application of modern, scientifically proven biomedical achievements enables connection of male and female gametes to achieve pregnancy and childbirth.^[14] Methods of medically assisted insemination are now treated 70–80 % of all causes of infertility. Apply only when all other methods of infertility treatment proved unsuccessful.

The right to medically assisted insemination is of legal age and legal capacity of women and men who are married or in common-law and that due to the age and general health condition capable of parenting a child.^[15] The right to

medically assisted insemination has adult, legally capable woman who does not live in marriage, common-law or same-sex unions, whose previous fertility treatment proves unsuccessful or hopeless and that is due to the age and general health condition capable of parenting a child. The right to medically assisted insemination and the person who has the decision on deprivation of legal capacity is not restricted to making statements concerning personal status.

CONCLUSION

Very high percentages of marital infertility indicate that this is a serious worldwide health problem affecting a large number of people of reproductive age, and the WHO defines it as a reproductive system disease. As it is disease, modern science has introduced a series of scientifically-based evidence on the success of treating this disease. Across the world, there are scientists and physicians involved in the studying and treatment of this disease, so it can be said that the problem is not unsolvable. When considering methods of medically assisted insemination, it should be said that in most cases it is uncomfortable for couples to talk about that problem with physicians and other medical professionals, but when the results are presented to them, the initial discomfort disappears. In a scientific sense, it is important to point out that the procedures of medically assisted insemination in rare cases end without success. The infertility diagnosis begins with the estimation of fertility of both partners. The gynecologist determines an estimation of female fertility based on data on general and gynecological health, on the duration of infertility, and on the actual exposure to pregnancy. After a gynecological examination, the ability of women to ovulate is determined. Men also have to do their part of the job and visit the andrologist who will do the determines of man infertility. When these estimates are obtained, the process of medically assisted insemination can begin. It must be said that a large number of states have their own legislation which legally regulates these issues, and one of the most important questions is the age of a woman who has right to medically assisted insemination. For example, in Croatia, this age is limited to 42 years of age. Exceptionally, due to justified health reasons, the right to medically assisted insemination can be enabled after the age of 42.

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