Fertility preservation and reproduction in patients facing gonadotoxic therapies or gonadectomy: an Ethics Committee opinion

Ethics Committee of the American Society for Reproductive Medicine

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Patients receiving treatment that has the potential to negatively affect their gonads, including chemotherapy, surgery, and radiation therapy, should be informed of options for fertility preservation and future reproduction before initiating treatment. Reproduction in the context of fertility-affecting treatment raises a number of ethical issues related to the welfare of both patients and offspring. This document replaces the document titled, "Fertility preservation and reproduction in patients facing gonadotoxic therapies: an Ethics Committee opinion," last published in 2018. (Fertil Steril® 2026;125:260–6. ©2025 by American Society for Reproductive Medicine.)
El resumen está disponible en Español al final del artículo.

Key Words: Cancer, gonadotoxic, gamete, cryopreservation, ethics

KEY POINTS

- Prior to receiving treatment that has the potential to negatively affect their gonads, patients should be informed about options for fertility preservation and future reproduction, whenever possible. Initial counseling and referral to a fertility specialist or specialty team are important first steps in this process. A collaborative multidisciplinary team approach between physicians prescribing such treatments and fertility specialists is encouraged.
- All available and relevant options for fertility preservation should be discussed with patients. These can often be performed without causing significant delays to treatment.
- Disposition decisions regarding stored gametes, embryos, and gonadal tissue should be specified at the time of cryopreservation, including instructions in the event of the patient's death or an inability to contact them.
- It is ethically acceptable to allow the surviving partner to use the gametes or tissue for their reproduction in cases where there is no prior documentation, when there was a presumed intent by the deceased to allow for posthumous reproduction (1).
- Counseling for fertility preservation should clearly differentiate between established treatments and experimental procedures.
- Concerns about the welfare of future offspring are not sufficient reasons to deny patients who are facing gonadotoxic treatments assistance in reproducing.
- When the patient is a minor, consent to medical treatment, including decisions regarding fertility preservation, is usually made by parents or legal guardians and should be based on the potential benefit to the minor child. In such situations, the input and assent of the minor patient should be obtained in accordance with their developmental and chronological age.
- To support an open future, it is recommended that embryos not be created from the gametes of minors, as this limits their future family-building options.
- Parents of minors undergoing cryopreservation of gametes or gonadal tissue should be informed of the recommendation that once the minor reaches the age of majority, the minor should update the disposition and informed consent agreements.

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- If a minor patient does not survive into adulthood, it is recommended that their gametes and reproductive tissue be discarded or donated to research upon their death. This should be explicitly discussed at the time of cryopreservation and included in the initial consent forms and disposition agreements.
- Programs offering posthumous reproduction should be aware that state laws vary, and should counsel patients regarding this and reduced fertility.

When fertility preservation is considered for patients requiring treatment that has the potential to negatively impact their reproductive capacity, a number of ethical issues arise. These include posthumous reproduction (1, 2), the future use of reproductive tissue when it is cryopreserved when the patient is a minor, and the welfare of any resulting children. A distinction should be made between established and experimental therapies. In some respects, gonadotoxic treatment-related infertility is not markedly different from other kinds of infertility. In other respects, the context of potentially life-threatening illnesses gives rise to issues of patient and offspring welfare that do not arise in other infertility settings. This statement addresses the ethical issues that may arise relating to the reproductive use and disposition of cryopreserved gametes, embryos, and gonadal tissue. It also seeks to inform both clinicians who provide such treatments (oncologists, hematologists, rheumatologists, surgeons, etc.) and fertility specialists as they work together to help patients preserve their fertility and consider the future use of their cryopreserved gametes, embryos, and gonadal tissue.

Improvements in treating cancer with surgery, chemotherapy, and radiation have greatly increased survival for many younger people diagnosed with cancer (3). Five-year survival rates may be 90% or greater after testicular cancer, hematologic malignancies, and other cancers that affect young people (3). The increased cure rates and longer disease-free survival have expanded the population of reproductive-aged individuals who stand to benefit from fertility preservation. Gonadotoxic therapies have also helped reduce morbidity and mortality in patients with nonmalignant conditions such as sickle cell disease, thalassemia, and rheumatologic conditions, but with potentially detrimental effects on reproductive function. For those undergoing gender-affirming care, hormonal therapy and surgery may also impact their fertility, and fertility preservation options should be discussed before initiating treatments that affect their reproductive potential (4).

Assisted reproductive options include gamete, embryo, and ovarian and testicular tissue cryopreservation. For prepubertal boys, testicular tissue cryopreservation is currently considered experimental. Some patients may be candidates for fertility-sparing surgery, ovarian transposition, or gonadotropin-releasing hormone (GnRH) agonist therapy during chemotherapy. The reproductive risks of cancer therapies and options for fertility preservation are reviewed in the American Society for Reproductive Medicine (ASRM)'s Practice Committee Opinion on Fertility Preservation (5).

ENSURING SHARED DECISION-MAKING AND INFORMED CONSENT WHEN CONSIDERING GONADOTOXIC TREATMENT AND FERTILITY PRESERVATION

In addition to the physical and emotional impact of cancer and other medical diagnoses on health and survival, children and adults of reproductive age may face the potential loss of reproductive function, the opportunity to have genetically related children, or the possibility of carrying a pregnancy. Surveys of cancer patients reveal a strong desire to be informed of available options for fertility preservation and future reproduction (6). These options are best discussed when patients receive a diagnosis of cancer or other disease whose treatment may affect their reproductive potential. When fertility preservation requires an alteration or delay of standard treatment protocols, in-depth counseling regarding risks, benefits, and uncertainties should be provided. Shared decision-making and informed consent are the cornerstones of this process, ensuring that patients have the tools to make the best possible choices about whether and how to proceed with fertility-preserving options in a manner that reflects their values and desires. In some situations, their options may be limited to using donor gametes, pregnancy via a gestational carrier, adoption, or child-free living, and this should be discussed as early as possible so that patients are informed of their future options.

In all cases, patients should be counseled regarding which treatments are established and considered standard of care, and which are experimental. Experimental procedures should only be offered under an institutional review board (IRB)-approved protocol and after a thorough discussion of the potential risks and benefits.

Counseling should include the differences between freezing gametes and embryos. It should include a discussion regarding the fact that if embryos are cryopreserved using a partner's gametes, both individuals would need to provide consent for the use of the resulting embryos, and such consent may change over time. Referral to a mental health professional should be strongly considered for patients facing such decisions.

THE ROLE OF PHYSICIANS WHO PRESCRIBE GONADOTOXIC THERAPIES IN PRESERVING FERTILITY

Fertility preservation is a core component of care in children and individuals of reproductive age who require potentially gonadotoxic therapies. This involves informing patients and/or their families of options, benefits, and risks, and promptly referring them to fertility specialists when desired

by the patients or their proxies. Unless patients and their families are informed or referred before treatment, options for later reproduction may be lost.

Physicians prescribing gonadotoxic treatments should be aware of the adverse effects of these treatments on fertility and ways to minimize those effects. Issues to be considered in choosing a treatment plan include the risk of gonadal failure and/or damage to reproductive organs with the proposed treatment; the overall prognosis for the patient; the potential risks of delaying treatment; the impact of any future pregnancy on the condition for which the treatment is being prescribed; the risk of cancer recurrence or worsening of nonmalignant diseases; and the impact of any required hormonal manipulation on the disease process. There can be great variability in how these treatments affect fertility, and it may be difficult to predict with certainty an individual's risk; patients should be counseled about this uncertainty.

Although oncologists and other medical specialists focus on providing the most effective treatments available, consideration should also be given to selecting treatment modalities that minimize negative effects on fertility in children and reproductive-aged patients. With the growing number of cancer survivors, much attention is now focused on their quality of life and the physical, psychological, social, and spiritual issues that they confront (7). A high quality of life for younger survivors may include the ability to have genetically related children or carry a pregnancy. As survival rates for younger patients continue to improve, it is important to counsel patients on the impact of treatment on fertility and ways to preserve it. Such discussions should start as early as possible in the planning of treatments that have the potential to be gonadotoxic, and prompt referral to specialists with expertise in reproductive medicine should occur. Fertility-preservation modalities such as oocyte cryopreservation can usually be completed within 2 to 3 weeks, often without negatively impacting the outcomes of cancer treatment. Sperm cryopreservation can often be arranged without delay. Gamete or reproductive tissue cryopreservation can often be performed before the initiation of gonadotoxic therapy. Although discussion about potential threats to fertility is of great importance, clinicians should also discuss the need for contraception when appropriate, as accidental pregnancies may occur in patients who believe they are infertile.

Research has shown that patients prefer that their oncologists be attentive to issues of fertility (8), and oncologists should inform patients of options for gamete, embryo, or gonadal tissue cryopreservation when such options are viable. In a 2016 study of male cancer patients, for example, only 29% of patients received fertility counseling and 11% attempted sperm banking (8). Another study published in 2009 showed that although 60% of oncologists reported awareness of American Society of Clinical Oncology guidelines for fertility preservation, less than 25% of the respondents reported following them on a regular basis, distributing educational materials, or referring patients for fertility-preservation discussions (9). A study of children's oncology practices found that only 44% of female patients and 39% of male patients received fertility-preservation counseling (10). Reproductive medicine physicians should collaborate with oncologists and other physicians providing potentially gonadotoxic therapy, update them regarding available technologies, and facilitate consultations with newly diagnosed patients. To further these alliances, education about fertility preservation should be incorporated into training programs in oncology, rheumatology, and other specialties that prescribe potentially gonadotoxic therapies.

THE ROLE OF FERTILITY SPECIALISTS IN PRESERVING FERTILITY

Reproductive endocrinologists and urologists play an important role in helping to preserve the reproductive capacities of children and reproductive-aged individuals who require treatments that may be gonadotoxic. They should provide patients facing potential loss of reproductive function with all viable options to preserve their fertility as soon as possible after a diagnosis that necessitates potentially gonadotoxic therapy. Later, they are the ones who will counsel patients in assessing their reproductive capacity and in using their previously cryopreserved gametes, embryos, or reproductive tissue.

Variations in the type of disease, time available until the onset of treatment, age, partner status, type and dosage of any chemotherapy and radiotherapy, and the risk of sterility with a given treatment regimen require an individualized treatment strategy. Consultation with the patient's treating physician is essential. A key issue at the time of treatment is whether it is medically feasible to obtain gametes or gonadal tissue for the creation of embryos or for storage for later use. Questions about the patient's health and prognosis will also arise when the patient later decides whether to pursue reproduction. When patients are partnered, they may choose to include their partners in such discussions, but should also be counseled individually to ensure that they do not feel coerced regarding decisions to store embryos as opposed to gametes.

CONSIDERATIONS FOR MINORS FACING GONADOTOXIC THERAPIES

Fertility preservation should also be considered in children, many of whom will not be old enough to provide informed consent or fully understand the implications of gonadotoxic treatments on their future ability to build a family. Ethical and legal norms require that procedures performed on minors serve their best interests. If invasive procedures are necessary, minors who can understand the choices presented should give their assent in accordance with their chronological age and developmental stage. Minors should be encouraged to actively participate in the decision-making process as appropriate, with their parents or legal guardians providing informed consent. To provide minors with an open future, fertility preservation should be limited to gamete or tissue cryopreservation, and it is recommended that disposition be limited to use by the minor, donated for research, or discarded. Alternative disposition of the

gametes or tissues, including donation to others for reproductive use, should be determined solely by the minors when they reach the age of majority, and in accordance with state and federal regulations. Fertilization of gametes should be avoided as it removes the option for gametes to be fertilized in the future with the child-turned-adult's chosen partner or gamete donor. These methods of preserving gonadal material for minors should be offered in a developmentally appropriate manner, in accordance with the American Academy of Pediatrics' statement on pediatric assent (11, 12). When reaching adulthood, minors who underwent fertility-preserving procedures should execute new dispositional agreements that include choices to continue storing their reproductive tissue or to donate it for reproduction, research, or clinical training. Clinics should attempt to reach patients who cryopreserved gametes or reproductive tissue as minors and have now reached adulthood to encourage them to execute new consent forms.

The wishes of postpubertal minors regarding egg or sperm procurement and cryopreservation should be respected, and these procedures should not be pursued if minors object to them. If the child is too young to give assent, parents may consent to the cryopreservation of ovarian or testicular tissue if the procedure is deemed to offer a potential benefit to the child, and once the parents have been fully informed regarding the risks and whether the procedure is deemed experimental or has been established as effective.

USE OF EXPERIMENTAL PROCEDURES IN MINORS

The same requirements of assent and net benefit would apply to the use of experimental procedures in minor children (13). However, in the context of research, the nature and extent of the risks and benefits of research participation are often unknown. For this reason, experimental procedures should be offered only as part of an approved research protocol. Because the minor patient is intended to derive some benefit from the research, the following conditions should be met: assent from the minor if developmentally appropriate, consent of the parents, and a finding from an IRB that the expected benefits to the child of future reproduction outweigh the burdens of the experimental procedure.

DIRECTIONS FOR DISPOSITION OF STORED GAMETES, EMBRYOS, AND GONADAL TISSUE

Documented plans and agreements before treatment regarding the authorization of tissue disposition should be developed for those whose gametes, embryos, or gonadal tissue will be stored to preserve future fertility, either by the individual or their legal guardian(s), as appropriate. Patients should specify disposition in the event they die or are otherwise unavailable; do not pay storage fees; or cannot be located in the future. Given the potential for loss of contact because of prolonged time, illness, or death, it is particularly important that patients specify in writing in advance whether they want tissues discarded or used posthumously for research, clinical training, or reproduction, and by whom (1, 14).

LATER REPRODUCTION IN CANCER SURVIVORS

Reproductive options may vary after fertility-affecting treatments. Discussions about fertility should be incorporated into survivorship programs, including considerations surrounding the continued cryopreservation or use of previously stored gametes, embryos or gonadal tissue. If patients were unable to cryopreserve gametes, embryos, or tissue before treatment, they may consider doing this after treatment, when feasible. Patients who have retained reproductive function may be able to reproduce without assistance but may wish to seek counseling from fertility specialists.

In addition to the risks posed by fertility treatment, physicians may be concerned about the risks posed by pregnancy on cancer recurrence and the risk to the fetus. The optimal timing of pregnancy after cancer treatment may be uncertain for some patients. It is generally recommended that pregnancy be delayed until cancer treatment is concluded to avoid the impact of treatment on the fetus, although patients' values and preferences should guide this process under a shared decision-making model. Consultation with oncologists and maternal-fetal medicine specialists should be offered before pursuing pregnancy.

Studies that have examined pregnancy outcomes in cancer survivors have found no statistically significant increase in congenital malformations or malignant neoplasms in the resulting offspring (15); however, these studies primarily evaluated women who conceived spontaneously many years after chemotherapy treatment. Cancer survivors should be counseled on the current state of knowledge about the risks to the health of their offspring.

Additionally, counseling patients regarding the potential psychological implications of reproduction when the life expectancy of the parent may be limited is important as part of comprehensive patient care.

Reproductive physicians treating cancer survivors should be cognizant of the patient's medical status, treatment plan, prognosis, and potential harmful effects of previous therapy. They should also be aware of the potential risks of cancer recurring as a result of fertility treatments.

POSTHUMOUS USE OF STORED REPRODUCTIVE TISSUE

In some cases, adults who have stored gametes, embryos, or gonadal tissue will die before they have had an opportunity to use them. Surviving spouses/partners might want to use the gametes, embryos, or tissue for reproduction (1). Two relevant legal issues arise from the potential use of posthumously stored reproductive tissue, gametes, and embryos: 1) whether the deceased consented to posthumous use in a manner recognized as legally sufficient in the applicable jurisdiction and 2) whether a child resulting from posthumous use of the deceased's gametes, embryos or tissue will

be deemed the deceased's legal child, and thereby legally entitled to inherit from, or receive federal benefits for, the deceased, under the law of the applicable jurisdiction. The law regarding posthumous reproduction and posthumous parentage is not consistent. A decedent's prior instructions that their reproductive tissue may be used, or should not be used, should be respected. In the absence of legally recognized sufficient instructions, courts have come to varying conclusions on whether surviving partners or family members may use (or extract and use) a deceased's gametes or embryos. As two examples, in New York, a court permitted the surviving parents of a single man to extract and use his sperm for procreation without his prior consent, whereas a California court rejected a widow's request to use her deceased husband's stored sperm without his clear prior instructions. The US Supreme Court has ruled that state law determines the question of whether any resulting offspring will be legally recognized as the child of the deceased. As a result, legal precedent varies from state to state, even when the deceased has left a written record of intent to be legally recognized as a parent (16–18).

Given the complexity and variability of state law on these issues, which may include a child's legal status turning on how long after the deceased's death they were born, patients interested in considering this option should be advised to consult with knowledgeable legal counsel before executing any dispositional documents. Potential recipients of any posthumously stored gametes or embryos should also be advised to seek such consultation.

RISK OF POTENTIAL CANCER IN OFFSPRING

Although there does not appear to be major mutagenic effects in offspring born to patients successfully treated for cancer (1, 19), children of patients with cancer-predisposing germline mutations are at increased risk of developing cancer over their lifetimes. Some people with heritable cancers want to reproduce only if they have reasonable assurance that their child will not have a high risk for their cancer and the burdens entailed in that risk.

Patients who wish to minimize the risk of transmitting known cancer genes to their offspring may be interested in utilizing preimplantation genetic testing for monogenic disorders (PGT-M) for that purpose and should have access to this option (18).

CONCLUSION

Children and adults of reproductive age facing fertility-affecting therapies should be counseled as early as possible after their diagnosis regarding all available fertility-preservation options. Oncologists and others providing potentially gonadotoxic treatments are encouraged to refer patients to a reproductive specialist early in the treatment planning, when possible. A team-based approach should be taken in the counseling and management of patients in the setting of specialty fertility care. When damage to reproductive organs because of gonadotoxic treatment is unavoidable, clinicians should inform patients, before treatment, of options for cryopreserving gametes, embryos, and gonadal tissue. Counseling, including issues of reproductive autonomy that may be impacted by cryopreserving embryos instead of gametes, should be discussed before initiating fertility preservation. Including mental health professionals and genetic counselors, when appropriate, will maximize fully informed consent. Referral to legal counsel to explore the potential legal implications of preserving gametes or embryos, and the differences between those choices, as well as legal issues surrounding posthumous reproduction, should be recommended.

Experimental fertility-preservation procedures should be offered to patients only in an experimental setting under IRB oversight.

Parents and legal guardians may act to preserve the reproductive options of minor children undergoing gonadotoxic treatment as long as they do so for the benefit of the child and obtain the assent of a minor as dictated by their age and developmental stage. The fertility-preserving interventions should not pose undue risks to minors and should offer them a reasonable chance of net reproductive benefit.

Concerns about the welfare of resulting offspring because of the potential for a shortened lifespan of the parent are not a sufficient reason to deny patients assistance in reproducing. Programs storing gametes, embryos, or gonadal tissue should require clear, advance instructions regarding the disposition of stored reproductive materials in the event of the patient's death, unavailability, nonpayment of storage fees, or other contingencies. For minors cryopreserving gametes or gonadal tissue, disposition agreements should be revisited when they become adults.

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Preservación de la fertilidad y reproducción en pacientes tratadas con terapias gonadotóxicas: opinión del Comité Ético

Los pacientes que reciben tratamientos con el potencial de afectar negativamente sus gónadas, incluidos la quimioterapia, la cirugía y la radioterapia, deben ser informados sobre las opciones de preservación de la fertilidad y de reproducción futura antes de iniciar el tratamiento. La reproducción, en el contexto de tratamientos que afectan la fertilidad, plantea una serie de cuestiones éticas relacionadas con el bienestar tanto de los pacientes como de la descendencia. Este documento reemplaza al documento titulado "Preservación de la fertilidad y reproducción en pacientes tratadas con terapias gonadotóxicas: opinión del Comité Ético" publicado en 2018.