When Ethical Dilemmas Split Teams: A Case Study of Fertility Preservation In the Context of Metastatic Disease

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AOSW Annual Meeting Disclosure: Elizabeth Farrell LICSW and Fremonta Meyer MD

• With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the parties listed above (and/or spouses) and any for-profit company in the past 24 months which could be considered a conflict of interest.

Psychological distress associated with infertility

- Grief & loss -> sense of taboo, lack of culturally prescribed mourning rituals
- Anger, envy & a feeling of “Why me?”
- Hopelessness, helplessness & despair
- Feelings of failure around body image, legacy-making
- Identity crisis with regard to gender, role in family & society

Cancer-specific considerations

- Potential loss of fertility - more painful than confronting cancer itself?
- Possibility of having children after cancer - powerful stimulus for recovery
- In one patient survey, >50% cited that having a child was "most important" in their life; 62% were "most concerned" with the impact their cancer treatment would have on fertility
- Concerns about treatment-related infertility may affect treatment decisions.
  - In one study (n=620), up to 11% of young women with breast cancer considered rejecting, shortening, or changing their chemotherapy or endocrine therapy in order to preserve long-term fertility

As a result...

ASCO (American Society of Clinical Oncology) and ASRM (American Society of Reproductive Medicine) recommend that:

- the impact of cancer treatment on fertility should be discussed with all cancer patients of reproductive age...
- fertility preservation options should be offered routinely and as early as possible in the treatment process.

Established FP options for women

- Embryos may be generated via hormone stimulation & IVF, and cryopreserved for years
  - Requires 2-4 week delay in cancer treatment
- Limiting factors include time, expense (≈ $8K initially + $400/year storage fee), access to sperm
- In setting of pelvic radiation, ovaries can sometimes be surgically transposed higher in the abdomen and outside the field

References:

5. Ethics Committee of the ASRM. Fertility and Sterility 2005, 83: 1622.
Emerging FP options for women

- Cryopreservation of unfertilized eggs (oocytes) has become better-established as a technique in recent years.
- Freezing of ovarian tissue requires surgery and has thus far resulted in few if any live births; still considered experimental.

However...there is limited to no structured research on women who undergo FP procedures in the setting of recurrent or metastatic cancer.

Case Study

- 31 year old childless African-American female initially diagnosed with triple negative breast cancer, BRCA+, in October 2011.
- At the time of diagnosis patient was approximately 6 months into a new relationship.
- Declined fertility preservation consultation.
- Treated with bilateral mastectomy, 4 cycles of AC + 3 cycles of Taxane (discontinued early due to side effects) and radiation therapy.
- Completed treatment in May 2012.
• July 2012 (2 months post-treatment) patient recurred with metastatic disease to her lungs

• Patient expressed an interest in fertility preservation and was referred for a fertility preservation consultation which took place in November 2012

• Patient and partner were able to preserve 4 embryos and began discussions of utilizing a family member as gestational carrier

• Patient began chemotherapy while continuing to talk about the necessary steps in order to move forward with an embryo transfer into a gestational carrier

• Her cancer began to progress through treatments without any stability

• Anxiety increased culminating in several panic attacks resulting in presentations to ED and subsequent hospitalizations with negative medical work-up

• Several team members were feeling uncomfortable in conversations with the patient and partner about their understanding of her prognosis

• Expressed these concerns to patient’s medical oncologist and arranged for an appointment where patient could ask more targeted questions about her prognosis in order to make a decision about her plans for a baby

• Appointment took place in March 2013 and patient was told by her medical oncologist that her life expectancy was likely 12-18 months.
As discussions amongst the various team members continued, it became clear there was a divide. Several team members did not believe an embryo transfer should happen, while others were very comfortable with the process moving forward.

An ethics consult was called to further discuss the concerns that everyone was having and this took place in the summer of 2013.

Results of the ethics consult

- We learned that our primary responsibility is to the patient, not the unborn child
- Neither the partner nor the related gestational carrier have a right to patient’s medical information
- While there are legal documents that intended parents must sign accepting responsibility for the intended child/children, these are not unique to oncofertility

Outcomes

- November 2013 embryo transfer took place and was successful
- No preimplantation genetic diagnosis
- A baby boy was born on August 24th, 2014
- Patient died on October 24th, 2014
Existing ethical positions in oncofertility8-9

- Concerns over the welfare of resulting offspring should not justify denying cancer patients assistance in reproducing.
- Parents may consent to preserve fertility of minor children if the children assent.
- Precise instructions should be given for the disposition of stored gametes, embryos, and gonadal tissue in case of death/availability/other contingency.
- Preimplantation genetic diagnosis is ethically acceptable.


Ethical considerations related to gestational surrogacy10

- Reasonable economic compensation is ethically appropriate.
- Informed consent including counseling regarding risks of pregnancy (esp. multiple gestation).
- No evidence so far of psychological harm to the GC but little data.
- GCs should be at least 21, have had a prior pregnancy/delivery, stable social situation.
- Should have independent legal counsel.

**None of these guidelines are cancer-specific.


Reflection

- What is your emotional reaction/countertransference to this case?
- In a situation like this, what roles should different team members play?
• Should metastatic patients be offered fertility preservation?

• Should prognostic discussions be the same or more detailed in metastatic patients who have existing cryopreserved oocytes or embryos?

• To what extent should family be involved?

• Do you agree with the ethical position that one should not consider the unborn child’s welfare?

• What if the child has a genetic mutation—BRCA, P53?

Do we need separate ethical and procedural safeguards for patients who:
(a) undergo FP in the setting of metastatic disease;
(b) Undergo embryo transfer into a GC?
• Do any of your thoughts/opinions change if it is a male patient with metastatic cancer considering FP?