

Fertility preservation options for people with cancer

April is Cancer Awareness Month in British Columbia.

When a young person is diagnosed with cancer, conversations about survival, staging, and treatment timelines understandably dominate early visits. In busy oncology clinics, discussions about future fertility can feel secondary—especially when care pathways are complex and time-sensitive.

In British Columbia, hundreds of individuals of reproductive age are diagnosed with cancer each year. Survival rates are high, and many will live long lives after treatment, but infertility becomes an unexpected and devastating consequence of cure.

Breast cancer is the most common cancer diagnosed in individuals of reproductive age—affecting over 4200 people in British Columbia in 2025,¹ 10% to 15% of whom are estimated to be of reproductive age. Hematologic malignancies; colorectal, thyroid, and testicular cancers; and melanoma are also among the most prevalent cancers in younger patients referred for fertility preservation. Encouragingly, 5-year survival rates are over 80% for children and adolescents and over 70% for adults.² With improved survival comes a responsibility to address life after cancer, including the possibility of biological parenthood.

Many cancer treatments, including chemotherapy and ionizing radiation, can significantly compromise future reproductive potential or cause permanent sterility. A 2024 clinical practice guideline from the Canadian Fertility and Andrology Society provides an excellent framework for fertility preservation in patients facing gonadotoxic treatment.²

First and foremost, it's essential to acknowledge that coordinating care between medical, radiation, and surgical

oncology teams is complex and involves difficult conversations. Survival takes precedence, but fertility and future childbearing should be included in any informed-consent discussions for those facing gonadotoxic therapies. Even when family building feels distant, research consistently shows that many cancer survivors want biological children.² The psychological impact of infertility after cancer can be devastating, contributing to depression, anxiety, grief, and reduced quality of life.³

Fertility preservation for people with ovaries

Ovaries contain a finite number of eggs at birth, so approaches to protect and/or cryopreserve eggs are important to consider before beginning cancer treatment. High-dose alkylating agents, such as cyclophosphamide for breast cancer, are particularly gonadotoxic and can damage ovarian reserve and future reproductive potential. Although menses may resume after chemotherapy, this does not reliably indicate ongoing fertility. Long-term follow-up studies consistently demonstrate poorer reproductive outcomes among childhood cancer survivors.² Pelvic radiation or radiation prior to bone marrow transplant can reduce ovarian reserve, and uterine exposure can complicate future pregnancy.²

Considerations:

- Egg freezing is the most common option for reproductive-aged patients with ovaries. Ovarian stimulation with gonadotropins typically takes 8 to 14 days and, if necessary, can begin at any time of the menstrual cycle. Fertility clinics prioritize oncology referrals and can often initiate treatment promptly to avoid delaying cancer therapies.⁴

- Embryo freezing may be preferred when a patient has committed to a sperm source. Embryos provide additional prognostic information, allow for preimplantation genetic testing, and generally demonstrate stronger survival than eggs in freeze-thaw.
- Gonadotropin-releasing hormone agonist therapy (e.g., leuprolide acetate) during chemotherapy for breast cancer may offer ovarian protection.⁵
- Ovarian transposition can reduce radiation exposure in patients requiring pelvic radiation.
- Ovarian tissue freezing is currently the only fertility preservation option for prepubertal patients. Tissue is removed laparoscopically and frozen for future transplantation.⁶

Fertility preservation for people with testes

Spermatogenesis takes about 70 days and continues throughout life. Although a normal semen sample contains more than 40 million sperm, counts may be reduced due to illness or treatment, so reassessment over time may be appropriate.

Considerations:

- Sperm freezing remains the standard approach for postpubertal patients. Even very low numbers may be sufficient for future in vitro fertilization (IVF). Banking multiple samples can improve prognosis and give the flexibility to use the sample for insemination or IVF.
- For patients unable to produce a semen sample, sperm-retrieval techniques are available.
- Testicular tissue freezing in prepubertal patients remains experimental.

Ideally, fertility preservation would occur before exposure of the gonads to cancer treatment. However, discussions about reproductive health are valuable at any stage of care. The updated 2025 American Society of Clinical Oncology guideline reiterates that people with cancer should be counseled about reproductive implications throughout treatment and survivorship.⁷ Despite advocacy, fertility preservation is not covered under the Medical Services Plan. Fertility clinics and pharmaceutical companies often substantially reduce fees for fertility preservation in cancer patients, and there are also charitable organizations that assist with fees in eligible patients.

Oncology care is demanding, and clinicians are rightly focused on timely treatment in a resource-constrained environment. Yet, as survival rates continue to improve, fertility conversations are increasingly a part of comprehensive cancer care. For many young patients, the possibility of a future

family represents hope, normalcy, and life beyond cancer.

To my oncology colleagues, thank you. The emotional and clinical weight of your work is immense. Making space for fertility discussions, when possible, is a powerful extension of the compassionate care you already provide. ■

—Caitlin Dunne, MD

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Cutting the Interim Federal Health Program is the wrong prescription for cost savings in health care

The strength of a health care system can be measured by its commitment to those who need it most. For decades, the Interim Federal Health Program (IFHP) has served as a critical, albeit temporary, safety net for refugees, asylum seekers, and others fleeing violence while they await provincial coverage. Many of these families are fleeing persecution and humanitarian disasters in settings where health care and social systems are non-existent or inaccessible. Often, prioritizing safety and other basic needs means that physical and mental health concerns have gone unmet. For these families, Canada offers the promise of a new start.

The federal government's recent announcement to introduce co-payments for "supplemental" health care products and services, effective 1 May 2026, marks a concerning shift that risks the health and well-being of these newcomers.¹ Patients will be required to cover a \$4 co-payment for every prescription and 30% of the cost of supplemental services, including dental care, vision care, and mental health counseling. Immigration, Refugees and Citizenship Canada (IRCC) has framed these changes as necessary for "long-term sustainability."

Professional associations and advocacy groups have spoken out about the deep problems inherent in the IRCC's position, decrying the negative impact on affected families and underscoring the duty to uphold basic rights to health care.² The policy change is wrong, not only from a human rights perspective, but also from an economic one. While the revised program provides funding for doctor and hospital visits, co-payments for the treatments we prescribe constitute a major barrier to

accessing the medicine patients need to stay healthy. We know that co-payments prevent the use of essential treatments and have measurable morbidity and mortality risks.^{3,4} Social determinants of health such as poverty and trauma, which affect many IFHP beneficiaries, amplify those effects. The combined impact will result in a need for more emergency room visits, more inpatient hospital stays, more physician time, and, ultimately, higher costs overall. Shifting the financial load from one silo to another is cost shuffling, not cost saving.

While the harm will be felt most directly by IFHP patients whose supports are cut, the wider threats to Canadian health care will affect us all.

None of this is new. In 2012, the federal government repealed the IFHP, once again claiming that cuts would decrease health care costs. Research from Ontario following those cuts found that while the number of emergency room visits by refugee children decreased, the admission rate nearly doubled, from 6.4% to 12.0%.⁵ Children were presenting sicker, because they could no longer access or afford the preventive care and medications that keep chronic conditions stable.

While the harm will be felt most directly by IFHP patients whose supports are cut, the wider threats to Canadian health care will affect us all. By pushing people who are unable to afford entry-level access to

care into clogged emergency departments and hospitals bursting with patients, the IRCC decision tightens critical bottlenecks in an already overstretched health system and makes it harder for everyone to access what they need.

To sustain the health care system for future generations, there is no doubt that we need innovation to address the rising costs and demands; however, limiting the care provided through the IFHP is not the answer. ■

—**Kristopher Kang, MD, FRCPC**

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