We read with interest the thought provoking commentary by Dr. Henkel (1) in response to the practice recommendations by Agarwal et al. (2). Dr. Henkel appropriately pointed out the shortcomings of conventional semen analysis in predicting the outcome of assisted reproductive technologies (ART), to which we concur as discussed extensively elsewhere (3-7). The author also recognized the role of sperm DNA fragmentation (SDF) tests as complementary to semen analysis. Moreover, Dr. Henkel discussed important technical issues concerning SDF tests and argued that the guideline by Agarwal et al. (2) could have been more detailed with regards to the technical differences among the various tests. Lastly, Dr. Henkel suggested the use of tests to measure redox potential as an alternative to SDF testing. Here, in our response to his commentary, we wish to elaborate upon the (I) technical aspects of SDF testing, (II) methods to select sperm with low DNA fragmentation, and (III) usefulness of redox potential measurement in male infertility.

Although clinicians would like to have a definitive diagnostic test for male infertility with precise cutoff level above or below which they could make a decision regarding diagnosis and management, it is unlikely that the perfect test will be available in the near future (8). The reasons stem for the complexity of semen as it consists of a heterogeneous population of spermatozoa produced over approximately 70–80 days. Furthermore, spermatozoa are mixed with and diluted by fluid secreted from accessory glands. As a result, semen quality is governed by (I) the state of testicular sperm production (II) epididymal transit, and (III) activity of accessory glands (9). To complicate matters, laboratory analysis of semen is subjected to variability due to operational and technical factors and ejaculatory abstinence period (4,10).

Despite recognizing the current limitations of SDF testing, we ponder that conventional semen analysis, i.e., sperm concentration, motility, and morphology, does not live up to the level of scrutiny or rigor that is often asked from SDF testing (8). In fact, routine semen analysis lacks the power to discriminate between fertile and infertile men, and rarely provides a clear path for management, unless the results are in extremely abnormal range (3,4,8). Given the overwhelming evidence of a negative association between SDF and male infertility and impaired reproductive outcomes, both natural and assisted, it seems sound to include SDF as an integral test of semen analysis to improve its predictive diagnostic value (6,8,11,12).

We agree with Dr. Henkel that SDF testing methods are not interchangeable. Indeed, SDF testing does measure different aspects of DNA, although these aspects are interrelated to a greater or lesser extent by the properties of the DNA molecule (13). The ideal method to measure SDF
is still to be determined, so any decision to consider SDF testing should take into account the limitations of testing methods and the possible benefits for clinical outcomes, as highlighted in our recent publications (2,11,13-16). Therefore, suggesting the use of a specific assay to measure SDF is not scientifically correct until a gold standard method is established. Nevertheless, it is essential that a reliable SDF assay with a validated threshold is used (6,8).

Dr. Henkel ponders that more studies have to be conducted to widen and clarify the scope of sperm DNA testing. In fact, the number of studies published in this regard is increasing steadily; the reader will be astonished to learn that more than 2,000 articles about sperm DNA damage are indexed in PubMed, half of which was published in the last 5 years. As far as the tests to select viable sperm with reduced SDF for ART are concerned, the literature is also rich in studies comparing different methods. In a recent report, we examined some of these tests and concluded that they in general reduce the amount of sperm with SDF in the selected specimen, but none of them, alone or combined, can completely remove sperm with SDF (Table 1) (17).

However, a recent report indicated that among motile sperm organelle morphology examination (IMSI), physiological ICSI (PICSI) using hyaluronic acid-selected spermatozoa, frequent ejaculation, and testicular sperm, the latter was more advantageous with regards to ICSI live birth rates (18).

Lastly, Dr. Henkel pointed out that given oxidative stress is a major contributor to SDF, it would be beneficial and possibly easier to determine the redox potential either in semen or in the serum to determine that OS is causing SDF. Indeed, oxidation-reduction potential (ORP) has been advocated as a new measure of oxidative stress, as it reflects the balance between the total available oxidants and reductants in a given specimen (19). ORP seems to be a simple alternative to multiple individual markers of OS such as ROS (chemiluminescence), antioxidants (total antioxidant capacity and individual enzymatic and nonenzymatic antioxidants) and lipid peroxidation (MDA) (19-22).

In addition to real-time measurement of redox capacity by ORP in semen specimens, other qualitative methods are still to be determined, so any decision to consider SDF testing should take into account the limitations of testing methods and the possible benefits for clinical outcomes, as highlighted in our recent publications (2,11,13-16). Therefore, suggesting the use of a specific assay to measure SDF is not scientifically correct until a gold standard method is established. Nevertheless, it is essential that a reliable SDF assay with a validated threshold is used (6,8).

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to measure OS have been investigated. In a recent multi-center study, we analyzed nitroblue tetrazolium reactivity in human semen as a potential marker of OS (23). Despite promising results, the potential clinical value of the newly aforementioned markers of OS warrants further validation.

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None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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