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The function of the Catholic urologist in the management of apparently infertile marriages is two-fold. He is concerned primarily with the diagnosis of infertility or sterility in the male partner, and secondarily with the treatment of such abnormalities. In both these concerns, his medical enthusiasm is tempered by Catholic principles of morality. It is the purpose of this paper to describe how these objectives are achieved within the framework of a hospital out-patient clinic.

Patients are usually referred by the obstetrical clinic or family physician, after at least superficial studies of the wife have been made and no obvious cause of infertility found. At this point it is frequently desirable to investigate the male partner, in an effort to determine his role, if any, in the etiology of the problem.

When he is first seen, the husband's attitude may vary from genuine interest and enthusiasm, to polite skepticism, or ill-concealed antagonism. A little time spent in establishing rapport at this point pays dividends later, not only to the urologist and referring physician, but also to the patient's wife, whose repeated urging has frequently been necessary to get the patient to the clinic. For this reason, an effort is made to personalize each original interview at the clinic to avoid any impression of assembly-line tactics. At the same time, for consistency in record maintenance, a printed blank form is used, which has adequate space for entering the necessary historical, physical, and laboratory data.

In addition to establishing the usual details of medical history, the patient is questioned concerning previous marriages or pregnancies, episodes of genital infection, especially gonorrhea, mumps orchitis, or epididymitis. Inquiry is also made concerning previous operations for hernia, cryptorchidism, hydrocele, or varicocele, or allied conditions. Detailed information concerning the use of tobacco, alcohol, and other drugs is sought, as well as facts concerning the patient's occupation, with particular reference to his exposure to industrial poisons, x-ray, or other noxious agents. Finally, detailed information pertaining to the patient's marital life is worth eliciting. It is surprising how much variance there may be in the history obtained from the two partners on such fundamentals as potency and libido, frequency of intercourse, contraception, premature ejaculation, and so forth.

General physical examination is then carried out, with particular

attention to the normal development of secondary sex characteristics and especially the external genitalia. The majority of these patients are not hypogonadal from the endocrine standpoint. However, such important abnormailties as hypospadias, cryptorchidism, varicocele, hernia and hydrocele, to mention a few, may be demonstrated and their importance evaluated. Careful physical evaluation of the testes and their adnexae, with thoughtful search for evidence of prior epididymitis, or vas deferens abnormalities is essential. Rectal examination, including palpation and massage of the prostate and seminal vesicles, is always carried out to detect associated pathology, usually of an inflammatory nature, in these vital structures.

Routine laboratory studies include a urinalysis and inspection of the expressed prostatic secretion, a complete blood count and blood serology and semen analysis. Material for the latter may be obtained by the use of Doyle's cervical spoon, or by the perforated condom technique.[1] The material thus obtained is examined within a few hours and note is made of its volume, gross appearance, including color and viscosity, motility including an estimate of its duration and vigor, and count, which is usually reported in number of sperm per cc. together with a percentage estimate of the number of abnormal forms. If significant abnormalities are noted, one or preferably two repeat examinations are made at intervals of one or two months to rule out temporary depression of spermatogenesis by acute toxic influences.

With the above information at hand the urologist can then venture a diagnosis. This is frequently best expressed as an opinion of the degree of fertility. For example, adequately fertile, relatively infertile, or sterile, together with the pathology present, and such etiologic factors as have been discovered. If the patient appears adequately fertile no treatment is indicated and further management of the couple is largely a problem for the wife's physician.

If complete azoospermia is confirmed by repeated examinations, testicular biopsy, a simple, relatively painless out-patient procedure, is indicated, and if the pathologic examination discloses absent spermatogenesis with permanent tubular damage, the case is hopeless. The patient is so informed and adoption is recommended. In this connection, an effort is made to emphasize for the patient the dual function of the male gonad, to impress on him that in spite of the lack of spermatogenesis, his androgenic production is normal, and consequently his virility. These men need some such reassurance at this time. Very occasionally, in the presence of azoospermia, testicular biopsy discloses

[1] For the moral status of this latter procedure, see footnote 3 of the concluding article of this series, p. 55.

normal spermatogenesis, and search must then be made for some pathology in the vas or epididymis. An occasional such case may be suitable for epididymovasostomy in an effort to re-establish a patent duct system.

Varying degrees of oligospermia, which arbitrarily is considered to be a count of less than 60 million per cc. may be encountered. The basal metabolic rate is determined for these patients, and if they have minus readings, thyroid is administered. With a normal metabolism, thyroid, although widely used, is probably of no value. When possible, testicular biopsies are also obtained in persistent oligospermic patients to correlate the degree of spermatogenic depression with the degree of oligospermia, as well as for scientific interest.

Unfortunately, therapy directed at improving spermatogenesis *per se* is not very productive of results. Wherever indicated, surgical correction of genital abnormalities is always recommended. General measures, which include consumption of a diet high in protein, minerals and vitamins, adequate rest and exercise, the elimination of foci of infection, are certainly of some value. Such common spermatogenic depressants as jockey-type underwear or scrotal suspensories are eliminated. Occasional cases are treated by gonadotropis or testosterone. The latter has been reported to produce a complete azoospermia in oligospermic patients when administered over several weeks or months, followed by a rebound of spermatogenesis, after the drug has been withdrawn, to levels higher than before its administration. This rebound is apparently not consistent, and the recovery of spermatogenesis may require a period of a year or more. We are skeptical of its value and reserve it as a last resort for oligospermic patients when all else has failed.

The Catholic urologist, then, has a definite place in the diagnosis and treatment of the male partner of apparently infertile marriages. Such a function can be closely integrated with the obstetrician or gynecologist in the operation of a fertility clinic. Not the least function of such a clinic is the protection of Catholic patients from the immoral techniques and practices to which they will not infrequently be exposed by clinics or physicians who do not consider themselves limited in their investigative or therapeutic enthusiasm by established principles of morality. These unhappy couples have high motivation for the most part, and accept without question, usually, whatever is recommended to them by the medical authority to whom they have entrusted their problem. The Catholic urologist and gynecologist, operating in unison in the management of a fertility clinic, can offer much to such people.