

oxalate intake was not tightly controlled: the patients were only instructed to reduce the consumption of foods containing high levels of oxalate. Third, the highest dose did not result in a reduction of oxalate excretion. The latter might be due to these bacteria having an impact on oxalate-degrading bacteria already residing in the fecal flora, such as *Oxalobacter formigenes*. Nevertheless, these results are encouraging, and more carefully designed studies are needed to determine the efficacy of probiotic therapy for this patient group and other types of hyperoxaluria. Preliminary reports suggest that those with other types of hyperoxaluria might benefit from probiotic therapy. Campieri and colleagues¹ previously demonstrated that the administration of Oxadrop to calcium oxalate stone formers with idiopathic hyperoxaluria produced a significant reduction in oxalate excretion. Hoppe and associates² reported that the administration of an *Oxalobacter formigenes* preparation to a small group of patients with primary hyperoxaluria resulted in a significant reduction in oxalate excretion in some individuals. ■

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Fertility

TESA or TESE: Which Is Better for Sperm Extraction?

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Many azoospermic patients with nonobstructive azoospermia (NOA) might be candidates for sperm aspiration as part of their in vitro fertilization procedure. Because sperm might be present in some but not all parts of the testes of such men, multiple samplings of the testicular tissue are usually performed to increase

the probability of finding sperm in NOA patients. These samplings can be done by 2 methods: 1) TESE (testicular sperm extraction), which is actually a surgical biopsy of the testis; or 2) TESA (testicular sperm aspiration), which is performed by sticking a needle in the testis and aspirating fluid and tissue with negative pressure. Sperm extraction is being performed more and more by non-urologists (called andrologists) who are actually either internists or obstetrician-gynecologists. It stands to reason that these non-urologists prefer TESA, given that they are not surgically trained. There has always been debate, however, as to which procedure is “better” at obtaining sperm for successful intracytoplasmic sperm injection.

Comparison of Efficacy of Two Techniques for Testicular Sperm Retrieval in Nonobstructive Azoospermia: Multifocal Testicular Sperm Extraction Versus Multifocal Testicular Sperm Aspiration

Hauser R, Yogev L, Paz G, et al.

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To better answer this dilemma, Hauser and colleagues from Tel Aviv, Israel, compared the results of TESE with

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those from TESA in the same testis of NOA patients. Three samples by TESE and by TESA were taken in each testis, and the results were compared. The investigators found that TESE was markedly superior to TESA at obtaining sperm and in terms of the quantity and subsequent motility of the sperm found. This meant that there was a better chance of cryopreservation of sperm obtained by TESE rather than TESA. The import of this is that such cryopreserved sperm can be used in subsequent cycles rather than the patient having to go through another TESE or TESA procedure.

One of the “complaints” about TESE by non-urologists is that general anesthesia is necessary for such a procedure. This is not necessarily true: it can be done safely and comfortably with a cord block, as we perform it at the University of California, Los Angeles. Therefore, according to Hauser and colleagues’ data, it seems that TESE is the preferred method of sperm aspiration in men with NOA.

Recurrent Pregnancy Loss: Who Is to Blame?

For those of us who deal with male infertility, one of the most frustrating aspects of this subspecialty is the question of what to do with couples experiencing recurrent pregnancy loss (RPL). Rarely is it assumed that the issue is with the male partner, and there is no scientific evidence to link problematic sperm to this process. However, this thinking might be undergoing a change. An intriguing article was recently published that showed some preliminary evidence that a microdeletion in the structure of the Y-chromosome might be involved with RPL.

Y-Chromosome Microdeletions and Recurrent Pregnancy Loss

Dewan S, Puscheck EE, Coulam CB, et al.

Fertil Steril. 2006;85:441-445.

Dewan and colleagues tested the DNA from buccal swabs of male partners in couples with RPL and found that 82% of them had at least one microdeletion in the Y-chromosome. This finding is extremely high compared with a random group of men presenting with male infertility due to oligospermia and/or azospermia.¹ Y-microdeletions are exactly what they sound like: deletions of certain parts of the Y-chromosome in an area of the long arm believed to be involved in spermatogenesis. This area of the chromosome is called the azospermia factor (AZF) area, and 3 subregions of the AZF area have been identified, termed

AZFa, AZFb, and AZFc. Previous data have shown that patients who have AZFa and/or AZFb deletions do not have sperm at all. Only patients with AZFc lesions alone (excluding those who might also have an AZFa and/or

With couples experiencing recurrent pregnancy loss, rarely is it assumed that the issue is with the male partner.

AZFb with an AZFc deletion) have any chance of spermatogenesis.² What was most intriguing in the Dewan study was that the men who had microdeletions primarily had an AZFc microdeletion.

There are still some questions to be answered by the authors. For example, did their RPL men all have oligospermia, as most AZFc patients are found to have, or were these couples all undergoing in vitro fertilization (IVF) and did some process within the IVF procedure lead to the RPL? Nevertheless, the results suggest that RPL might be a "couple disease" rather than simply a "female issue." Obviously, more information will be needed before it can be recommended that all men involved in miscarriages undergo a Y-deletion test. ■

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