

Sexual Infertility Treatment using Stem Cell Therapy

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ABOUT THE STUDY

Infertility is one of the most frequent problems in the world, with severe consequences for society and infertile individuals. Male infertility accounts for over half of all infertility cases among the many causes of infertility. Despite medical improvements, contemporary male infertility therapies, such as Assisted Reproductive Technology (ART), have failed to address all kinds of male infertility. Because of their self-renewal and excellent differentiation, stem cells have recently been investigated as therapeutic targets for various disorders, including infertility. The goal of this study is to analyse various forms of male infertility and the influence of various stem cells on male infertility therapy. The occlusion of the ejaculatory duct is a well-defined and possibly treatable cause of male infertility. It is present in up to 5% of infertile males and is detected seldom.

Even if some spermatozoa are present in the ejaculate, male infertility owing to ejaculatory duct constriction is frequently related to azoospermia or, in rare cases, substantial impairment of sperm parameters. Because most of these men's spermatogenesis is still normal, surgical sperm retrieval for assisted reproduction with intracytoplasmic sperm injection is viable and frequently recommended as the first line of infertility therapy. Another factor contributing to the unpopularity of transurethral resection of the ejaculatory duct for blockage is the risk of serious consequences such as incontinence, chronic epididymitis, persistent anejaculation, retrograde ejaculation, urine ejaculation, and, in rare cases, rectal damage.

Although these consequences are rare and avoidable, they can be devastating in an otherwise healthy young man and, if they occur, can lead to lawsuit. These risks may appear unwarranted in light of the availability of assisted reproduction as a treatment option for these men's infertility. Furthermore, urologists who perform a high volume of transurethral resections for enlarged prostates causing lower urinary tract symptoms may be lacking in expertise in male infertility management; similarly, reproductive urologists may be lacking in transurethral resection of the prostate experience. Even at big academic facilities, these variables contribute to the limited volume of cases in transurethral resection of ejaculatory duct blockage. The various

organisations have discussed the use of holmium lasers for transurethral resection of the ejaculatory ducts in the literature, should be applauded for providing a much needed instructional film. They not only describe the diagnostic and counselling techniques for ejaculatory duct blockage, but they also go over some of the critical procedures for conducting the treatment safely and competently. Holmium lasers have been used for prostate excision for over two decades. Holmium lasers have demonstrated benefits in terms of safety, result durability, and practicality in even the most anticoagulated patients. These procedures are also less expensive since they allow for reusable endoscopic equipment, multiuse laser fibres, and brief postoperative hospital stays. All of these reasons have contributed to holmium lasers' broad and rising acceptance in prostate excision. Some researchers have even proposed that holmium laser prostate enucleation is the gold standard for prostate excision. The holmium laser prostate enucleation treatment, on the other hand, has a high learning curve, which has been a substantial hurdle to its widespread acceptance. Certainly, early exposure to this operation during residency, together with a well-defined method to teaching the technique, is critical to overcome the learning curve. As with prostate enucleation, further research is needed to properly examine the results, safety, durability, and cost-effectiveness of ejaculatory duct resection with the holmium laser before its position in male infertility care is established. There is a possibility of postoperative azoospermia due to ejaculatory channel closure caused by fibrosis of tissue along the course of resection in the excurrent ductal system. Thus, sperm cryopreservation (perhaps many sessions) is recommended for patients having positive spermatozoa in their ejaculate prior to surgery. In situations of postoperative azoospermia, this will protect the potential of assisted reproduction. This crucial step in defining how to properly do transurethral ejaculatory duct excision using a holmium laser. Notably, as mentioned in the video, the holmium laser's modest depth of penetration (0.4 mm) is an intriguing feature since it may minimise the likelihood of severe consequences (such as rectal damage) associated with transurethral resection of the ejaculatory ducts. More urologists should be motivated to create their own case series and disclose their findings in order to affirm the function of holmium lasers in the surgical arsenal of reproductive urology.

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