Transplantation of cryopreserved ovarian tissue is a technology that holds promise for preserving reproductive potential for the future. It may be apropos for cancer survivors who will undergo treatment with sterility-inducing chemotherapy or radiation. Although there is some evidence suggesting cellular and molecular injury with the freezing and thawing process, there are examples in both animals and humans that transplantation of cryopreserved ovarian tissue can lead to successful restoration of fertility. Currently, cryopreservation of ovarian tissue is the only option available to preserve fertility in prepubertal girls or women who cannot delay their cancer treatment. For this patient population, ovarian tissue banking and subsequent transplantation is the only fertility-preserving method that has resulted in live-born pregnancies. The technology of ovarian tissue banking is currently at the forefront of the emerging field of oncofertility.

Indications for Ovarian Tissue Banking

Scope of the Clinical Problem and Incidence of Ovarian Failure

There are more than 9 million cancer survivors living in the United States today. Furthermore, it is estimated that by 2010, 1 in every 250 people will be a survivor of cancer [1]. The prognosis for patients with childhood cancers is excellent, with greater than 70% surviving, and therefore, attention can be focused on patients’ quality of life rather than just survival. Unfortunately for many young women, the chemotherapy or radiation therapy used to treat them is toxic to their ovaries and renders them infertile and dependent upon hormone replacement therapy. The incidence of ovarian failure may approach over 90% in patients undergoing high-dose chemotherapy [2]. Given that 1 in 52 females between birth and age 39 are diagnosed with cancer [3], many people are potentially affected.

One potential solution is to remove, freeze, and bank ovarian tissue before a patient undergoes gonadotoxic treatment, thereby removing the ovaries from harm, and then transplant the tissue back after completing treatment (autografting). Alternatively, ovarian tissue could be transplanted to an immunocompromised mouse host in order to minimize the risk of cancer transmission within the grafted ovarian tissue (xenografting), or oocytes isolated from the tissue could be matured in culture (in vitro maturation). Clinical decisions must always weigh the potential risks and benefits. Since there has been limited success with the aforementioned strategies, and since ovarian tissue banking requires removal of ovarian tissue, it is necessary to have a clear idea of the risk of ovarian failure from chemotherapy and/or radiation therapy. If the risk of ovarian failure is inevitable, it is reasonable to undertake these fertility-preserving strategies.
Gonadotoxicity of Chemotherapy

Chemotherapy can cause sterility in 38–56% of Hodgkin’s lymphoma patients and the majority of bone marrow transplant patients [2]. The clinical course can be unpredictable. Oligomenorrhea can be followed by normal menses or premature ovarian failure (POF). Treatment with alkylating agents is particularly harmful (Table 8.1) [4,5]. The incidence of ovarian failure is dependent on the agent, dose, and age of the patient. Younger patients are more resistant to the gonadotoxic effects of the chemotherapy (Table 8.2) [6–9]. Offspring born to women who have received prior chemotherapy do not appear to be at increased risk for birth defects.

Table 8.1 The gonadotoxicity of chemotherapeutic agents

<table>
<thead>
<tr>
<th>Group</th>
<th>Mechanism</th>
<th>Agents</th>
<th>Odds ratio for ovarian failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alkylating agents</td>
<td>Crosslinks DNA strands</td>
<td>Cyclophosphamide</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>Inhibits RNA formation</td>
<td>(Cytoxan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chlorambucil</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Mustine</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Melphalan</td>
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<tr>
<td></td>
<td></td>
<td>Busulfan</td>
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<tr>
<td></td>
<td></td>
<td>Carmustine</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lomustine</td>
<td></td>
</tr>
<tr>
<td>Platinum derivatives</td>
<td>Crosslinks DNA strands</td>
<td>Carboplatin</td>
<td>1.77</td>
</tr>
<tr>
<td>Vinca alkaloids</td>
<td>Disrupts microtubules and spindle</td>
<td>Vincristine</td>
<td>1.0</td>
</tr>
<tr>
<td>Antimetabolites</td>
<td>Inhibits pyrimidine or purine synthesis or incorporation into DNA</td>
<td>Cytarabine</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Methotrexate</td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Multiple (transcription inhibition, DNA intercalation)</td>
<td>Adriamycin</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bleomycin</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>Unknown</td>
<td>Procarbazine</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Table 8.2 The gonadotoxicity of cyclophosphamide is dose and age dependent

<table>
<thead>
<tr>
<th>Dose of cyclophosphamide before amenorrhea</th>
<th>Age of patient (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,200mg (3g)</td>
<td>40</td>
</tr>
<tr>
<td>9,300mg (10g)</td>
<td>30</td>
</tr>
<tr>
<td>20,400mg (20g)</td>
<td>20</td>
</tr>
<tr>
<td>&gt;50,000mg (50g)</td>
<td>Pubertal</td>
</tr>
</tbody>
</table>

Table 8.3 Dose estimated to cause ovarian failure in 97.5% of patients as a function of age

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Ovarian dose (cGy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>20.3 Gy (2.030 cGy)</td>
</tr>
<tr>
<td>10</td>
<td>18.4 Gy (1.840 cGy)</td>
</tr>
<tr>
<td>20</td>
<td>16.5 Gy (1.650 cGy)</td>
</tr>
<tr>
<td>30</td>
<td>14.3 Gy (1.430 cGy)</td>
</tr>
</tbody>
</table>
**Gonadotoxicity of Radiation Therapy**

Radiation therapy can adversely affect the ovaries, uterus, and hypothalamic-pituitary-ovarian axis such that future fertility is severely compromised.

**Ovary**

Radiation is harmful to the oocytes within the ovary. The LD50 of irradiation to the oocyte is 4 Gy [10], and some estimate that 5–10 Gy of radiation to the ovary causes ovarian failure in 97% of women. Younger patients are more resilient to radiation. Wallace et al. estimated that 18–20 Gy of ovarian radiation are necessary to induce ovarian failure in 97.5% of patients (Table 8.3) [11]. More conservative estimates by Chiarelli et al. showed that childhood cancer survivors receiving 20 Gy of abdominal irradiation had a relative risk of ovarian failure of only 1.02 [8]. Doses of 20–35 Gy caused infertility in 22% of patients, and doses greater than 35 Gy caused infertility in 32% of patients.

**Uterus**

High doses of abdominal irradiation (20–30 Gy) [12] and lower doses used in total body irradiation (14.4 Gy) [13] can adversely affect the growth and blood flow of the uterus. If subsequent pregnancy occurs, there is a statistically significant risk of preterm labor, low birth weight babies, and miscarriage.

**Hypothalamic-Pituitary-Ovarian Axis**

Cranial radiation to treat brain tumors can adversely affect the hypothalamic-pituitary-ovarian axis. Doses greater than 24–50 Gy are associated with delayed puberty [14,15], while lower doses of cranial irradiation are associated with precocious puberty [14,16].

**Limitations of Fertility: Preserving Techniques**

Potential approaches to preserving fertility in women surviving cancer include ovarian suppression with gonadotropin releasing hormone (GnRH), pexying the ovaries outside the field of radiation, embryo freezing, oocyte freezing, and ovarian tissue banking with subsequent in vitro oocyte and follicle maturation. Each of these options has unique problems as summarized in Table 8.4.

Ovarian pexying involves surgically moving the ovaries medially behind the uterus, which is subsequently shielded, or laterally, outside the field of radiation. The ovaries can be sutured to prevent subsequent migration. The surgery can compromise the blood supply to the ovary, however, and transposition of the ovary does not always remove it from the field of radiation. Kwon reported that ovarian failure can still occur in 30–80% of cervical cancer patients undergoing pelvic irradiation after ovarian transposition. In addition, pexying does not protect the ovary from chemotherapeutic agents [17].
Gonadotropin releasing hormone agonist treatment may reduce the risk of POF; however, equivocal results indicate additional controlled trials are needed [18,19]. The observation was made that prepubertal girls had lower rates of ovarian failure after chemotherapy and radiation therapy than post-pubertal patients. With this in mind, some postulate that continuous GnRH exposure leads to downregulation of the pituitary and induction of a prepubertal state. This ovarian quiescence during cancer treatment might decrease susceptibility to gonadotoxic treatments. While some data in monkeys [20,21] and in small, non-randomized clinical studies [18,22] show benefit with GnRH therapy, one prospective randomized trial [23] showed no benefit. Primordial follicles in humans do not have follicle-stimulating hormone (FSH) receptors, so suppression of FSH with a GnRH agonist theoretically would not be protective. Younger patients may be less susceptible to chemotherapy because they have a greater number of oocytes, not because their ovaries are quiescent during chemotherapy.

In vitro fertilization (IVF) with embryo cryopreservation can be performed with pregnancy rates of 20–30% per frozen embryo transfer, but this approach requires ovarian stimulation and a male partner. Consequently, it is not applicable to children and can also create “orphan embryos” should the patient not survive. In addition, 2–6 weeks are required for ovarian stimulation and egg retrieval, which often delays initiation of cancer therapy.
Cryopreservation of mature oocytes eliminates the need for a male partner and prevents creation of orphan embryos. To date, there have been 148 pregnancies in the world via oocyte freezing [24]. However, it too requires time and resources for ovarian stimulation. Second, ovarian stimulation is inappropriate in prepubertal girls because it initiates pubertal changes. Third, monitoring the growth of follicles and extraction of oocytes requires transvaginal ultrasound, which can be problematic in virginal or young patients. Fourth, a limited number of oocytes (15–20) are typically obtained at retrieval. Fifth, mature oocytes are challenging to freeze. The

<table>
<thead>
<tr>
<th>Table 8.4 Summary of treatment options to preserve fertility</th>
</tr>
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<tbody>
<tr>
<td><strong>Method</strong></td>
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<tr>
<td>------------</td>
</tr>
<tr>
<td>Gatifin</td>
</tr>
<tr>
<td>Oocyte</td>
</tr>
<tr>
<td>Embryo</td>
</tr>
</tbody>
</table>

Cryopreservation of mature oocytes eliminates the need for a male partner and prevents creation of orphan embryos. To date, there have been 148 pregnancies in the world via oocyte freezing [24]. However, it too requires time and resources for ovarian stimulation. Second, ovarian stimulation is inappropriate in prepubertal girls because it initiates pubertal changes. Third, monitoring the growth of follicles and extraction of oocytes requires transvaginal ultrasound, which can be problematic in virginal or young patients. Fourth, a limited number of oocytes (15–20) are typically obtained at retrieval. Fifth, mature oocytes are challenging to freeze. The
spindle is temperature sensitive, the zona pellucida hardens, and their relatively large size predisposes them to intracellular ice formation. Finally, the success rates are less than 2% per frozen oocyte [24–27].

Cryopreservation of immature oocytes with subsequent short-term in vitro maturation is another alternative and has been demonstrated in the mouse [28]; however, it has not yet yielded human embryos [29]. To date, there is no clear solution to this overwhelming clinical problem.

The Promise of Ovarian Tissue Banking

One potential solution is to freeze and bank ovarian tissue before patients undergo gonadotoxic treatment. Ovarian tissue banking involves surgically removing and cryopreserving ovarian tissue prior to the patient undergoing gonadotoxic cancer therapy, thereby removing the oocytes from harm's way. The technology involves freezing immature primordial follicles in situ within the ovarian cortex or whole ovaries. Once the ovarian tissue is frozen, there are several options available for its future utilization, including autografting, xenografting, and in vitro maturation.

Ovarian tissue banking has several theoretical advantages over other fertility-preserving strategies. First, a 1-mm³ piece of ovarian cortex may contain hundreds of oocytes [4]. Thus, cryopreservation of ovarian tissue is a potentially more efficient method of storing reproductive potential. Second, unlike collection of oocytes and production of embryos, which require time-consuming hormonal stimulation, oophorectomy does not delay cancer treatment. Oophorectomy or ovarian biopsy can usually be performed laparoscopically in less than an hour on an emergency basis. Third, primordial follicles consist of immature oocytes surrounded by a single layer of flattened pre-granulosa cells. These oocytes are much smaller, metabolically less active, and are not arrested at a stage where the spindle is present. All of these characteristics may make them better suited for cryopreservation than mature metaphase II oocytes. Finally, the immature oocytes within the ovarian tissue would be matured much later in life, thereby obviating the need for exogenous gonadotropin stimulation. Thus, ovarian tissue banking is appropriate for prepubertal girls.

Ovarian tissue banking has its disadvantages as well. First, surgery is required to obtain the ovarian tissue. Second, ovarian cortex is theoretically difficult to freeze because of its heterogeneity. Each cell type that comprises ovarian tissue (oocytes, granulosa cells, interstitial cells) has unique biological characteristics that require different freezing protocols. Finally, oocytes within ovarian tissue are immature, and require maturation before fertilization can occur. Follicles within ovarian tissue are arrested in early meiosis and cannot be fertilized. The process of follicular maturation is complex and requires multiple steps. The primordial to primary follicle transition involves numerous factors, primarily of the transforming growth factor (TGF) and platelet-derived growth factor families [30–35]. The formation of a fluid filled cavity, the antrum, within the layers of granulosa cells signifies the next stage of follicle growth and development, and is dependent on increased follicular vascularization and permeability of the blood vessels. As the follicle continues to grow, it resumes meiosis. In the primate, it is estimated that 150 days are required for growth from the primordial to the large preantral stage, followed by up to 70 days to reach the preovulatory stage [36,37]. Hence, with ovarian tissue banking, transplantation or extensive culture are needed before the harvested oocytes can be fertilized.
Emerging technology utilizing three-dimensional follicle culture systems have led to successful in vitro maturation of mouse follicles [38–41]; IVF performed with these cultured oocytes has led to the birth of live, viable offspring [42]. These developments hold promise for the future use of banked, cryopreserved ovarian tissue for in vitro maturation and IVF. The current status of how these disadvantages have been overcome will be discussed below.

**Cryopreservation of Ovarian Tissue has been Successful**

Ovarian tissue banking is a two-step process. First, ovarian tissue must be cryopreserved with viable oocytes recovered upon thawing. Second, the primordial follicles within the frozen/thawed tissue must be matured. The freezing and thawing process can damage cells by both the formation of intracellular ice as well as the toxicity of the cryoprotectants. Cryoprotectants are molecules that help to prevent intracellular ice formation (see Mullen and Critser, this volume). The majority of pregnancies from banked oocytes have come after slow-rate freezing. Slow-rate (or equilibrium) freezing involves low, non-toxic concentrations of cryoprotectants and dehydration during cooling. Slow cooling involves the precipitation of water as ice, resulting in the separation of water from the solution. In contrast, vitrification involves very rapid freezing where solutions go directly from the aqueous phase to the glass state (amorphous solid) without going through the crystalline solid state in which damage can occur. Much higher concentrations of cryoprotectant are needed for this technique.

Oktay et al. [43] showed that ovarian tissue could be cryopreserved employing 1.5 M ethylene glycol and 0.1 M sucrose [44] and a slow-rate freezing process. A high percentage of primordial follicles survived the freezing/thawing process [43]. Our lab developed a novel system for vitrifying ovarian tissue (Fig. 8.1) [45]. We demonstrated that follicle viability was equivalent with vitrification (70.4% ± 4.8%, n = 1,705) and slow-rate freezing (67.3% ± 4.7%, n = 1,895). Thus, this first step in ovarian tissue banking has been successful.

![Fig. 8.1 A novel containerless system for vitrifying ovarian tissue developed by the authors. Pieces of ovarian cortex were placed into cryoprotectant and drops of the solution containing tissue were added directly to liquid nitrogen. Frozen droplets were then transferred into cryovials filled with liquid nitrogen for storage.](image)

**Autotransplantation of Ovarian Tissue has been Successful**

The second step in ovarian tissue banking involves maturation of immature follicles. Primordial follicles are immature eggs, arrested in the dictyotene stage of prophase I, and are surrounded by
a single layer of flattened, pre-granulosa cells. Oocytes within primordial follicles cannot be fertilized before undergoing maturation. The maturation process is thought to take about 200 days, and the initial stages of growth are not dependent on FSH [36].

Autografting involves transplanting the ovarian tissue back into the donor from whom it was obtained. With autografting, the thawed, transplanted, immature oocytes would mature in vivo, thereby obviating the need for exogenous gonadotropin stimulation. Autografting of ovarian tissue would theoretically preserve a woman’s endocrinologic function, unlike IVF and oocyte cryopreservation, which only address fertility.

**History of Ovarian Transplantation**

Ovarian transplantation is not new; it has a long history dating back to the early 1900s. People believed that waning sex steroids resulted in somatic cell aging, and that transplantation held the key to rejuvenation and eternal youth. However, it was not until the turn of the twentieth century that widespread interest was generated in reproductive organ transplantation. Despite many attempts of allogeneic ovarian transplantation in the 1900s, no clear clinical benefit was realized, primarily due to immune reactions. A breakthrough occurred in 1948 when the first cryoprotectant, glycerol, was discovered. The development of freezing methods using cryoprotectants led to work on the transplantation of cryopreserved gonadal tissue in the 1950s [46,47], eventually leading to viable offspring in mice [48]. In the 1990s, investigators begun to realize the potential clinical applications of cryopreservation, and research began again using new cryoprotectants.

**Cortical Strips**

Most recent experience with ovarian transplantation has utilized strips of ovarian cortex. Most of the primordial follicles in ovarian tissue lie in the “outer skin”, just beneath the tunica albuginea (see Fig. 8.2). After the ovary is removed, it can be bi-valved, and the inner medullary tissue dissected away, leaving a thin “rind” of ovarian tissue that contains most of the eggs. Thinness (1 mm) of the cortical tissue is important to allow adequate exposure to and diffusion of cryoprotectants into the ovarian tissue prior to cryopreservation. In addition, since ovarian cortical strips are transplanted without vascular anastomoses, thinness of the tissue is important since the graft must initially survive via simple diffusion until neovascularization can occur.

**Heterotopic vs. Orthotopic Grafts**

The ideal location for transplantation of ovarian tissue has not yet been defined. Orthotopic transplantation is grafting tissue back to its native site. For ovarian tissue, this would include transplantation of cortical tissue back to the ovarian hilum or a nearby location such as the pelvic sidewall [49]. Orthotopic transplantation provides the potential for spontaneous pregnancy without IVF (i.e., the oocyte can ovulate from the transplanted ovarian tissue, be picked up by the tube, fertilized, and implant in the uterus) [50,51].

Heterotopic transplantation involves grafting tissue back to a non-native, ectopic site. Ovarian tissue has been transplanted into the arm and abdomen [52,53]. Heterotopic transplantation
allows for easier monitoring of follicular development. **Fig. 8.2 (A)** The density of primordial follicles is greatest just under the tunica albuginea. **(B)** The outer ovarian cortex has been cut in preparation for transplantation and retrieval of oocytes. It also allows for easier monitoring of cancer growth within the transplanted ovarian tissue.

**Animal Data**

To date, successful cryopreservation and transplantation of ovarian tissue has been achieved in various animals. Cryopreservation of mouse ovarian tissue was found to produce good results with restoration of fertility after transplantation [48,54,55]. Fertility has also been restored using autografts stored at −196°C in ovariecotomized sheep, whose ovaries more closely resemble those of humans [44]. Schnorr et al. transplanted autologous ovarian tissue into the upper arm of cynomolgus monkeys [56]. Menstrual cyclicity resumed in 5/6 (83%) fresh transplants and in 2/4 (50%) of thawed transplants.

Our lab [53] performed laparoscopic bilateral oophorectomies on seven rhesus macaques, and subsequently autologously transplanted fresh ovarian cortical tissue to the arm, abdomen, and kidney. Ovarian cortex was cut into 1×3×4 mm pieces (n = 219) in 4°C Leibovitz medium and transplanted immediately to the animal of origin in subcutaneous pockets or flaps juxtaposed to muscle or kidney (Fig. 8.3A, B). Four monkeys had transplants to both the arm and abdomen (n = 23–54), two to the kidney and abdomen (n = 18–42), and one to the arm only (n = 26). When 4 mm follicles developed, oocytes were collected via follicle excision 26–30 h after injecting 1,000 IU of human chorionic gonadotropin (hCG). Mature oocytes were fertilized via intracytoplasmic sperm injection (ICSI). All monkeys demonstrated estradiol (E2) levels greater than 50 pg/ml within 70–150 days post-transplantation. Estradiol and progesterone (P4) levels were higher in the local venous drainage of an arm transplant than in systemic venous blood, indicating the presence of functional grafted ovarian tissue (Fig. 8.3C). One monkey with renal and abdominal grafts showed repeated increases in P4 levels greater than 3 ng/ml approximately every 60 days, which is longer than the normal 28-day cycle (Fig. 8.4). FSH rose in this animal to 10.5 mIU/ml 84 days post-transplantation, but then declined to 2.79 mIU/ml by day 169, indicating adequate estrogen production. Several animals developed multiple follicles without exogenous gonadotropin stimulation; abdominal subcutaneous grafts showed the best follicular development (50%, Table 8.5). Follicles were excised (n = 23) from 4 hCG-treated monkeys; 16 oocytes were obtained. Eight were mature; six were fertilized via ICSI and cleaved in vitro. A five-cell, an eight-cell, and two morula-stage embryos were transferred laparoscopically to the oviducts of
three recipient monkeys. A normal singleton gestation resulted from the transfer of the morulas, and ended in the birth of a healthy, 500-gram female in 2003 (Fig. 8.3D). She is named BRENDA for Bilateral oophorectomy, Resumption of ENDocrine function and Abdominal follicle pregnancy.

From the BRENDA data, several important conclusions can be drawn. First, transplantation into subcutaneous sites resulted in endocrine function and follicular development. Second, the abdomen appeared to be the best transplant site. Third, the resumption of endocrine function after about 130–150 days post-transplant is consistent with the time frame required for progression of primordial to antral follicle development [36,57,58]. Therefore, most likely, antral follicles are lost in the tissue preparation and transplantation process, and subsequent antral follicles represent in vivo maturation of the remaining primordial follicles.

Fig. 8.3 (A) Ovarian tissue transplanted to the abdomen in flaps (B) and to subcutaneous pockets in the arm and abdomen (C) An ovarian follicle developing in the arm shows high local estrogen and progesterone secretion. Estradiol increased from 72 to 575 pg/ml in venous blood from the transplanted tissue. (D) Oocytes retrieved from heterotopic grafts were fertilized resulting in a healthy, term live-born monkey. From Lee DM et al. Nature 2004;428:137–138
Human Data

Oktay and colleagues first reported that ovulation occurred in autografted human ovarian tissue after gonadotropin stimulation [49,59]. A 29-year-old woman had undergone bilateral oophorectomy for benign indications. The ovarian tissue was cryopreserved in 1.5 M propanediol, thawed, and transplanted laparoscopically to the pelvic sidewall. The patient had follicular development documented by ultrasound with high doses of gonadotropins. In another case [52], ovarian tissue was transplanted to the forearm, and E2 measurements showed a gradient between the hand and cubital fossa, demonstrating functionality of the graft.

Radford et al. reported successful orthotopic transplantation of ovarian cortical tissue from a patient treated with chemotherapy for Hodgkin’s lymphoma [60]. Seven months after transplanting ovarian cortical strips to the ovaries, she had resolution of hot flashes, E2 in the serum, a 10-mm endometrial lining, and a 2-cm diameter follicular structure seen by ultrasound.

Oktay et al. reported the first embryo derived from cryopreserved ovarian tissue that was heterotopically transplanted to the abdomen of a 30-year-old breast cancer patient [61]. Since then, four human pregnancies have been reported using both fresh and cryopreserved orthotopic ovarian tissue [50,51,62,63]. Donnez et al. [50] reported a 25 year-old patient with Hodgkin’s
lymphoma who underwent laparoscopic left ovarian cortical biopsies prior to MOPP/ABV chemotherapy and 38 Gy of radiation. She became amenorrheic with an FSH level of 91 mIU/ml. She then underwent laparoscopic peritoneal excision to promote vessel formation prior to ovarian tissue transplantation, followed by laparoscopic ovarian tissue transplantation to the pelvic sidewall 7 days later. A second laparoscopic transplant was also performed. She developed a follicle and became spontaneously pregnant. Although this is the first reported human pregnancy after ovarian tissue transplantation, it is possible that the pregnancy may have originated from an oocyte released from the ovary left in situ, and not from the transplanted ovarian tissue.

Silber et al. [51] subsequently reported a pregnancy from orthotopic transplantation of fresh ovarian tissue between monozygotic twins discordant for POF. One of two 24-year-old twins developed POF at age 13. The other twin went on to conceive three children spontaneously. After unsuccessful donor egg IVF, the sterile twin received a transplant of ovarian cortical tissue (fresh) from her sister via a mini-laparotomy. Within 3 months, the recipient’s cycles resumed, and she conceived on the second cycle.

Meirow et al. [62] reported a definitive pregnancy from orthotopic transplantation of frozen/thawed ovarian tissue after chemotherapy-induced ovarian failure. The patient was a 28-year-old non-Hodgkin’s lymphoma patient who had ovarian tissue harvested after first-line chemotherapy but before high-dose chemotherapy. Her FSH levels were consistently elevated (40–104 mIU/ml). Ovarian cortical tissue was transplanted via strips onto one ovary and via injection of a tissue slurry into the other ovary (Fig. 8.5). FSH levels decreased; Müllerian inhibiting substance and inhibin B increased. She conceived after natural cycle IVF.
Demeestere et al. [63] performed simultaneous orthotopic and heterotopic transplantation of ovarian tissue. Follicles developed at the ovary, peritoneum, and abdomen. A spontaneous pregnancy ensued, but unfortunately ended in a miscarriage secondary to aneuploidy.

**Whole Ovary Transplantation by Vascular Anastomosis**

Transplanted ovarian cortical pieces rely upon simple diffusion for survival until new blood vessels form. Initially, the grafts are subject to ischemia. As an alternative approach, some have examined whether the intact ovary can be cryopreserved and subsequently transplanted via vascular anastomosis [64–67]. Wang et al. cryopreserved and then transplanted the upper uterus, fallopian tubes, and ovaries in mice, with a subsequent pregnancy [65]. Leporrier et al. performed heterotopic transplantation of an ovary to the arm using vascular anastomosis with extraction of a post-mature egg [64]. Bedaiwy et al. performed whole ovary transplantation in sheep, but in 8 of 11 animals, the vascular anastomosis had occluded completely [66]. Recently, Imhof et al. reported a live-born sheep from transplantation of a whole, frozen/thawed ovary [67]. One ovary was removed and the vessels cannulated so that the entire ovary could be perfused with cryoprotectant. After freezing and thawing, the contralateral ovary was surgically removed, and the thawed ovary transplanted back to the vascular pedicle. One of nine sheep became pregnant.

**Problems with Ovarian Transplantation: Re-Introduction of Cancer**

Although autografting seems promising, it is not without potential risks. Theoretically, ovarian tissue could carry micro-metastases that could “re-infect” a patient who had been previously cured of her cancer. Ovarian transplantation might be particularly concerning with blood-born malignancies, such as leukemia, where the cancer cells are already in the blood, and therefore presumably within the cryopreserved ovarian tissue. Shaw et al. showed that fresh and cryopreserved ovarian tissue samples taken from donors with lymphoma transmitted the cancer into previously healthy graft recipients [68]. This may bode poorly for the future of autografting, particularly for hematogenous malignancies like leukemia, or for patients with cancers known to metastasize to the ovary.

On the other hand, another study utilizing human tissue suggests that autologous ovarian transplantation is safe [69]. In this study, ovarian tissue from lymphoma patients was xenografted into immunodeficient mice. None of the mice developed lymphoma. However, when lymph nodes from the lymphoma patients were xenografted, mice transplanted with lymph nodes from the Hodgkin’s disease patients did develop lymphoma (positive control).
Hence, it is necessary to develop screening methods to detect minimal residual disease in ovarian tissue to eliminate the risk of cancer cell transmission with transplantation, or to consider xenografting or in vitro maturation, which would minimize re-introduction of cancer cells. A recent review attempts to stratify the risk of ovarian metastases (Table 8.6) [70].

**Xenografting as a Potential Solution**

Xenografting is another option for maturation of oocytes within cryopreserved ovarian tissue. Xenografting involves transplantation of ovarian tissue from one species (human) to another [severe combined immunodeficient (SCID) mice]. Because of the concern about re-introduction of cancer into patients via transplanted ovarian tissue, investigators have explored transplanting frozen-thawed ovarian tissue into an animal host that would serve as a biological incubator. With this technique, the possibility of cancer transmission and relapse can be minimized since maturation of the primordial follicles occurs in the animal host. When the follicle has matured in the mouse, a single egg can be isolated and fertilized, thereby theoretically eliminating exposure of the patient to cancer cells. However, xenografting may raise some ethical considerations; the concept of maturing human oocytes within another species is distasteful to some. Furthermore, xenografting raises the possibility of transmitting infectious agents or potentially altering the human genome.

**Animal Data**

Xenografting of cryopreserved ovarian tissue from non-human primates is feasible. Ovarian tissue from marmoset monkeys, which had been frozen and grafted into immunodeficient mice, developed viable, estrogen-producing follicles. Our lab [71] showed that rhesus ovarian tissue could be xenografted to SCID mice and that pre-antral and antral development could occur upon prolonged gonadotropin stimulation. The kidney capsule was a better site than subcutaneous sites
for the grafts. There have already been live births reported from xenografting cyropreserved mouse ovarian tissue [72,73].

**Human Data**

Transplantation of frozen-thawed ovarian tissue into an animal host with subsequent gonadotropin stimulation and oocyte retrieval may offer considerable advantages to cancer survivors. Several groups have shown that human ovarian tissue can survive and grow to large antral stages in immunodeficient mice when transplanted subcutaneously, over the peritoneum, or under the kidney capsule [74–77]. Revascularization is critical for graft survival, and these sites are well vascularized, especially the subcapsular region of the kidney. Finally, Cha’s group demonstrated that human fetal ovarian tissue could be vitrified in ethylene glycol and xenografted into NOD-SCID mice with resumption of follicular growth [78].

While these results are promising, a recent study raised the question of whether oocytes derived from xenografted ovarian tissue are ultrastructurally and

![Image](https://example.com/image.png)

reproductively competent [79]. When these oocytes were analyzed immunocytochemically, the microtubule organization and chromatin configuration were abnormal. It is possible that xenografting of human ovarian tissue will be more valuable as a research tool than as a clinical treatment. Xenografts could be used to examine which conditions might optimize autologous transplant conditions. Numerous factors, including anti-apoptotic agents [71], antioxidants like vitamin E or ascorbic acid, and angiogenic factors like vascular endothelial growth factor (VEGF), TGF, and FSH have been postulated to be beneficial. Further research is necessary to maximize the efficiency of ovarian tissue transplantation.
Conclusion

Ovarian tissue cryopreservation and transplantation is currently the most effective fertility-preserving treatment for prepubertal girls undergoing gonadotoxic cancer treatment and for women whose chemotherapy or radiation therapy must start immediately. Although there have been human pregnancies reported utilizing these methods, the underlying principles of cryobiology and transplantation biology must be further refined within the new field of oncofertility before widespread clinical application is possible.

References

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