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Nusrat Mahmud, Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders
Eshita Sharmin, Emory University
Md. Arif Mamun, Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders
Zayan Shamayeen, Emory University
Natalie Rivadeneira, Emory University
Roger Rochat, Emory University
Akanksha Mehta, Emory University

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 Decline in semen parameters from 2000 to 2016 among Bangladeshi men attending a tertiary care hospital

Nurul Mahmud1, Eshita Sharma2, Md. Arif Mumun3, Zayan Shamsu4, Natalia Riva4n4, Roger Rocha2, Akanksa Mehta3

1 Department of Obstetrics and Gynaecology, Centre for Assisted Reproduction, Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders, Dhaka, Bangladesh
2 Hubert Department of Global Health, Rollins School of Public Health, Emory University, Atlanta, GA, USA
3 Department of Biology, Emory University, 3Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta, GA, USA
4 Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta, GA, USA
5 Department of Urology, School of Medicine, Emory University, Atlanta, GA, USA

Correspondence Address:
Eshita Sharma
Hubert Department of Global Health, Rollins School of Public Health, Emory University, Atlanta, GA, USA

Abstract

Introduction: The objective of this study was to analyze longitudinal changes in sperm parameters of Bangladeshi men. We hypothesized that semen parameters declined for this population.

Methods: We retrospectively analyzed semen data from men aged 18–60 years who sought care for general sperm quality or updates on fertility status at an infertility clinic in Dhaka, Bangladesh, from January 2000 to June 2016 (n = 13,810). Samples with incomplete data were excluded (n = 143). The WHO normal criteria and semen analysis procedures were used to evaluate parameters of the remaining 13,667 specimens. Samples with missing values on sperm concentration (n = 148) were excluded from concentration analyses. Age and duration of abstinence at testing were recorded and adjusted for. Data were imported into SAS© 9.4 statistical software. Temporal significance was investigated using one-way ANOVA for mobility parameters and Chi-square test for raw concentration. Logistic regression analysis evaluated the effects of confounders on azoospermia and raw concentration, while median regression modeling adjusted confounders for concentration, total motility, and rapid linear (RL) motility. Results: Age distribution was significantly correlated with annual parameter changes (concentration, total motility, and RL motility; P < 0.0001). Adjusted total motility and RL motility declined by 20% from their maximum values to end of the study (P < 0.0001). Raw concentration lacked clear trends and was unaffected by adjustment. Azoospermia increased by 18% between the 2000–2010 and 2011–2016 participants (odds ratio = 0.16 [0.14–0.16]).

Conclusion: In agreement with the hypothesis, Bangladeshi men attending this clinic have experienced decline in semen parameters (total motility and RL motility) and increased frequency of azoospermia.

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Introduction

Changes in sperm quality indicators – sperm count, percentage of sperm motility, sperm density, and normal sperm morphology – have been explored globally over the last two to three decades.[1] Longitudinal and cross-sectional studies in Israel showed that the average sperm parameters in the nation have dropped over the last 25 years, with significant decrease of total motile sperm count per ejaculates and percentage motility.[2] A retrospective analysis of sperm in men aged 18–50 years showed a significant decrease in motile sperm and increase in immotile sperm from 1997 to 1999.[3] Another study highlighted a similar trend in Europe.[4] This study, as well as a review on all sperm density studies done from 1934 to 1998, concluded that while geographical location of nations may result in regional disparities for semen quality, parameters have declined for overall and in both regions.[5][6]

While semen data are available for most of the global communities, South Asian countries lack research studies. A 2007 study conducted by the infertility unit at the Bangabandhu Sheikh Mujib Medical University found that almost 62% of couples attending the infertility unit faced primary infertility, while 35% experienced secondary infertility. Sperm analyses results from this study indicated that among the male partner, oligozoospermia, or sperm concentration of < 20 × 10^6/mL, accounted for 40% of cases.[7] In 2010, an estimated 3 million Bangladeshi couples were infertile, and for 60% of those couples, the male partner was responsible.[8]

The objective of this study was to analyze changes in sperm quality of a subset of the Bangladeshi male population attending an infertility clinic between 2000 and 2016. Through this study, we hope to evaluate whether there is an observable decline of semen parameters in Bangladeshi males, as determined by trends recorded for motility, morphology, and concentration. Based on trends observed in the global community, we hypothesized that there is a temporal decline in semen parameters for the study population.

Materials and Methods

The Ethical Review Committee of the Diabetic Association of Bangladesh approved the protocol of this study (Mem: no: BADAS-IRB/EC/16/009). Participants were required to provide signed consent for their analysis results to be included in the study database and received signed analysis reports for their personal records.

Study population and participants

Data collection for this study was conducted in the Centre for Assisted Reproduction (CARE) at the Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders (BIRDEM) from January 2000 to June 2016. CARE is one of the largest infertility clinics in Bangladesh and a major clinic for infertility referrals. A majority of patients at CARE reside in Dhaka, Bangladesh, but services are also provided to patients from other regions in the country and those visiting from overseas.

The overall study population consisted of 13,953 participants. A total of 143 participants were excluded from analysis due to incomplete data. 6187 datasets did not have quantitative sperm concentration values and were excluded from raw concentration analysis. Data is not available for 2006 and these data from 2000 to 2005 and 2007 to June 2016 is included.

Semen analysis procedures and calculations

All semen analyses were conducted by a single laboratory technician who used the same type of laboratory materials for the entire duration of the study. The methods used for semen analysis were outlined in the WHO's Laboratory Manual for Examination and Processing of Human Semen (4th and 5th ed.).[10] Participants provided semen samples through masturbation or intercourse at the on-site masturbatorium. 3–5 days of abstinence before sampling was advised, and duration was recorded. Samples were liquefied for 30 min and then gently swirled to achieve homogeneity. Concentration was found by estimating the total number of spermatozoa (in millions per milliliter) in 10 consecutive grid squares. If the count was < 15 M 10^6/mL, the sum of spermatozoa in 25 squares was used to calculate concentration. The sperm with rapid, streamline motion in the semen were grouped as Grade A. Grade B sperm moved slowly, and Grade C sperm lacked movement. Total motility was calculated as Grade A sperm + Grade B sperm. Rapid linear (RL) motility only accounted for the percentage of Grade A sperm.

The laboratory technician determined morphology by adjusting the microscopic view to a higher magnification so that physical characteristics of the spermatozoa were visible. The count of sperm that were not in the normal teardrop shape or were abnormally considered to be abnormal morphology. The percentage of sperm with abnormal morphology was estimated based on the magnification of the grid, proportional to the overall 10 × 10 Mallick chamber grid.

Statistical analysis

The dataset (n = 13,681) was imported from an electronic database into SAS® 9.4 statistical software (Cary, North Carolina, USA). Because normally tests showed the semen parameters to be severely skewed, median (interquartile range) was reported for parameter baseline. Age, duration of abstinence, and liquefaction were reported as mean ± standard deviation. Significance of difference between annual means and medians was found through parametric one-way analysis of variance (ANOVA) and non-parametric Kruskal-Wallis tests. Median regression modeling adjusted confounders for concentration, total motility, and rapid linear (RL) motility. Results: Age distribution was significantly correlated with annual parameter changes (P < 0.0001). Adjusted total motility and RL motility declined by 20% from their maximum values to end of the study (P < 0.0001). Raw concentration lacked clear trends and was unaffected by adjustment. Azoospermia increased by 18% between the 2000–2010 and 2011–2016 participants (odds ratio = 0.16 [0.14–0.16]).

Conclusion: In agreement with the hypothesis, Bangladeshi males attending this clinic have experienced decline in semen parameters (total motility and RL motility) and increased frequency of azoospermia.

Results

Baseline semen characteristics, age, and duration of abstinence of the study population (n = 13,681) are shown in Table 1. The average age of participants was 34 ± 6.6 years, and age distribution was significantly correlated with annual parameter changes (P < 0.0001) [Table 1]. Duration of abstinence (P = 0.05) and liquefaction (P = 0.07) remained unchanged in annual comparisons, both averaging around 3.2 ± 3.8 days and 1.0 ± 0.8, respectively. All semen parameters (concentration, total motility, RL motility, and normal morphology) appeared to vary...
Our study shows that for Bangladesh men, there has been a decline of total-motility and RL motility on semen analysis from 2000 to 2016, and the trends and magnitude of decline are more evident upon adjusting for age and duration of abstinence. The incidence of azoospermia also increased when adjusted for age and duration of abstinence.

Interestingly, the overall frequency of normozoospermia increased upon adjusting for the WHO 2010 consultation diagnosis. However, this finding does not indicate that the actual frequency of fertile males increased. The criteria changed from ≥20 × 10⁶/mL to >15 × 10⁶/mL, and may be solely responsible for the shift in normozoospermia because more participants qualified for the new criteria. Therefore, comparison between the WHO 1999 and 2010 parameters, frequencies between these years and decades have a more reliable comparison. The increase in frequency of azoospermic patients from 10.9% of the 2000–2010 cohort to 14.9% of the 2011–2016 indicates a slight decrease in concentration across the population. This finding is consistent with past meta-analyses of international literature that describe semen concentration trends over the last few decades.[1] More recent studies on concentration trends also show decreased parameters in countries not previously studied, such as Taiwan, India, and New Zealand.[2],[12],[13] However, adjusted and unadjusted new concentration analyses do not indicate a clear trend of decline in concentration for our study population.

The effect of risk factors on semen quality in our study participants may not be conclusive because there was only a clear trend of decline in motility. However, it is important to acknowledge risk factors as potentially associated with semen quality. Literature extrapolates that there is a potential for decline in semen quality due to endocrine disruptor exposure, which is associated with increased industrialization, especially in developing countries.[1] Regions of widespread industrialization generally have higher rates of oligozoospermia than other areas.[14]

Occupational and environmental exposure to toxins also stems from industrialization and can have detrimental effects directly on reproductive organs or hormonal balance that is crucial for growth, sexual development, and physiological functions.[15][16][17]

The longevity of data collection provides support to this study and shows that studies of this nature are feasible despite Bangladesh being a low-resource setting. Moreover, semen analysis readings and methodology should be consistent because the analyses were conducted by a single observer who used the same type of laboratory materials for the entire duration of the study.

Conversely, several improvements were needed in the study design and dataset. Although it was previously described that normozoospermia and azoospermia increased with time, characterization of the diagnoses was limited by the absence of raw concentration readings for all datasets. If these data were available, the qualifications for oligozoospermia stratification could be described more accurately. It is also important to note that simple ejaculate did not remain consistent throughout the study. There was a fluctuation of participants during the second half of the study. Therefore, the increase in frequency of azoospermia may have offset the expected decrease in normozoospermia. Moreover, there appeared to be a lack of consistency in the data collection methods when the parameters for 2000 and 2004, which may or may not be associated with the reduced sample size compared to post-2008 data. Association could be explained for the population because the parameters would not have been affected by the WHO criteria changes until 2010, but simple ejaculate is not a conclusive factor because none of the factors other than mobility showed association.

Among the correlated dataset, outliers who do not reside in Dhaka or have drastically different life course exposures are not eliminated. Therefore, the effect of confounding due to influential risk factors (i.e., exposure to toxins, preceding health conditions, environmental factors, and drug use) is not clear. All the study participants were from a single clinic, thus limiting generalizability of our results. Moreover, we were unable to follow single participants over time and determine whether multiple datasets represented a single participant due to a lack of patient identifiers. Significant measurement bias exists when the WHO 2010 semen parameters have been deemed as unreliable from emerging studies because they are determined by the world population at large, thus potentially not providing a true measure for the burden of infertility as differed regionally.[10] An absence of raw concentration counts for 618 participants makes it difficult to assess whether the laboratory technician’s classification of oligozoospermia versus normozoospermia is consistent over time. Although consistently reported by a single technician, this introduces the risk of within- and between-person variation in semen parameter readings from 2011 to 2016.

This study provides a rationale for conducting observational studies on male infertility in the context of Bangladesh and neighboring South Asian countries. As we established the trend of decline in motility and slight increase in azoospermia in a clinic population, the next step might be to determine whether this is also true for the overall population and evaluate the reasons for trends. Controlled studies tracking life course exposures of males in Bangladesh that are supplemented with extensive patient history, semen data, lifestyle factors, and effects of xenobiotics on reproductive hormones would help describe how the burden of male infertility may be reduced and prevented. There is a need for global action to solidify an understanding of declining semen holistically in order to combat specific causes for the prosperity of future generations. Moreover, improvement of the WHO parameters to provide a cleaner definition for male infertility as varied as context would improve treatment regiments of male partners significantly.

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There are no conflicts of interest.

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