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A pioneer in menopause research, Dr. Utian founded the world's first menopause clinic in Cape Town, South Africa, in 1966 and established the Cleveland Menopause Clinic in 1983.

Recipient of many research grants and awards, he is the author of more than 150 scientific publications and five books. He is the Honorary Past-President of the International Menopause Society and Honorary Founding President and Executive Director of The North American Menopause Society. He is also Chairman of the Council of Affiliated Menopause Societies (CAMS) of the International Menopause Society.

Pregnancy After Menopause and The North American Menopause Society (NAMS)

It was really inevitable. Given the remarkable sequential breakthroughs in reproductive technologies over the past three decades, it was only a matter of time before women could begin to consider the option of salvaging fertility, and be able to achieve pregnancy with their own eggs after menopause. Who would have thought that pregnancy and menopause would need to be considered a single area of health care?

Evolution of a New Technology

My own personal professional career ran a parallel course for many years. From 1967 until the mid 1990s, my two main medical interests in women's health were infertility and menopause. The early 1970s into the early 1980s were exciting years as a handful of us introduced, first, the technology of infertility microsurgical repair of the reproductive tract,¹ and then, as rapidly as that area had evolved, the superseding technology of in vitro fertilization (IVF).²

In almost the blink of an eye, we, at my infertility center at the Mount Sinai Medical Center of Cleveland, moved away from giving courses in microsurgery and laser technology to advanced workshops on establishing IVF programs.

New applications of IVF developed rapidly. In the early 1980s we reported the world's first surrogate IVF pregnancy in a woman whose ovaries had been conserved after hysterectomy.³ Obviously, she was premenopausal, with her egg being fertilized in vitro with her husband's sperm and the resultant embryo transferred to a friend willing to carry the pregnancy. The baby even made the cover of *LIFE* magazine! Soon, oocytes were being donated or donor embryos were being transferred successfully into postmenopausal women with an intact uterus and appropriate exogenous hormonal support. In these instances, however, the genetic makeup included the genes of the egg donor and not the pregnant woman herself.

The Latest Breakthrough

I now find it quite gratifying for my parallel interests to have suddenly merged. The next breakthrough has arrived. Reporting in the October 16, 2004 issue of the *Lancet*, a research team from the Catholic University of Louvain in Brussels, Belgium describe cryopreservation of ovarian tissue from a 30-year-old woman prior to undergoing chemotherapy-induced menopause. Subsequent retransplantation of the tissue to the ovarian site 2 years later resulted in return of spontaneous ovulation, pregnancy, and the successful outcome of the birth of a baby girl.⁴

This is heartwarming and exciting, but brings with it major questions and responsibilities. For NAMS, this new healthcare technology blurs the distinction between

menopause and fertility in a select group of women. Certainly, it opens the concept of temporary menopause. Beyond that, it mandates that NAMS now incorporate aspects of these advanced reproductive technologies into our educational programs for the organization, meaning that we will address these issues in our publications and at our annual scientific meetings.

Technical and Ethical Considerations

The issues include technical considerations with their direct risks and outcomes, appropriate identification of potential candidates, the ethics and the sociocultural implications.

The easiest area to address will be technique, not because a perfect treatment has yet to be introduced, but really because it is a nuts and bolts issue. Even then, in the first patient, laparoscopy was required pre-chemotherapy, and then, 2 years after recovery, a second laparoscopy to prepare the 'bed' on the remaining ovarian surface to ensure that it would be receptive to the actual graft at the time of yet another laparoscopy. This is a considerable amount of surgery, anesthesia and risk exposure.

The selection of potential candidates is less straightforward. What age limit, what diagnosis, what stage of disease, what personal demographics and relationships are just a few of the dilemmas that come to mind.

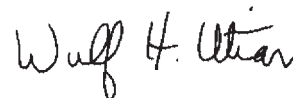
The ethics will be the real challenge. Is it appropriate to expose an individual to risks, including that of re-transferring cancer post-cure? Should there be a societal issue because of healthcare costs? With inadequate data on fetal outcome and childhood development with this new procedure, when does such a therapy move from experimental to routine? These are just a few of the multitude of questions that will need discussion and resolution. Ultimately, the overriding question will be whether this technology will serve the interest of women and children.

NAMS Needs

NAMS, by the very nature of its broad and all-inclusive scientific and multidisciplinary membership, has focused on all aspects of the perimenopausal transition and beyond. Now that same diverse base is admirably situated to add a new dimension to its agenda—all the issues regarding pregnancy after menopause.

Accordingly, we will conduct a comprehensive survey of our members in an attempt to determine the breadth of interest; particular areas of concern; needs assessment for future educational programs, materials and scientific meetings; and evaluation of how much of this concept should be integrated into our professional and consumer activities.

Expect a plenary session designed to cover some of these aspects around postmenopausal reproduction at the NAMS meeting in San Diego, September 28 through October 1, 2005. Who would have believed it?



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