In 2010, the World Health Organization established new reference values for human semen characteristics that are markedly lower than those previously reported. Despite using controlled studies involving couples with a known time to pregnancy to establish the new limits, the reference studies are limited with regard to the population analyzed and the methods used for semen evaluation. The present review discusses concerns related to the new reference values for semen characteristics, including the effect on patient referral, diagnosis, and treatment of recognized conditions, such as varicocele, and on the indications for assisted reproductive technologies.
several concerns arise from a careful examination of the current edition of the WHO manual is to provide evidence-based thresholds that could aid clinicians in estimating the relative fertility of a given patient. However, several concerns arise from a careful examination of the

Table 1. Cutoff reference values for semen characteristics as published in consecutive WHO manuals

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Volume (mL)</td>
<td>ND</td>
<td>≥2</td>
<td>≥2</td>
<td>≥2</td>
<td>1.5</td>
</tr>
<tr>
<td>Sperm count (10⁶/mL)</td>
<td>20-200</td>
<td>≥20</td>
<td>≥20</td>
<td>≥20</td>
<td>15</td>
</tr>
<tr>
<td>Total sperm count (10⁶)</td>
<td>ND</td>
<td>≥40</td>
<td>≥40</td>
<td>≥40</td>
<td>39</td>
</tr>
<tr>
<td>Total motility (% motile)</td>
<td>≥60</td>
<td>≥50</td>
<td>≥50</td>
<td>≥50</td>
<td>40</td>
</tr>
<tr>
<td>Progressive motility† (%)</td>
<td>≥2‡</td>
<td>≥25</td>
<td>≥25</td>
<td>≥25% (grade a)</td>
<td>32 (grade a + b)</td>
</tr>
<tr>
<td>Vitality (% alive)</td>
<td>ND</td>
<td>≥50</td>
<td>≥75</td>
<td>≥75</td>
<td>58</td>
</tr>
<tr>
<td>Morphology (% normal forms)</td>
<td>80.5</td>
<td>≥50</td>
<td>≥30§</td>
<td>14§</td>
<td>4‖</td>
</tr>
<tr>
<td>Leukocyte count (10⁶/mL)</td>
<td>&lt;4.7</td>
<td>&lt;1.0</td>
<td>&lt;1.0</td>
<td>&lt;1.0</td>
<td>&lt;1.0</td>
</tr>
</tbody>
</table>

WHO = World Health Organization; ND = not defined.
† Lower reference limit obtained from lower fifth centile value.
‡ Forward progression (scale 0-3).
§ Arbitrary value.
¶ Value not defined, but strict criterion suggested.
‖ Strict (Tygerberg) criterion.

WHERE THE DEBATE STARTS

The inclusion of reference values for semen analysis from controlled studies involving fertile fathers with a known TTP represents the most important feature of the fifth WHO manual. In comparison, previous versions reported reference values based on the clinical experience of investigators who had studied populations of healthy fertile men with unknown TTPs. Previous WHO manuals acknowledged the limitations of their reference values by stating that each laboratory should determine its own reference values for each variable.

The goal of the lower reference limits included in the current edition of the WHO manual is to provide evidence-based thresholds that could aid clinicians in estimating the relative fertility of a given patient. However, several concerns arise from a careful examination of the studies that generated the current reference values. First, it should be noted that apart from a single Australian study, all others came from Northern hemisphere countries. The Australian study included 206 subjects, representing approximately 10% of the “fertile” reference population. Roughly, 55% of the data came from 4 Western European cities (Paris, Turku, Edinburgh, and Copenhagen). The remaining patients came from a small study from another Western European city (Oslo) and from the United States. According to the investigators of the original study that referenced the 5th edition WHO manual, the laboratories and data were identified through the known published data and personal communication with the investigators and the editorial group of the 5th edition of the WHO laboratory manual. Interestingly, 4 of 5 studies were from the same group of investigators or was collaborative work among them (Table 2). The semen analyses results for the group of fertile men differed among these “reference” studies. It was not clear whether these differences represented real biologic dissimilarities among the men in different regions or laboratory-dependent biases of measurement, despite their adherence to the WHO manual methods. Cooper et al stated in their report that generated the reference values that “the studies included in the present analysis were conducted in different regions of the world with some areas over-represented, such as Northern Europe, and others, such as Africa, parts of Europe and Central and South America, under-represented.” However, their reference limits for the fertile population with a known TTP came only from Northern Europe, Australia, and the United States; as such, other areas were not represented at all. Millions of fertile men living in China, India, Africa, Middle East, and South America were not incorporated into these data analyses. From these data, it seems unsound to assume, as proposed by Cooper et al, that the reference values represented the global semen characteristics of fertile men.

Second, although the co-authors of the 5th edition WHO manual claim to have included only studies using
Cooper et al. For instance, when referring to the study the data from the 5 reference studies were pooled by classification. sent either the Tygerberg "strict" method or the David the 5th edition WHO manual do not accurately repre-

sent with standardized methods and a recognized quality
were applied. As a result, additional well-conducted stud-
ies should provide the semen quality in various populations should give the
obtained before 1 man's fertility status is depicted.1-4

Several guidelines, including the WHO manual, recom-
mend that 2, but preferably 3, semen samples should be
obtained before 1 man's fertility status is depicted.1-4

Third, it is not easy for the reader to understand how
the data from the 5 reference studies were pooled by
Cooper et al. For instance, when referring to the study
by Swan et al., 593 samples were tabulated, but only 512
were reported in their original study. Moreover, a TTP of
≤12 months was clearly defined as an eligibility criterion
for patient inclusion in only 2 studies7,10 but in all
remaining studies, it must be inferred.6,8,9

Finally, a single semen sample was taken to represent
each man in the reference studies. The assumption that I
ejaculate is representative of a given man’s semen profile
argues against the current knowledge of the high biologic
variability of semen variables from the same individuals.
Several guidelines, including the WHO manual, recom-
mend that 2, but preferably 3, semen samples should be
obtained before 1 man's fertility status is depicted.1-4

Ideally, a systematic review of the published data on
semen quality in various populations should provide the
recommendation for lower reference values. However,
this is not feasible owing to the variability in the methods
used in assessing the sperm count, motility, and morphol-
ogy, even among studies claiming that WHO standards
were applied. As a result, additional well-conducted stud-
ies with standardized methods and a recognized quality
control procedure are required to confirm the validity of
the global reference ranges proposed by the 5th edition
WHO manual. Beyond spontaneous conception, it will
be of interest to determine the success of various clinical
management protocols in relation to the chosen lower
reference limits. If regional differences are revealed, their
mechanism and significance for fertility will need to be
evaluated, before it can be decided whether there should
be specific reference values for different ethnic groups or
regions.

### IMPLICATIONS OF THE NEW SEMEN CHARACTERISTICS REFERENCE VALUES IN CLINICAL PRACTICE

It is tempting to suggest that the lower reference limits of semen parameters, as proposed by the 2010 WHO manual, are a part of the gradual declines in sperm count extensively reported during the past 2 decades. The hypothesis that endocrine disrupters and other environmental pollutants, such as insecticides and pesticides, are responsible for declining overall sperm quality have attracted supporters,17-20 as well as critics.21-25 However, 2 other explanations are possible that could explain the difference in the reference values between the current and previous WHO manuals. The first is the adherence by many laboratories to greater quality control standards, especially when assessing sperm morphology. The second is that the previous WHO reference values were obtained mainly from the clinical experience of investigators who have studied populations of healthy fertile men with an unknown TTP rather than controlled populations of fertile men, such as in the current edition.1-4 For these reasons, one must exercise caution when concluding that the newly proposed lowered WHO reference values can be justified by the suggested decline in global sperm quality. It is more probable that such differences are instead related to a methodologic bias created by different methods of generating the reference values.
Will Referrals for Assessment of the Male Partner Decrease?

The answer to this question is not straightforward, because it will depend on the acceptability of the new WHO manual reference values. The use of the new WHO manual reference values into clinical practice will likely result in a reclassification of many infertile couples. Specifically, those couples previously classified as having male factor infertility with sperm parameters greater than the new reference limits but less than the previous values will now be diagnosed as having unexplained or female factor infertility. It is also likely that some patients previously categorized as having an abnormal semen analysis will now be considered “normal,” with referral for evaluation postponed or not undertaken. This deferment poses a potential problem, because it has been exhaustively reported that the male and female reproductive age are clearly associated with reproductive outcome. It is unclear whether this reclassification will result in a more cost-effective evaluation of the infertile couple or in a delay in the male factor evaluation, with subsequent delay in the definitive diagnosis and management of the infertile couple.

In contrast, it is important to acknowledge the limitations of the semen analysis results in predicting the health and functional capacity of the male reproductive organs and cells. The male evaluation regarding fertility must go far beyond counting spermatozoa and assessing motility and morphology. It has to be complemented by a proper clinical examination, comprehensive history taking, and relevant endocrine, genetic, and/or other investigations.

Did We Overtreat Our Male Patients Before?

According to the new reference values, a man with 6% strict morphology, 16 million sperm/mL, and 40% progressive motility is considered to have a semen analysis within the so-called normal reference values; however, the same patient would be categorized as having an abnormal analysis according to the reference values proposed by the 1999 WHO manual.3 According to preliminary results of a current study involving individuals seeking fertility evaluation, 380 (38.7%) of 982 of a group previously classified as having an abnormal semen analysis by the 1999 WHO 4th edition manual would now be within the normal range (S.C.E.; unpublished data). This contradiction raises another question: Do we, as clinicians have to correct our semen analysis reports from the previous years or contact our couples for a reassignment of the infertility diagnosis? Caution must be exercised when interpreting these new reference values, because it is obvious that the prevalence of couples facing difficulties in conceiving has not changed, despite the publication of new reference values. Every couple attempting to conceive for >1 year of unprotected intercourse, or less in the case of advanced female age or in men with a recognized fertility problem, deserves a medical evaluation that must include both partners, irrespective of the semen analysis results. It is known that about 30% of men misdiagnosed as having unexplained male infertility, according to the normal semen parameters on routine analyses, present with sperm deficiencies that can be solely identified by sperm functional tests, such as the assessment of DNA integrity, oxidative stress, and anti-sperm antibodies.26-29 Semen analyses, as routinely performed, are limited in their validity as surrogates for the assessment of male fertility potential. Therefore, it has been suggested that sperm function tests should be included in the semen analysis of individuals seeking fertility evaluation.30

The couples’ probability to conceive is influenced by multiple factors, and our task, as treating physicians, is multifaceted. It is our responsibility to diagnose existing conditions that might compromise, now or in the future, the fertility potential of our patients. The goal is to identify potential life-threatening diseases and to treat reversible conditions, including poor lifestyle habits, subclinical infections, hormonal disorders, and clinical varicocele, to cite a few.

Dilemma of the Clinical Varicocele and the New Reference Values: to Treat or Not to Treat?

Approximately 8% of men of reproductive age seek medical assistance for fertility-related problems. Of these, varicocele accounts for roughly 35% of the cases.31 Several studies have demonstrated that surgical treatment of clinical varicoceles is highly effective in decreasing seminal oxidative stress, increasing the seminal concentrations of antioxidants, and improving the sperm quality and pregnancy rates.32-37 However, the current guidelines propose that varicoceles should be treated if palpable and in the presence of abnormal semen analyses.38-40 The application of the new WHO reference values into clinical practice will result in patients previously deemed candidates for varicocele repair now ineligible for treatment if their semen parameters are greater than the fifth centile. Health insurance companies might not grant authorization or might refuse reimbursement if treatment is performed in men with semen parameters now reclassified as “normal.” The concern is that by denying these men varicocele repair we might prevent them from achieving a substantial improvement in semen parameters and a greater chance of spontaneous pregnancy. Men with a clinical varicocele and mild oligozoospermia or normozoospermia achieve greater spontaneous pregnancy rates after varicocelectomy than couples with moderate to severe oligozoospermia.41,42 As such, the available data would support the practice of varicocelectomy for infertile men with clinical varicocele and low “normal” semen parameters according to the new WHO reference values. Nonetheless, it would be very informative to reanalyze the prospective and randomized, controlled studies on varicocelectomy to determine the magnitude of sperm quality improvement and pregnancy outcomes
in the subgroup of patients now classified as having “normal” semen analysis results.

The repair of adolescent varicocele must also be re-evaluated in light of the new WHO reference values. According to several professional societies’ guidelines, varicocele repair is recommended in adolescents and young adults with clinical varicocele and ipsilateral testicular atrophy or abnormal semen parameters. It is still unclear whether and how the application of the new WHO reference values will affect the management of the adolescent and young adult with varicocele. Mori et al., studying a group of 360 adolescents attending a public school in Brazil, found that 27.8% presented with a palpable grade 2 or 3 varicocele, but only one half of them had testicular asymmetry. More importantly, the semen analysis results revealed that adolescents without varicocele had significantly greater numbers of progressively motile sperm (134.1 million) than did the adolescents with grade 2 (72.7 million) or 3 (30.3 million) varicocele. Despite the marked difference in the seminal profiles between adolescents with and without varicocele, all were still within the reference range for normality according to both the fourth and fifth WHO manual editions. Given the progressive deleterious effect of varicocele on testicular function, the goal of treating varicoceles (in the adolescent) is to halt the deterioration of sperm quality and prevent individuals with low “normal” semen parameters from crossing into the defined infertile range. Moreover, adolescent varicocele repair can also improve sperm quality and male reproductive potential. Adolescents and adults with palpable varicocele can also present with normal semen analysis results but altered sperm function, as shown by elevated DNA fragmentation rates and oxidative stress levels.

Taken together, this knowledge challenges the current WHO recommendations for varicocele treatment and highlights the importance of continued debate.

Effect of New Reference Values on Assisted Reproductive Technology Treatment

At first glance, one might expect that the lower reference values in the new WHO manual would result in a lower use of advanced assisted reproductive technology (eg, intracytoplasmic sperm injection [ICSI]—a technique largely designed to treat male factor infertility), because there will be relatively fewer couples with subnormal semen parameters. However, ICSI is generally reserved for couples in whom the man has severe abnormalities in sperm count and motility; thus, ICSI use is unlikely to change because the sperm parameters of these men will certainly be less than the new reference values. Moreover, many centers are already using low morphology thresholds (<5% normal morphology by strict criteria) as an indication to proceed to ICSI rather than intrauterine insemination or conventional in vitro fertilization; thus, the effect on ICSI use based on morphology criteria will likely be minimal. Along the same lines, intrauterine insemination candidates include not only couples with mild male factor infertility but also those with normal semen parameters and unexplained infertility. As such, it is unlikely that the new semen parameters reference values will have a profound effect on the indication of intrauterine insemination.

It is important to stress that the reference semen values proposed by the new WHO manual are not suitable to indicate a treatment modality. They merely represent the distribution of the semen profile of a small group of fertile individuals. The choice of assisted reproductive technology should be determined by the clinical features of each case, as well as on the center’s experience and reported results with different assisted reproductive technology modalities rather than on the semen analysis reports.

Expanding Interpretation of New WHO Reference Values: Focus on 50th Percentile

The 95% reference interval for semen characteristics of recent fathers included in the 5th edition WHO manual has been generated in line with clinical chemistry standards, and the fifth centile was proposed for the lower limit of semen characteristics (Table 3). As such, reference values are important for comparison with the values obtained from the patient being assessed. The observed values can be used to aid in the clinical decision-making process by comparing them with the reference distributions and reference intervals. Therefore, it is important, not only to compare patient results with the lower reference limit, but also with the 50th percentile, which represents a value into which 50% of the reference population of “fertile” men falls. This strategy might be more realistic and can help in understanding a patient’s seminal profile in relation to the reference group.

SHOULD THE NEW REFERENCE VALUES BE ADOPTED?

At present, whether the new reference values should be adopted remains unresolved, and more debate is needed.

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**Table 3. Distribution of semen characteristics of fertile men whose partners had a time-to-pregnancy of ≤12 months, used to establish 2010 WHO manual reference limits, according to percentiles**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>5%</th>
<th>50%</th>
<th>95%</th>
</tr>
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<tbody>
<tr>
<td>Volume (mL)</td>
<td>1.5</td>
<td>3.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Sperm count (×10⁹/mL)</td>
<td>15.0</td>
<td>73.0</td>
<td>213.0</td>
</tr>
<tr>
<td>Sperm count (×10⁹/ejaculate)</td>
<td>39.0</td>
<td>255.0</td>
<td>802.0</td>
</tr>
<tr>
<td>Motility (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>61</td>
<td>78</td>
</tr>
<tr>
<td>Progressive</td>
<td>32</td>
<td>55</td>
<td>72</td>
</tr>
<tr>
<td>Normal†</td>
<td>4</td>
<td>15</td>
<td>44</td>
</tr>
<tr>
<td>Alive†</td>
<td>58</td>
<td>79</td>
<td>91</td>
</tr>
</tbody>
</table>

WHO = World Health Organization.  
* According to the strict Tygerberg criterion.  
† Eosin-nigrosin staining.  
Adapted from Cooper et al.
It is possible that global reference values are not achievable because of geographic and racial variations. It would be ideal to have well-funded prospective studies designed to evaluate several racial and geographic populations of fertile men. From our discussion, different laboratories seeking to adopt the new standard should determine a strategy that would aid in the clear communication of the clinical significance of their results.

CONCLUSIONS

The WHO manuals for the laboratory examination of human semen have been used over the years as a source of standard methodology for laboratories performing semen analyses worldwide. For the first time since the publication of its first edition 30 years ago, the WHO has reported evidence-based reference values for the semen characteristics of fertile men that, not surprisingly, are much lower than those recommended in previous editions. Despite the notable advance of using controlled studies involving couples whose TTP was <12 months to establish the new limits, the reference studies are limited with regard to the populations analyzed and the methods used for semen evaluation. As such, it seems unreasonable to assume that the reference values represent universal cutoff points of semen characteristics of fertile samples, such as was proposed in the 5th edition WHO manual. Moreover, caution should be exercised to not overinterpret the new reference values, because they have not been shown to accurately discriminate populations of fertile and infertile men. Properly performed semen analyses, coupled with an adequate clinical examination of the male, can give valuable information related to the organs producing “semen,” a highly complex fluid, and thus help in better understanding the physiology of the reproductive organs and the causes of dysfunction. In view of the expected effect of these new values on patient referral, diagnosis, and treatment of recognized conditions, such as varicocele, and on the indications for assisted reproductive technologies, we conclude that the WHO should have allowed for an extensive debate about the new values. The time has come for technological developments that bring robust and cost-effective clinically useful tests to assess the fertilizing potential of a semen sample, and that can replace, at least partially, the shortcomings of the standard semen analysis.

References


