

## Male fertility myths and misconceptions



### Myth 1: Infertility is usually a female problem

One of the most persistent misconceptions is that difficulty conceiving is primarily related to the female partner. Medically, infertility is a couple-based diagnosis, and male factor infertility contributes to a substantial proportion of cases. Sometimes the male factor is the main issue; sometimes it overlaps with ovulatory, tubal, uterine, age-related, or unexplained factors in the partner.

This matters because delayed male evaluation can cost time, emotional energy, and opportunities for targeted treatment. A man may have no symptoms at all and still have low sperm concentration, reduced motility, abnormal morphology, obstruction of the reproductive tract, hormonal abnormalities, or genetic causes affecting spermatogenesis. Conversely, a low or borderline semen result does not automatically mean pregnancy is impossible.

A balanced approach is to evaluate both partners when pregnancy has not occurred after an appropriate period of regular unprotected intercourse, commonly after 12 months if the female partner is under 35, and sooner when age, irregular cycles, known reproductive conditions, prior chemotherapy, testicular problems, or other risk factors are present. The goal is not to

assign fault; it is to identify modifiable or clinically relevant factors as early as possible.

## **Myth 2: Normal erections and ejaculation prove fertility**

Sexual function and fertility overlap, but they are not the same. A man can have normal libido, firm erections, orgasm, and ejaculation while producing too few sperm, sperm that do not move effectively, or sperm with impaired fertilizing capacity. Semen volume can also appear normal even when sperm concentration is very low, because most semen fluid comes from accessory glands rather than the testes.

Fertility depends on several coordinated steps: sperm production in the testes, maturation and transport through the epididymis and vas deferens, adequate seminal fluid, successful ejaculation into the vagina, sperm movement through cervical mucus and the uterus, and the ability to fertilize an egg. Problems can arise at any point. Examples include varicocele, infection or inflammation, prior testicular injury, undescended testes, ejaculatory dysfunction, obstruction after surgery or infection, and endocrine disruption involving the hypothalamic-pituitary-gonadal axis.

This is why semen analysis is such a central tool. It usually assesses semen volume and sperm concentration, total count, motility, and morphology. These parameters do not define a person's worth, masculinity, or sexual adequacy. They are laboratory measurements that help guide next steps, especially when interpreted by a clinician familiar with fertility medicine.

## **Myth 3: One semen analysis gives a final answer**

A semen analysis is important, but a single result is not always definitive. Sperm production takes roughly several months, and semen parameters can fluctuate because of fever, acute illness, sleep deprivation, recent heat exposure, abstinence interval, alcohol use, medications, laboratory variation, and collection factors. A sample collected after too short or too long an abstinence interval may not reflect typical values.

For this reason, clinicians often recommend a repeat semen analysis when results are abnormal or borderline. Preparation instructions matter: the

abstinence interval is commonly standardized, the entire sample should be collected, and the specimen usually needs to reach the laboratory within the advised time. Missing the first portion of the ejaculate can significantly affect measured sperm count because it is often sperm-rich.

Interpreting results also requires nuance. Low motility may have different implications than azoospermia, which means no sperm are seen in the ejaculate. Severe oligozoospermia may prompt hormonal and genetic evaluation. Low semen volume can suggest collection issues, retrograde ejaculation, androgen deficiency, or obstruction. No one should be expected to interpret these results alone from a printout. A reproductive urologist, fertility specialist, or appropriately trained clinician can connect the numbers with the medical history and physical examination.

#### **Myth 4: Testosterone always improves male fertility**

This myth is especially important because it can cause harm. Testosterone is essential for male reproductive physiology, but exogenous testosterone and sperm production have an inverse relationship in many men. Testosterone taken as injections, gels, pellets, or anabolic-androgenic steroids can suppress signals from the brain, particularly luteinizing hormone and follicle-stimulating hormone. Without adequate intratesticular hormonal stimulation, sperm production may fall dramatically, sometimes to very low levels or azoospermia.

A man may feel stronger, more energetic, or have improved libido on testosterone therapy while his fertility potential is reduced. This can be confusing and emotionally difficult, particularly when treatment was started for legitimate symptoms or low measured testosterone. The key message is not to stop or start any hormone without medical guidance, but to tell the clinician if pregnancy is desired now or in the future.

There are fertility-preserving approaches for some men with hormonal disorders, but the choice depends on the underlying diagnosis, laboratory findings, physical examination, and reproductive goals. Men using anabolic steroids for physique or performance should also be aware that recovery of sperm production can take time and may not be predictable. A reproductive specialist can discuss safer planning, monitoring, and options when fertility is a priority.

### **Myth 5: Age does not matter for men**

Male fertility does not end abruptly in the way ovarian reserve declines toward menopause, but age still matters. With increasing age, semen volume, motility, morphology, and sperm DNA integrity may be affected. Time to pregnancy can lengthen, and some risks, including certain genetic and neurodevelopmental outcomes, have been associated with advanced paternal age. These risks are not the same for every person, and age alone does not determine fertility, but it should not be dismissed.

The misconception that men have unlimited reproductive time can create pressure on female partners and delay shared planning. If parenthood is a goal, it is reasonable to discuss timing, medical history, and risk factors earlier rather than assuming male fertility will remain unchanged indefinitely.

Age often interacts with other factors: chronic disease, medications, weight changes, sleep apnea, smoking, alcohol, occupational exposures, and reduced sexual frequency. A supportive evaluation looks at the whole person, not just the birth date. Men who have had cancer treatment, pelvic surgery, testicular disease, or known genetic conditions may benefit from earlier counseling, including fertility preservation before cancer treatment when relevant.

### **Myth 6: Lifestyle changes can fix every sperm problem**

Lifestyle factors affecting sperm quality are real, but they are not the whole story. Stopping tobacco or nicotine use, moderating alcohol, avoiding anabolic steroids, maintaining a healthy weight, treating sleep disorders, improving diet quality, exercising sensibly, and reducing heat exposure to the testes may support reproductive health. Managing diabetes, thyroid disease, infections, and other medical conditions can also be important.

However, it is unfair and medically inaccurate to imply that all male infertility is caused by poor choices. Genetic conditions, congenital absence of the vas deferens, chromosomal abnormalities, prior undescended testes, chemotherapy, radiation, severe varicocele, obstruction, and endocrine disorders may occur regardless of lifestyle. Supplements are also frequently marketed with exaggerated claims. Some may be reasonable in selected

situations, but they should not replace a proper evaluation, and more is not always safer.

Practical lifestyle steps are best viewed as supportive, not punitive. The aim is to create the healthiest environment for spermatogenesis while also identifying conditions that need medical or surgical attention. If a couple has already been trying for many months, lifestyle optimization should occur alongside timely evaluation rather than postponing care indefinitely.

### **Myth 7: Stress alone explains infertility**

Stress can affect sexual frequency, sleep, hormone patterns, coping behaviors, and relationship dynamics. It may contribute indirectly to fertility challenges. But telling someone to "just relax" is rarely helpful and can feel dismissive. Infertility itself is stressful, and emotional distress is a response to uncertainty, repeated disappointment, financial pressure, medical appointments, and social expectations.

Clinically, stress should not be used as a substitute explanation before basic evaluation is complete. A man with severe oligozoospermia, azoospermia, varicocele, obstruction, or hormonal imbalance needs appropriate assessment, not reassurance alone. At the same time, emotional support is part of good fertility care. Counseling, support groups, clear communication with clinicians, and shared decision-making can reduce isolation.

Couples often cope better when they use neutral language: "We are investigating fertility factors" rather than "Who is the problem?" It can also help to agree on what information to share with family or friends. Protecting emotional boundaries is not secrecy; it is a way to keep care manageable during a vulnerable period.

### **Myth 8: There is nothing to do if a male factor is found**

A male factor finding is not the end of the road. Depending on the cause, options may include treating infections or endocrine disorders, addressing medication contributors, managing varicocele in selected cases, surgical sperm retrieval for some obstructive or non-obstructive conditions, or assisted reproductive technologies such as intrauterine insemination or in vitro

fertilization with intracytoplasmic sperm injection. The right pathway depends on the couple's overall fertility picture, age, duration of infertility, semen parameters, and preferences.

Evaluation may include medical and reproductive history, physical examination, repeat semen analysis, hormone testing such as follicle-stimulating hormone and testosterone, genetic testing for male infertility in severe sperm abnormalities, and imaging or post-ejaculatory urine testing in selected cases. Not everyone needs every test.

Perhaps the most important misconception to discard is that asking for help is a sign of failure. Male fertility care is healthcare. A clinician can help clarify what is known, what remains uncertain, and which next steps are evidence-based. Even when a condition is not fully reversible, having a diagnosis can reduce self-blame and help couples make informed reproductive decisions.