substantially increases from 20% at the age of 38 years to about 50% at the age of 41 years and 90% at the age of 45 years. Women who have banked their oocytes for anticipated gamete exhaustion envisage having their last child at the age of 43 years.[3]

There is a scarcity of published scientific literature about the outcome after fertility preservation through oocyte cryopreservation, but oocyte donation has established that the efficiency of using vitrified oocytes is similar to that achieved with fresh oocytes.[4,5] However, we could not retrieve the source of the age-specific outcome after oocyte vitrification for fertility preservation provided by Mol and Zoll, which we are, according to the authors, supposed to share with the public. We do consider the mentioned 30% success rate after fertility preservation at the age of 25 years is contradictory to the data provided in figure 1 of our paper and assume this does not take into account the possibility for women to perform multiple cryopreservation cycles.

We declare no competing interests.

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Contraception is as important as fertility preservation in young women with cancer

As part of the *Lancet* fertility preservation Series, Michel De Vos and colleagues (Oct 4, p 1302)[1] presented a concise overview of fertility preservation methods for women with cancer. Here, we aim to emphasise that contraception counselling is just as important.

Of the patients registered in our Cancer in Pregnancy database, 29 (3%) became pregnant during cancer staging or treatment. Median age was 34 years (range 16–48). Median gestational age was 6 weeks (3–26) at discovery of pregnancy. Pregnancy was identified during staging (n=3, 10%), before start of treatment (n=8, 28%), during treatment (n=17 [four at hormone treatment, three at radiotherapy, four at surgery, four at chemotherapy, and two at immunotherapy], 59%), and at an unknown stage (n=1, 3%). Pregnancy outcome was termination of pregnancy (n=9, 31%), spontaneous abortion (n=2, 7%), extrauterine pregnancy (n=1, 3%), and livebirth (n=17, 59%). At pregnancy diagnosis, contraception had been absent (n=13, 45%), had failed (n=7, 24% [three using condoms, two using hormonal contraception, one using ovarian ablation with goserelin, and one using radiosterilisation]), or was unknown (n=9, 31%).

Our data probably under-represent actual incidence of women who become pregnant during cancer treatment because the database is focused on cancer diagnosis during pregnancy.[2] Although some cancer treatment can be given during pregnancy, it should be avoided whenever possible. Risk of congenital malformation is high during the first trimester, especially after chemotherapy and tamoxifen exposure.[3] Termination of pregnancy causes major psychological distress, sadness, and grieving. These issues can easily be avoided by one of many contraceptive methods, such as a copper intrauterine device.[4] We propose that all young women diagnosed with cancer should have an appointment with a gynaecologist to discuss both fertility preservation and contraception before start of treatment.

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For the **Cancer in Pregnancy database** see www.cancerinpregnancy.org

Department of Error

Chatterji S, Byles J, Cutler D, et al. Health, functioning, and disability in older adults—present status and future implications. Lancet *2015;* **385:** *563–75*—In this Series paper, the affiliation for Professor Byles has been corrected: Research Centre for Gender Health and Ageing, University of Newcastle, Callaghan, NSW, Australia. This correction has been made to the online version as of Feb 6, 2015, and the printed version is correct.