Editorial

Coming out of deadly second wave – what next for fertility?

India did very well in first wave of pandemic. As everything was looking like returning to normal, deadly second wave hit harder. Almost every family was affected. All elective treatments were stopped including fertility treatments.

Stopping is always easy, but restart is fraught with difficulties. How do you restart? What measures to be put in place? How do you assess them? Who do you prioritize to treat? What treatments to restart? These have not been easy even in places where there has been national directive, let alone where decisions were left to individual clinics. In the mid of this are the patients whose hopes have been shattered to have the most wanted baby, who are still grieving from the death of a loved one.

As fertility professionals, we will need to provide not only the treatment, but also a lot more emotional support. The need for this along with fertility treatment should not be underestimated at this time.[1]

We now have experience from others who were ahead of curve and have to deal with it, regionally Coronavirus (COVID-19): fertilityservices − gov.scot (www.gov.scot), nationally ARCS-BFS-guideline-Covid-19-version-3-30-September-2020.pdf (britishfertilitysociety.org.uk), and internationally COVID-19 and ART(eshre.eu)

Although everyone's treatment is important, those with unexplained infertility and younger age can wait longer than those with known cause and are older.[2]

To reduce footfall to the clinic, we will need to reduce the number of treatments that can be provided in day or a week, to keep the safety of staff and the patients. Although fertility is very much treatment for couple together, at this time, there will need to be a case of individual attendance unless necessary. Not ideal but, for wider good everyone will need to sacrifice.

We need to change the way we provide treatments. How many tests do we really need to determine what Ovarian stimulation is needed? When we look at the evidence from international guidance, the answer is clear − not much really.[3] We should practice minimal mild stimulation to prevent Ovarian hyperstimulation and hospital admissions.[4]

Use of telemedicine has really advanced in last 12 months and is here to stay. How many times we need to monitor? There is no evidence that multiple monitoring or changing regimes in between really improves live birth rate. We need to minimize monitoring and limit to days where it can make a difference.[5] Home monitoring should be performed using LH kits rather than blood tests in clinic as it is equally effective.[6] This is the time to put this in practice if not already carried out so. Reducing the travel to clinic and exposure of patients as well as safety of staff will be paramount. We will be surprised how much little we really need to interfere!

Add-ons should not be used, at any more so at this time Treatment add-ons with limited evidence | Human Fertilisation and Embryology Authority (hfea.gov.uk). Plain simple fertility treatments that are evidence based and minimize treatment burden both in terms of costs and side effect will be the way to progress.

Vaccines should continue and not delay the fertility treatments (https://www.britishfertilitysociety.org.uk/wp-content/uploads/2021/02/Covid19-Vaccines-FAQ-1_3.pdf).

Another aspect of restart will be training for trainees who have time-limited training, more than 12 months (i.e., over 33%) of it has been just been pandemic. How we support our trainees so that their training is neither prolonged nor the standards are lowered especially for surgical training (RCOG Training in gynaecological surgery recovery plan).

Research is going to be integral for this stage. Consistency and uniformity in routinely collected data will help in giving quick answers to what is working and what is not working for simple things such as when to test someone

for COVID, during Ovarian stimulation. Communication to support rather than compete within professionals to learn from best practices will only improve the patient care.

A national effort will be ideal so that there is consistency. There is a real need for all professional societies in India to get together to agree on national guidance. If this pandemic has taught us anything that is: *Until everyone is safe no one is safe irrespective of race, ethnicity and Socioeconomic status.* Let us harness this in real life from now on. And work together for greater good rather than competing among ourselves.

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Abha Maheshwari

Aberdeen Fertility Centre, Aberdeen, Scotland, UK

Address for correspondence: Abha Maheshwari, Aberdeen Fertility Centre, Aberdeen, Scotland, UK.
E-mail: abha.maheshwari@abdn.ac.uk

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