The last decade has seen lots of advancements in the field of reproductive medicine. Apart from these changes, concepts are also changing. The purpose of these changing concepts is to improve conception rates, decreasing complications like OHSS and multiple pregnancies. Some of these concepts are really useful in achieving a better pregnancy rate and decreasing complication rates, at the same time making the program cost-effective by minimizing the number of fresh stimulated cycles and more and more frozen transfers, giving a better cumulative pregnancy rate. The major questions, which need to be answered, are we prepared for these changing concepts and putting them in practice and are they applicable to all cases or to be offered to selected patients. Two of these concepts are blastocyst culture for all and vitrification for all policies.

Blastocyst culture becomes a logical choice as it provides selection of better quality embryo with enhanced implantation potential, ensures genomic activation, and selection of an embryo with better survival potential; however, it remains debatable whether cumulative live birth rates are significantly improved when compared to clevage stage transfers. There are also concerns about the high cancellation rate, the risk of premature delivery, large for-date babies, and the increased risk of monozygose twins. In spite of these concerns and limitations of extended culture, the number of blastocyst culture is increasing globally. But concept of blastocyst for all is fiercely debated and currently consensus on blastocyst for all is still not reached. So what should be the strategy in clinical practice. We know that blastocyst culture requires a reliable culture system and a proven vitrification program.

Extended culture in women with very few embryos incurs the risk of either having no embryos for transfer in a fresh cycle or cryopreservation for future use.

It is suggested to improve the culture system, develop a robust vitrification program, and individualize the decision-making on the basis of the age of the patient, the number of good-quality cleavage-stage embryos available, and the growth rate in the treatment cycle.

This approach will help in decreasing the cancellation rate, improving cumulative pregnancy rates, and reducing the complication rate. We also need to have more data on perinatal outcomes in the blastocyst cycle so an informed decision can be made. The ultimate aim of any IVF program should be having a full-term singleton, healthy baby in the shortest possible time at an affordable cost.

Another changing concept in discussion is vitrification for all. Should we switch over to this concept? Is it really beneficial to all patients? What is the cost implication? Is it possible to practice in the current scenario? Are there any concerns? What is the acceptability from a patient's point? Are we having enough evidence in favor of vitrification for all? These are some of the dilemmas that need to be answered before the concept is fully implemented. Advancement in cryobiology/vitrification, good survival, improved pregnancy rates, a more physiological environment in an unstimulated cycle, and no risk of OHSS are some of the points in favor of vitrification for all. On the other hand, cryopreservation is not completely risk-free. Survival is not guaranteed, is there an increased risk of congenital malformation? Large for gestational age (LGA) is known to be associated with cryopreservation. Moreover cost-benefit analysis and patient's convenience are not in their favor, and most patients prefer a shorter time to the outcome.

It is clear that some subgroups of patients would greatly benefit from a freeze-only approach, and we should all be encouraged to recommend it. In the era of (personalized) medicine, we should stop following a one-size fits all approach, and applying this approach to ALL patients may be considered premature.

Freeze all policies may not be beneficial for all patients, and clinics should avoid blanket "frozen is best" policies. Egg numbers should be considered when recommending frozen or fresh embryo transfers, advantages in using fresh embryos, as there are fewer cycles of hormones and less waiting involved. Freezing can also lead to another 1 or 2 months of waiting, which can be emotionally draining for patients. So the current strategy should be based on current evidence; it is reasonable to recommend a freeze-all approach for patients at risk of developing OHSS, PGT for genetic testing, and premature elevation of serum progesterone. Finally, it is suggested that an individualized approach is needed rather than a "freeze all" protocol which considers clinical parameters, embryological outcomes of that cycle, and patients' characteristics.

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