COVID19 Pandemic - Impact on Pregnant Women and Those Seeking Infertility Treatments

Currently, very little is known about the impact of COVID-19 on reproduction and pregnancy. But as the COVID 19 pandemic began to affect lives around the world, out of an abundance of caution, the ASRM task force released a mandate on March 17th, 2020 recommending fertility clinics to suspend all new infertility treatments, cancel embryo transfers, and suspend all elective surgeries. Almost a month later, in an update#2 released on April 13, the ASRM states “While it is not yet prudent to resume non-emergency infertility procedures, the Task Force recognizes it is also time to begin to consider strategies and best practices for resuming time-sensitive fertility treatments in the face of COVID-19.”

We are talking to reproductive endocrinologist and virologist Dr Cindy Duke of Nevada Fertility Institute and infertility specialist Dr Aimee Eyvazzadeh (The Egg Whisperer) to learn about the rapidly changing recommendations in this field, how the patients are getting affected and the future landscape of infertility treatments.

Full Transcript:

Shweta Mishra: Good evening, everyone and welcome to Cure Talks. This is Shweta Mishra, your host. And today we are talking about the impact of Covid-19 pandemic on pregnant women and those seeking infertility treatments with our eminent experts Dr. Cindy Duke and Dr. Aimee. Dr. Duke is a reproductive endocrinologist and clinical Assistant Professor at the University of Nevada, Las Vegas, and she is also a PhD trained and research award winning virologist whose work has centered on the interplay of viruses with the human immune system. Dr. Aimee on the panel is a Harvard-Educated Board-Certified OBGYN specializing in reproductive endocrinology and infertility. She’s one of America’s most renowned fertility doctors, famously known as the “Egg Whisperer”. I welcome you to Cure Talks. Dr. Aimee and Dr. Duke. It’s my pleasure to have you both here to talk about the care of those who are already pregnant in Covid times and clear the air around the ASRM updates, on the care of patients who are in the middle of infertility treatments something that all who are fighting with infertility are really confused and worried about. On the panel to guide the discussion we have our infertility Patient Advocates. Amy Schmidt Zook and Valerie Landers. Amy is an emergency medicine physician who has personally struggled with infertility for five years and has had her current treatments put on hold during Covid and Valerie Landis has been working in the Women Health Care field for the last decade, focusing on guiding women through the complexities of fertility decisions. I welcome you to the show Amy and Valerie and thank you for joining the panel today. Before we begin I would like to tell our audience that we will be discussing questions sent in via email in the last few minutes of the show. So, you can email your questions to me at shweta@trialx.com or post them on the page where you are listening to the show right now, and we will answer them based on the availability of time. So, I’ll begin with you Dr. Aimee. As the Covid-19 pandemic began to affect lives around the world, out of an abundance of caution the American Society of Reproductive Medicine the ASRM task force released a mandate on March 17th, recommending fertility clinics to suspend all new fertility treatments, cancel embryo transfers and suspend all elective surgeries. A second update was released on April 13th and recently on April 24th update number three was released. So how has the advisory changed since this whole Saga of the Covid-19 outbreak began in January and what has been the most important concerns of the ASRM task force framing these advisories. I would really appreciate if you could take us through the summary of the first two mandate and the highlights of the new update number three for our audience.

Dr. Aimee Eyvazzadeh: Absolutely. So, the first update as you mentioned around March 30th

recommended suspension or putting on pause all new treatment cycles including for example, ovulation induction, IUI, IVF including retrievals and frozen embryo transfers as well as non-urgent embryo and egg freezing and a strong consideration for canceling all embryo transfers regardless of whether they are fresh. We need to have continued care for patients who are almost at the point of their egg retrieval for obvious reasons because of Medical situations that can occur if you're in-cycle, very swollen and you need to retrieve those eggs. They also recommended suspending all elective surgeries and non-urgent diagnostic procedures and to minimize all in-person interactions and to increase utilization of Telehealth. And the reason for that was because we didn't know what was going on. And there was this principle out there among all doctors, that we need to protect the public health of our patients and our communities and we know from stories out of Italy and Spain that there were shortages of PPE and fertility clinics were loaning ventilators to hospitals. And because we just didn't know what was happening at the time, it is very understandable that the task force made these recommendations and recommendations were made based on the principles of public health. Then there was an update on April 13th, my take away from it was that they recognized that——care was an essential service, but they still strongly recommended putting a pause on treatment. And then the latest recommendation which was a beautifully written document, April 24th, really outlined in very careful way how clinics can start providing care and a very appropriate way based on what's going on in their community. So, they basically gave us a very nice document that gave a risk assessment, outlining which patients we should be taking care of, how to mitigate risk for our staff and our patients as well as how to physically distance, sanitize surfaces in our own clinics. So, this allows physicians such as myself to resume caring for patients who need this essential care. So, it was a very nicely written document. I'm so happy to have had it and it's something that patients can read online as well.

Shweta Mishra: Sure. Well, thank you for that comprehensive overview Dr. Aimee. That was really very helpful. I will now move on to Dr. Duke. Dr. Duke some studies quote that viruses rarely cross the placental barrier and in utero-fetal viral infections are rare. I wanted to ask you, in the past have we seen viral infections that have been fatal for a pregnant mother and the developing embryo and how is this Corona virus- SARS Covid-II different from them in terms of virulence? And what are the chances of the fetus getting infected with Covid if the mom is infected? Have we found something new over the last couple of months? Have we been able to gather some data on this?

Dr. Cindy Duke: I think the first thing that I'd like every single patient who is out there to hear is that to date there has not been a single reported case of a baby becoming infected of fetus while mom is pregnant, if she were to become infected with SARS-Covid-II. Now, there are many concerns out there about viruses, viral infections and the proverbial question is, can a virus cross the placental barrier and the short answer is yes, certain viruses can. SARS scope-II does not appear to be one of those and in fact, the coronaviruses as a family of viruses are not known to cross the placenta. Now there are viruses though that cross the placenta and those include measles, mumps, Rubella, HIV, some herpes viruses can cross the placenta. And so those are the viruses in particular that we emphasize for moms, are cytomegalovirus is another one. Well, we recommend that the person who will be carrying the pregnancy should be vaccinated and have a robust immune response to these viruses before pregnancy so that their immune system can then protect the growing pregnancy and prevent that virus from crossing the placenta. However, SARS Covid-II is not considered one of those viruses and indeed so far when you look at the research that's coming out there is no report of a single fetus in utero being infected. Now there are some studies that suggest that placenta may be infected but not actually crossing the placenta to the embryo. I have some theories about that one is the primary way that this virus infects is via respiratory tissue. And so, fetus doesn't get its oxygen from breathing. As a matter of fact, if respiratory system, isn't really developed until just before birth, so the cells that the virus typically infect are not developed in a fetus. I really wanted to share that to give further reassurance to those who are listening about the public genesis and how this virus is ————.

Shweta Mishra: Sure. Okay, to my follow-up question, have we found in over the last couple of months some data that we did not know two months back from new studies or something?

Dr Cindy Duke: Well, there are a couple of studies that have come out so far that have been giving us a number of reassurance as it relates to the pregnancy and those who are attempting pregnancy. So, today we

know that there are no viral particles, meaning no evidence of virus in breast milk nor is it in semen and it's not in the testicle. That's really reassuring because for many people even in infertility patients, while their treatments were paused were still attempting to try to conceive from home. That would have been a concern. And so that was reassuring information to receive. In addition, there does not appear to be any evidence even in embryos that were tested, infection of the embryos. And so that's also reassuring. So, while it's still a new virus for us we only learned about it back in December. Remember gustation is 9 months. So far all of the interaction that we're seeing is very reassuring in general. Now, the one group of women that were concerned about are those who have underlying conditions such as diabetes or those who may have developed diabetes during pregnancy, high blood pressure and that may increase your risk for developing Covid-19 severity of illness versus someone who does not have that underlying issue.

Shweta Mishra: Sure. So, Dr. Duke, what suggestion would you give to patients who are pregnant and having flu like symptoms and how would your advice be different for them in these Covid times compared to if someone was pregnant and had a normal flu in Pre Covid times.

Dr Cindy Duke: Yes, my advice is actually very similar, which is the first thing to do is call your doctor, use telemedicine. Flu as an influenza and Covid-II are highly infectious and transmissible. And so while I would want both patients to be evaluated, I would really encourage them first to call their doctor go over the symptoms so that the doctor can determine the best place to send them. They need to be evaluated but the doctor can determine where they need to be evaluated. I will encourage that patient to wear a mask before leaving the house so that they protect themselves but also others from their potential infection. I would reassure them the good news is the sooner you determine that you have flu symptoms, the better it is to call your doctor particularly if it turns out to be influenza. Because we do have effective treatment for influenza if we can initiate it early. There are medications that we can prescribe and so if you're having flu like symptoms, I would recommend call your doctor right away if they can see you via telemedicine that would be ideal. But, you know many times depending on where you are in your pregnancy, if you're in your second and third trimester they may also want you to come in so they can assess how the fetus is doing.

Shweta Mishra: Absolutely. Thank you so much for that advice. Dr. Aimee coming back to you. So, I wanted to ask when this whole thing starts to come back on track and I believe many states have decided to start their infertility treatments, starting May 1. That is today. Yeah, of course it is not clear up to what extent but what special precautions will be needed going further while undergoing procedures like XE to ensure the safety of the embryos being formed. Because I'm sure as much as we all will be happy when infertility treatments get back on track. We will also be worried about the safety of the embryos, the safety of eggs and sperms and storage. Can you comment on that?

Dr Aimee Eyvazzadeh: I can and that's a very common question I'm getting. And how do I know that my embryos won't catch Covid and I can reassure people and tell them they won't and there are studies just like, Dr. Duke mentioned that are now published. I can share with you a study that looked at the virus and semen and they have not found any. So, we know it's not going to be in sperm because they've also done testicular aspirations and I feel sorry for those guys who went through that. But I guess it's for a good cause because it answers that question. And so as of course we don't know everything but it doesn't seem like the embryo can catch it. We know that from other things like HIV for example. So, you take a single sperm cell and you inject it into the egg. The embryo does not then carry that disease HIV.

Shweta Mishra: Okay, cool. Thanks for that answer. It definitely is reassuring for many. With that I'll just now move on to our panel questions and I'll invite Amy now. Amy Schmidt Zook is an Emergency Physician who herself is struggling with infertility and she is currently now leading a support group of over 1600 physician women with infertility and recently started the Infertility Advocacy Alliance to promote action based advocacy for infertility. Amy you are on. Please ask your questions.

Amy Schmidt Zook: Hi, I just want to say hi to Dr. Aimee and to Dr. Duke and we appreciate your time. So, the first question for Dr. Aimee is that I'm hearing from some of the physician women that are in the support group with me, they are concerned that going forward with their treatment might be put on hold due to their

work with high-risk Covid patients. Those kinds of doctors, nurses, techs that on the front line. Is there a different type of guideline that addresses frontline workers or are they using the same kind of risk profile for those as they are for patients that aren't in medicine?

Dr Aimee Eyvazzadeh: Oh, hi Amy. I love that I get to talk to you and I feel like I should be calling you. Dr. Amy too if you're going to call me Dr. Aimee I will call you doctor Amy back. Every clinic is going to be different and I do assure that is a concern, that some clinics will be prejudice against patients or physicians, nurses, techs working in the ER, are exposed to potentially high-risk patients and that is the reality. I've seen the questionnaires at some of the Clinic's put out there where the first three lines are, the questions like do you work in a hospital? Have you been exposed to a Covid patient? And if your answer is yes, you may not be allowed to move forward with treatment. I think that's a real concern and patients need to ask their Clinic what they can do to potentially still move forward with treatment or find a clinic that will help them. And we know there is test that you can do the hospital right here next to me, they do Covid test. I get a 24-hour turnaround time and that is potentially one strategy that clinics can use to test their healthcare workers. They feel really comfortable helping those people. I feel like it is incredibly unfair for these people who have put their lives on hold and are helping people in this pandemic. Then also, tell them they have to put their family goals on hold. I just won't do that for people but I can certainly understand why that's concerned and I haven't seen a guideline out there yet. I feel good.

Dr Cindy Duke: I feel the same way.

Amy Schmidt Zook: Thank you. Dr. Duke. I appreciate that. I know it's a huge concern for some of the doctors, like I said they are worried that, should they take a leave of absence or how are they supposed to now fit this in on top of everything else? It's just really confusing for them personally. The second question I have is when the guidelines first came out, the initial thought was to help to flatten the curve, let everybody catch up, get PPE, make sure that the hospitals locally don't get overwhelmed. Now, some of it seems to be leaning towards preventing pregnancy and in that vein I've seen that a lot of the REIs are planning to start retrievals with fretzol but are not doing FET's or even at some point to distract appease or polyp removals, which is leaving a lot of the women at a large. Is there data as to why they're picking or some clinic for picking one versus other or Is that just a personal risk assessment? How do you feel about limiting it to freeze all cycles for patients at this point.

Dr Aimee Eyvazzadeh: Yeah. I mean the way I think about it is to freeze all cycles you're limiting the in and out of patients in and out of the practice, right? So, if you're doing a fresh Embryo transfer you will screen that patient for her pregnancy. Obviously, a transfer after the egg retrieval, her pregnancy test and then her OB ultrasound. So, there's more in and out of patients from your clinic and I get it maybe in certain part of the country that's less desirable. But I personally feel like American College of OBGYN has not come out and said that women should stop trying to get pregnant in this country. So, it's incredibly unfair in my humble opinion to not allow women to do an embryo transfer, if the patient and doctor think that it is safe. We know if fresh embryo is transferred after IVF, sometimes patients can be at higher risk of things like ovarian hyperstimulation. Especially if you're transferring two embryos, that carries risk of a twin pregnancy being at higher risk. So, I feel like you should do what is lower risk. You make a sensible decision for yourself? Don't let the pandemic put your fertility goals on hold. And move forward with your plans if you and your doctor thinks that it's right for you. As far as polyp surgeries again is the same thing, depending on where you live, some surgery centers are not in a big hospital setting and then they're allowing patients to do a polyp removal, so that you can move forward with an egg retrieval on a transfer. I do think doing that right now in the current environment that we're in with Covid. I think in my community for example, is very acceptable. So, I am not limiting patients to freeze all Cycles. They still get the opportunity to do a fresh transfer if it makes sense for us. I have a fresh transfer scheduled here soon, and I'm very excited to be able to do that for her and I'm so lucky too because I know that not everyone has the opportunity to do that because of the clinic, the community and government guidelines where they live, but we can in here in the Bay Area.

Amy Schmidt Zook: Okay, fantastic. I mean I just want to say as a patient, that we genuinely appreciate and know that our physicians are doing things with our best health and outcomes in mind. So, I do

appreciate that. And moving on for Dr. Duke. Hello. How are you doing? I am so impressed by everything you said so far. So, I genuinely appreciate you being here. What is the most recent evidence for outcomes of Covid infections in pregnant women and the fetuses. You spoke earlier that there has not been an infectious fetus or a new born that you have seen other than the placental data. I guess throwing in there the same time, why do you think that there is not more data from other countries where this has been going on for longer. Everybody kind of got together and put out recommendations, but here it's been really spotty and I know some countries we may not have the best relationship with. But through scientific methods and channels, I feel like we should have more. What do you feel?

Dr Cindy Duke: I agree the data so far coming out is limited and preliminary. And again the first is because if we think of a gestation it's nine months. But even if we think of the first hardest hit place, which is Wuhan, China. They still haven't had someone who's conceived and gone through an entire pregnancy in the age of Covid-19 yet. So, so far a lot of the information that we're seeing either has to do with what's happening in the third trimester and data related to the few miscarriages that seems to be related to someone's Covid-19 infection. What I would say though is all the information that's coming out so far including preliminary data now from the United States and New York City in particular, which is especially hard hit as we know, the data is favorable. So, what we know first and foremost is pregnant women are not at any more increased risk for becoming infected with the SARS Covid-II virus when compared to other women in the general population who are not pregnant. Secondly, we know that generally, healthy pregnant women also do very well even if they became infected with Covid. The numbers that end up in the Intensive Care Unit or requiring ventilators to help them breathe are really low. So, far the case reports that do show the most severe in terms of morbidity happened to be who we would have expected based on the general data, which is women with underlying health conditions like diabetes etc. In terms of the when the baby is born, the neonates are doing really well. We're seeing that babies that are born, a few tested positive subsequent to birth. But in those, neonates, they still do quite well. We do see that most people who are infected with the virus and have developed the disease Covid-19 meaning symptomatic if they are delivered the delivery mode tends to be cesarean. But it's not because Covid itself that is requiring a cesarean delivery. It is that usually mom's symptoms, her clinical symptoms, her clinical picture meaning her difficulty breathing, difficulty getting oxygen to herself and the baby can prompt the need for an emergency delivery. One to rescue the fetus but also to help Mom recover sooner. And so, the rate of cesarean are higher in those particular severely ill Covid stations. But there are many patients who are coronavirus positive, for delivering vaginally. There are babies birthing centers. There's no guideline that says if you're positive for Coronavirus, you're now mandated to have a cesarean. I think it's important that patients hear that because there have been some unfounded rumors being spread that suggested if someone went to a hospital and tested positive, they are going to have a cesarean and that's not true. It's only when indicated and it's important to point that out. But overall the results so far are favorable that said we still don't have a full pregnancy yet because the gestation is, 40 weeks. We haven't really had a lot of it. It has been 40 weeks since we first discovered that there's this virus, and it causes a disease called Covid.

Amy Schmidt Zook: Thank you. That was amazing. Thank you. I am now going to pass it off to Valerie for her questions to you guys.

Valerie Landers: Hey everyone. Thanks so much for joining the call today. I have a couple of key questions. Dr. Aimee if you don't mind going first. It's a really confusing time right now with patients and having mixed messages. So, what are some key actions or activities patients can do to stay safe while trying to get pregnant either at home or the fertility clinic if they are open in their area. What are some key things that they can do to actively get pregnant and stay safe at the same time.

Dr Aimee Eyvazzadeh: I think that following the guidelines of whatever city or county or state that you're in is really important. It is a confusing time. There are patients who are on treatment, they in a fertility fog or estrogen fog when you're on hormones. And now on top of that a lot of patients are in a Covid fog, everything just seems so confusing with what we're hearing. But as far as how to stay safe while trying naturally is concerned. I just feel like it's important to talk to your doctor and they know you and if you have a higher risk because of your medical problems or the work that you do. When you consider trying naturally

right now then stay with your fertility doctor. Talk to them about your age, your fertility levels and if it seems like it makes sense to maybe wait a couple months to do so. And if you're certain here in your own situation, then talk to your doctor about when to time sex, how to monitor ovulation. For example, should you take progesterone as another example. So, there are things that you can do at home as you wait. In this very first rating I know to hear when you're hoping for something that will give you a much higher chance of pregnancy like idea but there are certainly things that you can do to still try and get pregnant at home. Stay safe with the help of your OB GYN or fertility doctor. Some of the things that I'm doing right now for patients who are quite ready to do ideas that they want to but were on pause. For example, prescribing fertility pills and then they are trying at home.

Valerie Landers: Great. Thank you for that help. Dr. Duke. If a patient or their partner test positive for Covid-19 and they contracted either now or in the future. Does that impact their fertility and how long after a positive test should they wait to anticipate trying to get pregnant if they aren't currently pregnant?

Dr. Cindy Duke: At present, we don't have any evidence that suggests coronavirus or SARS scope II infection causes any negative impact on say your egg towns or your fallopian tubes or your womb or sperm. We don't have such evidence, but I also have to be honest that no one's directly looked at that yet. But I would tell you knowing what we know about the family of coronoviruses in terms of MERS which is Middle Eastern Respiratory Syndrome and SARS which is Severe Acute Respiratory Syndrome both of which were troublesome and scary back in the early 2000s. We did not see any negative impact from those infections on sperm count etc in the long-term. Now in the short term, if someone is sick, when your immune system is the fighting off a virus, your body basically tends to the decide I have to delegate system here and so reproduction sort of falls back in terms of the priorities for your body. And so in the short-term once someone said for example, a guy, his sperm production may drop and so he may see that with a temporary fall in sperm count and maybe two to three months following infection. And so, he may have a temporary drop, but it is expected to rebound once he's better. We see that with generally any viral infection including the flu or the common cold. You may see increased white blood cells or immune cells and the semen sample, for example, while the person is sick or still fighting off the infection. But usually once the infection is cleared and the testicles are back into the top priority. For reproduction the sperm count bounce back and for guy he is ready to go again. For women we've never truly seen a direct impact on viral infections and egg counts. And that's because as we know your eggs are formed before you're born. So, they're not actively dividing either in terms of the cells. And so usually again, we recommend those getting better. We know that the viral particles can be in saliva. And so, if you are positive or your partner is positive you want to practice much social, physical distancing as you can and precautions. But once you're better and your test of cure being either serology or your nasal pharyngeal test are negative, then you should be clear to start again. Certainly, at my clinic that's what I'm doing with patients who previously tested positive or had a high exposure. I'm testing them before we proceed with treatment.

Valerie Landers: Great. Thank you. Dr. Duke, Dr. Aimee. Are there some good tips for patients to get through this difficult time? Whether they're either dealing with depression or you know due to the pandemic. Are there those key things to stay mentally strong while they wait for the pandemic and be able to start treatments again. If their clinic or area isn't allowing that at this time. Do you have any key things they can do while the pandemic is going on and they're sitting at home to be able to cope with the crisis?

Dr Aimee Eyvazzadeh: Absolutely and this is what I use in my daily life. I mean being a fertility doctor isn't just filled with happy phone calls. There are feelings with a really stressful situations all day long and trying to help people cope with some of the hardest things that they've ever faced. So, some of the things I tell my patients and it sounds really cheesy and lame, but I'm going to tell you anyways because what I think is important for people to know is to have a happy place. I mean literally find it so that whenever you're feeling really anxious and desperate you just signed a peaceful place you can go in your head because these excess thoughts that come in. That it's the end of the world. I'm never going to get pregnant, why me? why now? You got to replace it and you got to find peace. I tell my patients you can't let infertility take away your joy and you sure as heck can't let the pandemic take away your joy either. So happy place. The next thing is a fight song So find music that invigorates you, get a nice headset. Find some streaming service that you

really love and just dance and that's a tip that I give my patients too. And then the other thing is find a mantra. So, pick a phrase that works for you and you go online like positive quotes, Google it and find a quote that really resonates to yourself, that you can just repeat and repeat and repeat until you don't have to think about. It just automatically comes in your head. And then the other thing is talk to people. I mean at least one to two people a day. Don't just click like on Facebook. Don't just like an Instagram post. Really connect, take the time to do a video call at least one or two a day so that you're feeling socially connected with people. Find someone who will just listen and not judge and be like, well, what about all these other people in the world? You want someone to say it's okay to feel bad about what's going on in the world and it's okay to also feel bad about what's going on with you. So those are the things that I tell my patients and I think that they help people. And of course, moving and exercising and being outside if you can wherever you live is really helpful too.

Valerie Landers: Thanks, Dr. Aimee. That's really helpful advice, especially when you see pregnancy announcement or happy other events happening during this time. Patients are struggling with the same problem they've been may be struggling with for, privately or publicly for some time. So, thanks for the advice. Dr. Duke we've talked a lot with you about if patients are positive and if there's any reoccurring with their partner testing positive. But can we talk a little bit more about if the virus can be passed on to the baby. If there's risk from pregnant women that are already pregnant getting Covid. What that could do to their pregnancy or if they should postpone their care for a later stage or what your recommendations are regarding the outbreak?

Dr Cindy Duke: I would say my biggest recommendation is try to avoid becoming infected which means wearing a mask whenever you are outdoors. Practicing physical distancing if you are pregnant and work in the high-risk zone such as a healthcare worker. I strongly encourage what the CDC has recommended, which is talking with your supervisors to minimize your exposure. Perhaps taking you away from direct patient care, if that was possible. I know for some of our pregnant doctors, they're the only Specialists or experts in their area where they are working. But if it were possible for you to have backed up then maybe removing you from direct patient care during this time will be strongly recommended. And that's because mostly about what we know as —— Relates to the pathogenesis of the disease process of Covid-19 and it's manifesting differently in different patients. We do not yet understand fully what it is about certain patient's medical history. Maybe that prior infection histories that lead to them having exaggerated response to the virus. And so, if you can avoid it altogether that would really be the best. So, if you can maybe be switched, like I said, if you're high risk, can you tell it's from you? Can you maybe if you are healthcare worker instead of direct patient care? Can you go to something that's more administrative etc where possible? But other things that you can do would be again, if you think you're having symptoms. Calling your doctor right away, getting that testing done, having the fetus checked out with a non-distress tests etc. Depending on where you are as a pregnancy those are the precautions. Other precaution, I would say is if you live with someone who is high risk for exposure and or infection considering physical distancing even within your own social or home situation that helps to decrease your risk as well. Other than that, taking care of general health. If you have underlying diabetes, underlying heart disease, blood pressure issues. Now is the time to make sure you're checking your blood sugar, taking your medication, taking your insulin if it's prescribed. This is the time to be really diligent. Especially about your underlying medical health taking your prenatal vitamins etc. as a preventive measure for shoring up your own immune system.

Valerie Landers: Oh, that's great advice. Yeah, it's those little things like your fertility meds and vitamins and smoothies are good things to do at home. Since you are at home or safe at home.

Dr. Cindy Duke: I'm sorry. One more thing quitting smoking, if you smoke.

Valerie Landers: Yeah, that's very key. Right. It seems pretty basic but those would be the key things we would do to get pregnant in normal circumstances, not just an epidemic like the Covid-19 struggle. But Dr. Aimee are there any pros and cons that you would suggest or talk about for IVF and fertility treatments, since they are being reconsidered as non-elective and more essential medicare. Medical care that's being done right now to clear up any confusion on what are the pros and cons.

Dr Aimee Eyvazzadeh: Well, I mean the pros right now is that people don't have to tell their bosses because everyone's home. I mean, that's the pro. I mean a lot of my patients are so happy. They're like, this is the best time, it's almost like my teachers who are on vacation for spring break or the summertime like they're so happy that they don't have to allow the treatment to interfere with their work schedule. So, the cons of the treatment are just the lot of clinics they're just not allowing partners, support people inside the office and that's really stressful for some people, where they really like to have that person there for them and I get it. So that's the biggest con right now is just having support people. I think that's probably the main con, of course the biggest con of all is that not having access to all types of treatment that you need at your clinic because of the limited resources potentially that are there.

Valerie Landers: Great. Thank you. And Dr. Duke, for those struggling or possibly losing their jobs at this time. Is there any financial resources that you know of or ways that patients can cover for example, they lose their health insurance that may be covered fertility benefits? Or any suggestions that you would have the patient's help for the clinics during this during this like extraordinary time.

Dr Cindy Duke: Yes, so one of the first things I would say is if you are furloughed or losing your job, there's something called COBRA, but you should look into first of all where you can usually extend your fertility benefits, your health benefits by up to 90 days. It may have some out of pocket cost but might be a way to help you complete your fertility treatments before your benefits are gone. If you had fertility benefits through your employer, so that's one. The other is if you're in the job market, there are number of employers out there, way more now than even four years ago, who currently provide fertility benefit. And so, if you're someone for whom cost, and affordability is a concern I would encourage you to inquire about the benefit package and whether fertility benefits are part of the benefits package. I would tell you for myself, I have patients who call in and ask me what are the facility codes because there's a special code, that we have to spend to insurance in order to get fertility services covered. So patients take those codes and contact their potential future employer for example, or if they're in the market of insurance and say can you find out if my plan the proposed plan for me will cover these codes or are there other plans available that I can consider that will cover these codes. So that's one but they're also grants out there. And so there are number of funding agencies, number of nonprofits that have grants and those range from some that are specific to people of certain religious background, to people of certain ethnic backgrounds, and then for those who have different economic situations. And actually I have a resource book coming out next week. It's an e-book and it has an entire chapter all about this and will have of this information as well. I encourage people to look into it. Because yes, this is a concern we have up to 30 percent of people in some jurisdictions across the United States who are no longer working and so affordability and insurance benefits may be a concern but there are lots of options to consider.

Valerie Landers: Great, and I think there were a couple of pharmacies that were having rebates and or refund on any cancelled cycles that happened in March and April due to the COVA shutdown or the government shutdown. So, I think looking into those would be helpful as well. Any final thoughts. Dr. Aimee, or Dr. Duke about key things that patients should be thinking about at this time.

Dr Aimee Eyvazzadeh: Well, I think it's a great time to regroup with your fertility doctor and come up with a plan. But there's no better time than now. A lot of patients are waiting for their clinic to call them but I can tell you that everyone is really busy. Even though the clinic might not be full of patients, in the way it used to be. They are very busy planning things out to make things safe for patient. So, it's important to reach out to them. So, don't feel like you're bothering anyone by reaching out. There's no better time than now.

Valerie Landers: Thank you.

Dr Cindy Duke: Keep in mind that some clinics also are working with decreased staffs compared to usual. So honestly, I agree with what Dr. Aimee said, contact your clinic, email them, call them. I don't think they'll be upset to hear from you. They want to hear from you. Also, this information is changing fast. If you come across information that you're not sure about, contact your clinic and ask what's your thought on this? How are you coping with this particular issue? Is it real? Is it not?

Valerie Landers: Great. Shweta, I'll pass it back to you.

Shweta Mishra: Thank you. Amy do you have further questions for the doctors.

Amy Schmidt Zook: Sure. I have a few more if we have a little bit of time. So, for Dr. Aimee, I think last week was a big week and this week has been a big week for clinic re-openings and we are overrated that we've been able to resume fertility care here but a lot of barriers are location dependent and there are still guidelines that need to be followed. How much longer do you think it will be until we can kind of get back up and running, a hundred percent. Getting everybody and we have younger patients, they're not say 43 with really bad ovarian reserve like somebody over here. But they're 32, and they have a bad ovarian reserve and they although may not be critical. It is very tough for them to wait this out as well.

Dr Aimee Eyvazzadeh: Absolutely, doesn't matter this situation is really hard. So, I would say July, August, September is when most clinics will probably be up and running. Specially for patients who have younger donor egg cycles. Some people in June, less in May. The reason why I'm giving an end point because we just don't know what is going to happen in the winter months, with influenza. Is there going to be another surge of cases? That's why plan your cycles over the summer as much as you can. That's what I'm recommending to people.

Amy Schmidt Zook: Okay. That makes sense. I know that you've definitely heard that, if Covid would resurge, people are very afraid that the shutdown will happened all over again and that's very concerning in trying to get things restarted. Hopefully that doesn't happen. What you said is great advice. For Dr. Duke, the thing that I hear a lot, from women that have been affected by this is that all pregnant women haven't been told to stop trying and there's not even an announcement such as there were because, this is dangerous for all pregnant women. Why are fertility treatments being put on pause? And that is somewhat discriminatory towards women with fertility versus those without.

Dr Cindy Duke: I don't think the initial guidelines were discriminatory, I actually do agree with Dr. Aimee and the task force that in that very moment because healthcare system was being overwhelmed. We had an extreme shortage of resources. We also did not have very clear data on how infectious this virus was, how infectious it was across different patient population and also how dangerous it would be for patients if they were to develop complications from their fertility treatments and needed to go to the hospital. So, as physicians we do have ethical responsibility not just to the patient but to ourselves, our staff and the community at large. I think the revision made so far to the guidance and the guidelines also make sense. I think it should be patient, doctor and region based. Because we are seeing that some regions are more hard-hit than others. Some regions have more access to resources than others. Separate from the fertility issue, I do think it shouldn't be that case. We should all have equal access but that is not the case right now. So, if the prevalence of the disease has dropped to a point where not that many people are being exposed to the virus anymore. If we're seeing good compliance and adherence with in different regions, that people are following the safety guidelines even practicing it at the clinic. If the clinics can get ahold of testing, so they also have a way to quickly determine both positive or not. I say, it seems safer to move aboard. What's the caveat though? Because some patients who are truly high risk for Covid-19, even though they're younger, even though their reproductive age. We do have some patients. I have some patients who have underlying medical issues that I personally call them and recommended that we wait out a couple more months until there's a better handle on the infection rate and a better understanding of the medical treatment options. So, that if that person were to become infected their options to help preventing them from getting very sick. So, I wouldn't say it's the story but I am concerned that some Clinic might be feeling that the hands are so tired that they must get a complete clearance from ASRM. As opposed to what is around this thing, which is look at your individual region, look at your patient population, council your patients on what you know, and what we don't know. Because there's still a lot that we don't know but there's a lot of reassuring stuff that we can counsel patients on as well.

Amy Schmidt Zook: Okay, that sounds great. I think that you bring up a wonderful point that there are going to be patients, unfortunately that are high risk and we are all so different in our needs and in our

esterification. So, I appreciate your point of view. I will hand it back over to Shweta to ask any questions or move on with the program.

Shweta Mishra: Sure. Thanks a lot Amy. It was nice listening to your discussion with Dr. Duke and Dr. Aimee. Dr. Duke, Dr. Aimee we have a couple of questions coming in that are posted on our page. I'll just read it out for you both to answer. The first one says are fertility doctors looking into highly individualized egg retrieval method for women over 45?

Dr Aimee Eyvazzadeh: Yes. For those who don't know what that means that's related to a type retrieval where basically you're retrieving eggs that have smaller diameter. So, typically like to grow follicles over 18 millimeters. With this approach, the doctor who published this study in their group finds that they have really good success for women over a certain age when the follicles are 16 to 18 millimeters. I want to tell you, that it isn't that one size fits all. We all could be different. So, what I'm wondering is if this thing really worked for them that does not work for me and I don't think it's fair to say this is the way that all women over 40 should be cared for. I have really good luck getting really beautiful eggs for women when their follicles are triggered at 20 millimeters and they're over 43. I have even retrieved them for women who are 50 and 51. I have made an embryo for women between 49 and 50 mm. They were not normal embryos, and I'm not going to say oh, I should start triggering people at 13 to 15 mm. I do get it that some women are at high risk having a premature ovulation and that's like a really bad thing, when you are doing egg retrieval and there are no eggs. So, I would do that retrieval and take that approach. If the doctor you're using that's their special sauce and if that's what gives their patient success, you want to do that. But don't make your doctor who doesn't believe in that, like don't ask your doctor to trigger you at 13 millimeters because of this study that you read by one clinic, is kind of what my recommendation would be.

Dr Cindy Duke: I agree with that and I would say I echo Dr. Aimee because I have patients also who are under 40 where I had to trigger them a little bit earlier because they were moving so much faster, so much differently. And the converse is true for people over 40. So, the key word here is individualized. So, individualized means not every patient over 40 is going to need this particular protocol applied to them. And it's important to understand that as a patient because your doctor is looking at a gestalt as we call it. They're looking at your overall response or looking at your hormone levels. They're looking at the follicle sizes. They're looking at a number of things plus the medications may be different as well. And so, I would say if it's your first cycle, especially allow your doctor to learn what's happening to you. Sometimes that first cycle is more informative than any paper can ever be for about any patient.

Shweta Mishra: Right. Thank you. Thanks for that answer. The second question says I believe it's from the same person. What are you looking for in women aged 47 to 49 wanting to use OEM and what would you recommend?

Dr Cindy Duke: I'll jump in and I mean for women who want to use their own eggs at 47 to 49. They need to have realistic expectations. That's what I'm looking for. I'm not going to help a woman in 47 to 49 if she thinks that it's going to work. The likelihood of it working with her own eggs is around 0.001% and so its like 99.99999% it's not going to work. But there's so many people that need that closure. They need to feel like they gave themselves a chance so that they don't ruminate about what would have happened if I had used my own eggs. Yeah. So, I think it's very fair for doctors to give patients that option and choice. I think it's unfair to say no, I won't let you because George Kearney can have a baby at 50. But all these celebrities men can and women can't. I think its good for him. But why are we shaming women who are young at 47 and using their own eggs. So, it's just important to have realistic expectations, that's what I'm looking for. No matter what your AMH is no matter what your FSH is. That's what you need and that's the key word managing expectations and also understanding that this may well be foreclosure. And I don't think many patients truly understand that. The other is I sit down with my patients who are this age or over 50 and I ask them to think about one honest question, which is how much are you in terms of able to dedicate to your dream? Because if your goal is a take-home baby and you have a very finite amount of funds to achieve that goal, then we also consider is what is it that this funds will get me? Is it my take on baby or is it closure? So take home baby make more sense.

Shweta Mishra: Right, right. Okay. Thank you so much for that answer. I believe the follow-up question you already answered for her. And we have also reached the end of our scheduled time for the show now. So, thank you so much for your answers. I'll wind up the show now. The Covid-19 pandemic has changed the lives of many in different ways for the folks and the infertility community. They are dealing with added uncertainty emotional upheavals and concerns about when will they be able to resume infertility treatment and when they do so how would it be different from pre- Covid times? We heard Dr. Cindy Duke and Dr. Aimee discuss the changing recommendations and the field and share about the extra precautions that will be needed when we get back to the infertility treatments again. We hope people will be able to get back on their path to family building very soon. Dr. Duke, Dr. Aimee thank you so very much for your time and all the information that you shared with us today. Amy, Valerie and the audience thank you for your participation and your very insightful questions that brought out a very informative discussion today. The talk will be available on curetalks.com. Please visit our website for details on the upcoming talks. Until, next time wish you all well and stay safe everyone. Thank you and have a great day. Bye.