Letter to editor

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To the Editor

We read with interest the paper by La Marca and Nelson entitled “SARS-CoV-2 testing in infertile patients: Different recommendations in Europe and America” published in the *Journal of Assisted Reproduction and Genetics* on 17 July 2020 [1].

We appreciate the authors’ extensive descriptions of the currently available diagnostic tests for detection of SARS-CoV-2 infection, including their strengths and limitations. However, we would like to express our concerns regarding comments made and conclusions drawn that the two main professional societies for reproductive medicine, the ESHRE and ASRM, diverge on the clinical utility of the algorithms proposed to mitigate the risk related to COVID-19 at the restart of ART treatments.

Although the authors mention that both societies recommend a questionnaire-based triage to detect potentially infected staff and patients, the paper then focuses on proving dissimilarities between the two statements (ESHRE, Update 23 April 2020, revised 5 May 2020; ASRM Update #4, 11 May 2020 and #5 8 June 2020). According to the authors’ understanding, while the ASRM recognizes that there is insufficient information to recommend a specific algorithm or testing program, the ESHRE statement incorporates serological testing for clinical decision-making.

Even though there are, indeed, differences between the statements published by the two societies, we consider the

authors’ analyses quite superficial, as they do not take into consideration some crucial aspects.

1. Timing and context of the statements from the two societies. On the date of their publication [2, 3], the epidemiological situation was radically different in the two continents. In Europe, the number of daily new cases was declining in most countries (Fig. 1a), while in the USA the numbers were sharply increasing (Fig. 1b) [4].
2. Sars-Cov-2 testing. The statements from both societies acknowledge the existence of different testing strategies. Regarding the ESHRE document, La Marca and Nelson omitted to mention that the described algorithm was applicable to the safe reopening of centers in a situation where the transmission rate of new cases had started a sharp decline. Similarly, they failed to highlight that the document proposes serological testing in combination with repeated triage questionnaires. More precisely, the ESHRE statement, in full concordance with the ASRM document, stated that “Each ART centre should discuss with the laboratory testing service which SARSCoV-2 tests are available. The laboratory specialists should offer advice and guidance in interpreting the results, acknowledging that no test has 100% accuracy. COVID-19 data are emerging continuously, and both the testing tools and the advice given must be adjusted accordingly.”
3. Availability of Sars-Cov-2 tests in Europe and the USA. Different types of detection assays relevant for COVID-19 diagnostic testing and screening have been developed throughout these months. The use of these tests, especially for those offered by public services, depends on their availability.

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Without consideration of the above points, La Marca and Nelson draw the conclusion that “The failure to appreciate the characteristics and limitations of the diagnostic tests may lead to disastrous consequences for the patient and the multidisciplinary team looking after them.” We find this statement to be gratuitous and offensive to the two societies. More than that,

Fig. 1 Overview of the weekly reported COVID-19 cases and deaths in the USA (a) and European region (b) (reproduced from World Health Organization, 2020)

as we have an excellent reputation in the scientific community, it is indicative of the non-critical reading of the series of comprehensive documents, written by a group of experts appointed by the ESHRE and ASRM. Our working groups reacted to a complex and completely new situation, where the outburst of the pandemic and the different social situations greatly contributed to the geographical diversity.

Being fully aware of the circumstances, the ASRM and ESHRE, together with the IFFS, published a joint statement on 29 May 2020, where the three societies jointly affirmed the importance for continued safe reproductive care during the COVID-19 pandemic [5]. This document, posted simultaneously on the websites of the three societies and published at the same time in their corresponding journals, presents a shared position by providing a ten-point list of recommendations during resumption of clinical services in ART clinics. Unfortunately, La Marca and Scott omitted the citation of this document that was made public before the submission of their paper.

The joint statement recently elaborated with IFFS is just another example of our mutual relationship, specifically

aimed to support our professional colleagues with the most qualified guidance to provide optimal care to patients and staff with minimal risk of infection during all the uncertainties presented by COVID-19.

We are aware of the differences existing between our two continents, but we are also convinced that there is still much to learn about the effect of the virus on reproductive cells, pregnancy and newborns. With our joint statement, we committed to share experience and knowledge by collecting data on pregnancy and birth during the pandemic, with the intention of contributing even more to the wellbeing of patients and staff.

We would welcome the same spirit of collaboration that exists between our societies, to be shared by all reproductive medicine professionals in the common effort to overcome the unprecedented and difficult situation that we are experiencing. We believe that valid reasons are needed before trying to discredit the two major societies in the field of human reproduction, even more so when those societies, the ESHRE and ASRM, have a long story of productive collaboration.

Constructive criticism is well accepted; unsubstantiated accusations are firmly rejected.

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