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Q1 At this year's International Society of Gynecological Endocrinology (ISGE) Congress, which development in reproductive endocrinology or fertility treatment do you believe is most likely to influence clinical practice?

Congresses are important opportunities to connect with researchers, discuss new developments, and share knowledge. This Congress has highlighted developments that will influence practice. We are seeing several important advances that are already beginning to change how we work; for example, there are new medications being introduced.

Traditionally, many fertility medications were given through injections. Now we are seeing alternatives, such as oral medications and other delivery systems, being developed. These changes will likely reduce the need for injections and make treatments easier for patients.

I also believe that developments occurring at the intersection of reproductive endocrinology and reproductive medicine will drive many of the most important changes in the coming years.

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Q2 In many countries, women are delaying pregnancy and starting families later. From a clinical perspective, which factors most strongly determine reproductive outcomes later in life?

Age is the most important factor. It is very clear from demographic data that the age at which women have their first child has increased significantly. In previous generations, women often completed their families by their late twenties or early thirties. Today, many women over 30 years old are having their first child, and sometimes even later. As a result, many women come to fertility clinics in their late thirties or early forties, when fertility has already declined significantly. This creates a major challenge for clinicians.

Menopause usually occurs around the age of 50 years, but fertility begins to decline much earlier. The decline starts in the early thirties, becomes more significant in the mid-thirties, and accelerates further after women reach 40 years. The issue is that many women believe that because menopause happens around the age of 50 years, they remain fertile until then. Unfortunately, that is not the case.

Q3 One solution that has been discussed is egg freezing. What is your view on that and what age would you generally recommend for egg freezing?

I am generally in favour of egg freezing, because it can support women's reproductive autonomy. Women today often delay childbearing for many understandable reasons, such

as education, careers, financial stability, and social factors. Egg freezing allows them to preserve their fertility earlier in life and potentially use those eggs later.

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The important point is education. Women need to understand that freezing eggs at 40–42 years of age is usually too late. By that time, both the number and quality of eggs are already significantly reduced.

For this reason, timing is critical. Ideally, egg freezing should be considered between about 20–30 years of age, when egg quality is generally at its best. After around 34–35 years of age, the number of oocytes decreases, and the risk of chromosomal abnormalities begins to increase more significantly.

In practice, many women may undergo one cycle of egg retrieval and, if the number of eggs collected is insufficient, they may do a second cycle. Having around 15 frozen eggs can provide reasonable chances for success later.

Q4 We know that ovarian ageing varies significantly between individuals. From a biological standpoint, what aspects are still not fully understood?

There are several things we still do not fully understand. For example, in men, sperm production continues throughout life. In women, however, the number of eggs is fixed before birth. After birth, no new eggs are produced.

Women gradually lose eggs over time. We do not fully understand the precise mechanisms behind this process. To give a rough idea: at birth, a girl has around 1.2–1.4

million follicles. By puberty, this number drops to roughly 700,000. The number continues to decline over time until menopause.

Another key issue is egg quality. As women age, the proportion of chromosomally abnormal eggs increases. We understand that this happens, but the exact molecular mechanisms are still not fully known. If we could understand those mechanisms better, it might one day allow us to develop treatments to slow ovarian ageing.

Q5 Do you think public awareness of reproductive ageing is adequate?

No, I think awareness is still very limited. Many women who come to my clinic are surprised when they hear about these changes. They simply have never been told about them.

We now use certain markers to estimate ovarian reserve. One of the most widely used is anti-Müllerian hormone. If anti-Müllerian hormone levels are very low, it suggests that the ovarian reserve is reduced. However, even with these markers, education is still extremely important.



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Education about reproductive health should ideally begin much earlier, even in school. Young people should learn not only about contraception and sexually transmitted infections, but also about fertility and reproductive ageing. That knowledge allows people to make informed decisions later in life.

Q6 If you could change one aspect of fertility care or fertility education globally, what would have the greatest impact?

Education about the realities of human reproduction. Women and men should understand how fertility changes with age, how to maintain a healthy reproductive

life, how to avoid unintended pregnancies, and how to make informed decisions about family planning. This knowledge allows individuals and couples to decide for themselves what they want.

Q7 Another topic discussed frequently is decreased birth rates. How significant is this decline?

Declining birth rates are a major demographic issue, especially in Europe. Countries such as Greece, Italy, Spain, and South Korea are experiencing very low fertility rates.

Assisted reproduction can help, but it cannot solve the problem alone. For example, in Greece, around 6–7% of annual births result from assisted reproduction. In Denmark, it is closer to 9–10%. While this contributes additional births, it does not fully address the broader demographic trend.

Q8 What role should policymakers play?

Governments can support families by creating conditions that make raising children easier. For example: affordable housing, stable employment, childcare support, and workplace policies that support parents. Countries like Sweden have implemented systems where childcare facilities are widely available, even near workplaces. These policies can make a significant difference.

Q9 From the discussions in your congress session, what is the single most important message clinicians should take back to their practice?

Once again, it is education. We must educate both women and men about leading a healthy reproductive life, the biological realities of fertility, the importance of family planning, and sexual health. Once people have accurate information, they can decide for themselves what they want to do. Our role is not to impose decisions, but to provide the knowledge that allows informed choices.

